

Culture, health and well-being

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Introduction

In the 1970s, I spent two years travelling overseas – through Africa, Western and Eastern Europe, the Soviet Union and Asia. The most difficult cultural adjustment I had to make was on my return to Australia. My initial celebration of the material abundance and comfort of the Western way of life soon gave way to a growing apprehension about its emotional harshness and spiritual desiccation. In a way I hadn't anticipated, the experience allowed me to view my native culture from the outside, and in ways I hadn't appreciated before, I realised ours was a tough culture.

In his book, *Biology and the Riddle of Life*, the biologist Charles Birch says science inevitably leads to mechanical analyses. Is there nothing more to be said, he asks:

I think there is. It is to propose that there are two points of view – *the inside and the outside, the subjective and the objective, from within and from without . . .* There is an enormous gap between what science describes and what we experience . . . (T)he solution to the riddle of life is only possible through the proper connection of the outer with the inner experience (1999, p 58, italics in original).

This chapter is concerned with this connection as it relates to the social determinants of health, and as it is expressed in the relationships between cultural and socio-economic factors. 'Culture' is a difficult concept because it is defined and used differently between different disciplines, and even within the same discipline. Culture can be taken to include all aspects of society, to describe an entire way of life of a people. However, it is often distinguished from social structure, with a key research goal being a better understanding of how the two interact (Swidler 1986). Larazus (1991, pp 349–83), in his study of emotion and adaptation, distinguishes between 'culture' and 'social structure' in this way: 'culture' provides a set of internalised meanings that we carry into our interactions with the social and physical environment; 'social structure' refers to the detailed patterns of social relationships and transactions among people with different roles and status within a social system.

However, Hays (1994) challenges the separation of culture and social structure. Culture, she argues, is a social structure, both internal and external, subjective and objective, ideal and material. The notion that culture is arbitrary and objectively inaccessible would make many (sensible) social scientists hesitate to analyse culture at all, she says. It raises the image of a 'rational scientist' studying 'material reality', while a 'star-struck' interpretative sociologist studies 'subjective meanings'. Hays favours regarding social structure as consisting of two central, interconnected elements: systems of social relations (patterns of roles, relationships and domination that define categories of class, gender, race, education etc.) and systems of meaning (which is what is often called 'culture').

The literature on the social determinants of health, to the extent that it discusses culture at all, treats it as separate from the social structures on which research focuses (so tending to confirm the conceptual danger against which Hays warns). Given this separation already exists in the literature, and given her definitions of systems of social relations and meanings are similar to Lazarus's of culture and social structure, I will, for the sake of clarity, retain the distinction between culture and social structure in this chapter. However, my arguments could equally be framed in Hays' terms.

My key points are that: research into the social determinants of health has unduly neglected culture, in favour of socio-economic factors, notably inequality; cultural determinants can influence health and well-being by amplifying or moderating the impact of socio-economic factors, and also in other ways; they do this through the same psychosocial pathways by which socio-economic factors are thought to influence health; and recognition of the role of culture has important implications for our understanding of the social determinants of health and well-being and for what we should do about it. In essence, I argue that while socio-economic inequality is important, it is far from being the only important social determinant of population health and may not be the most important.

The chapter discusses, in turn: the research on social determinants of health and its treatment of culture; key trends in modern Western culture and their social significance; the psychology of well-being and its links to culture; and young people's psychosocial well-being. An important aspect of the chapter's perspective is that it goes beyond the usual 'mortality/morbidity' framework of health and draws on a different body of research than is usual in the mainly epidemiological literature on the social determinants of health.

Social determinants of health

In the remarkable resurgence over the past decade or so in scientific interest in the social determinants of health, culture has been largely excluded from consideration. In the social models, the role of culture is seen as distal and diffuse, exerting a pervasive but unspecified influence on health (see figure 4.1 and Turrell, this volume, p 98). Of the many books and reports on the subject published in this period, few give cultural determinants more than a passing mention (Evans et al. 1994; Daedalus 1994; Amick et al. 1995; Blane et al. 1996; Wilkinson 1996a; Bartley et al. 1998; Strickland and Shetty 1998; Adler et al. 1999; Keating and Hertzman 1999; Marmot and Wilkinson 1999; Turrell et al. 1999; Berkman and Kawachi

2000). None offers a comprehensive account of the health implications of the cultural characteristics of modern Western societies such as individualism and consumerism.

The overwhelming emphasis of this research is on socio-economic inequalities in health – the inequalities associated with income, education, occupation, residential area and class. Even social capital, with its basis in the qualities of trust, participation, cooperation and reciprocity, is discussed largely in terms of inequality (Kawachi et al. 1997a; Kawachi 1999; Wilkinson 1998a, 1999a). This focus is perhaps not surprising. Against a historical background of improving health, especially as measured by mortality rates and life expectancies, and the clear evidence of persistent and even increasing socio-economic gradients in health, it is logical to concentrate on reducing inequality as a means of further improving population health.

However, the very pathways by which inequality is believed to ‘get under the skin’ to affect health are also those by which culture could affect health. These pathways present a critical issue in opening the way for cultural influences. To date, they remain unclear and contested. A central issue of debate is whether health inequalities derive primarily from material

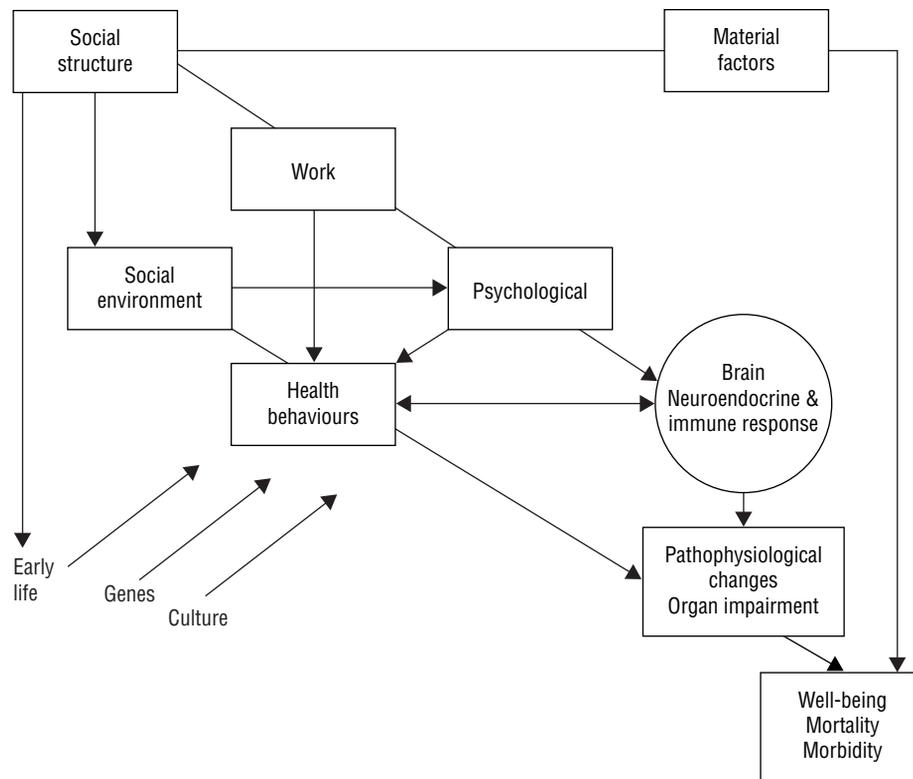


Figure 4.1 Model of the social determinants of health, linking social structure to health and disease via material, psychosocial and behavioural pathways. Genetic, early life and cultural factors are further important influences.

Source: Brunner and Marmot 1999. Reproduced with permission from Oxford University Press; copyright 1999 by Oxford University Press.

deprivation and disadvantage – from differential access to the material resources necessary for optimal health – or whether they result mainly from the psychosocial consequences of inequality (Marmot 1999; Lynch et al. 2000a; Lynch 2000). Put another way, are health inequalities a matter of (degrees of) absolute deprivation or relative deprivation? These different perspectives are labelled ‘materialist’ (or ‘neo-materialist’) and ‘psychosocial’, respectively.

Materialists emphasise factors such as the poorer quality housing, food, working conditions, neighbourhoods and access to services such as health care, transport and leisure that are associated with low socio-economic position. While affecting the poorest most, these absolute differences in material conditions can also affect health across the socio-economic spectrum. Advocates of the psychosocial perspective argue that the relatively uniform gradient in health, even among people who are not poor, indicates material deprivation is not the most important factor. They emphasise the significance of people’s relative position in the social hierarchy.

How people’s relative social position is translated into health outcomes remains uncertain. At the social level, inequality reduces social capital, weakening social cohesion and increasing social fragmentation. At the personal level, it may decrease social support and increase isolation. Socio-economic differences in the prevalence of behavioural risk factors such as smoking, drinking, diet and exercise explain at least some of inequalities in health. However, inequality also affects qualities such as personal control or mastery, optimism, hostility, coping style, and parenting, all of which may be important to health (Marmot 1999; Taylor and Seeman 1999).

While the stress associated with inequality can impact on health via direct adverse physiological effects, another important pathway may be through affective states or emotions (Gallo and Matthews 1999; Kubzansky and Kawachi 2000). Depression, hopelessness, anxiety and anger have been associated with higher risks of death and disease (the evidence is strongest for coronary heart disease, weaker for cancer). Conversely, happiness appears to be associated with good health (Argyle 1997). All these affective states tend to show a social gradient, making them a plausible pathway. However, the causal links remain to be clearly established.

The debate between the materialist and psychosocial perspectives is one of relative emphasis or importance, not mutual exclusivity, with the recent contributions focusing on issues of causality and intervention. Thus Lynch (2000), while acknowledging psychosocial factors are involved, argues that ‘there are real-world living conditions that should be the basis for understanding and analysing inequality’. It is hard to see, he says, how a psychosocial theory of health inequalities ‘can form the basis for an effective policy agenda to improve overall levels of population health and reduce health inequalities’. However, the need for a perspective that takes in more than material inequalities has been reinforced by recent findings that challenge the belief that there is a straightforward relationship between socio-economic inequality and health inequality.

A study of occupational class mortality in European nations found that while inequalities in health occur in all countries, these do not correlate with income inequality; in other words, the most equal nations do not necessarily have the most equal health (Mackenbach 1998; Mackenbach et al. 2000). A study of well-being (measured by life expectancy, self-reported health and happiness) and state welfare (social security expenditure) in 40 nations revealed no connection between the size of state welfare and either the overall level of well-being or the equality of well-being (Veenhoven 2000).

If psychosocial factors are important in explaining health inequalities, then culture must be an important part of the equation of social determination. Once we allow a role in health for perceptions, expectations and emotions, then cultural factors have to be taken into consideration, not only with respect to inequality but also in other ways. As Lazarus (1991, p 361) states: 'The most obvious way in which cultural meaning can influence the experience and expression of emotion is through how a person *perceives, understands, and appraises* what is happening socially . . .' (italics in original).

The most complete accounts of cultural factors in the recent social determinants literature are those by Corin (1994, 1995). She warns that socio-economic status far from encompasses all the ways in which the social environment may influence health, and that an exclusive emphasis on it could have 'the perverse effect of enforcing a purely objective and deterministic conception of environmental influences on the health of individuals and groups' (Corin 1994). Corin (1994) attributes epidemiology's neglect of culture to its origins in the conceptual framework of medicine. Its 'categorical' approach to sociocultural factors, which fits comfortably within prevailing scientific paradigms, strips human realities of much of their social context and disregards and dismisses other approaches to social and cultural realities, she says. Whereas epidemiological research defines culture through variables such as ethnicity, place of birth or language, anthropology considers it as a web or matrix of collective influences that shape people's lives.

. . . culture is above all a system of meanings and symbols. This system shapes every area of life, defines a world view that gives meaning to personal and collective experience, and frames the way people locate themselves within the world, perceive the world, and behave in it. *Every aspect of reality is seen embedded within webs of meaning that define a certain world view and that cannot be studied or understood apart from this collective frame* (Corin 1995, p 273, italics added).

Corin (1995) argues that cultural factors shape the experience of stress and psychosocial factors such as social support and coping strategies. Humans do not live in a purely objective world in which objects and events possess an inherent and objective significance; instead, these things are imbued with meanings that vary with individuals, times and societies, and which emerge from a network of associations. There is a complex interaction between the objective and subjective worlds, and between reality, expectations and values, she says. Within these interactions, values play an important role, mediating the effects of an experience by regulating its meaning and its importance.

Corin (1994) notes that cultural influences are always easier to identify in unfamiliar societies. Thus most studies of culture and health have not involved Western societies, but have examined other societies or specific sub-populations such as migrants and ethnic minorities. However, their conclusions, which indicate a potential role of culture in health and disease, also apply to Western societies:

Cross-cultural studies reveal the larger influence of culture and social structure that shapes the daily lives of individuals and collectivities . . . As long as one remains within one's own cultural boundaries, the ways of thinking, living, and behaving peculiar to that culture are transparent or invisible; they appear to constitute a natural order that is not itself an object of study. But this impression is an unsupported ethnocentric illusion (Corin 1994, p 119).

DiGiacomo (1999) also says that while epidemiology and anthropology may be natural allies in the study of population health, bioscientific uses of the concept of culture have led to 'the medicalisation of culture understood as "difference", which often stands in for social class'. Coming from a different perspective, Coburn (2000) has criticised the 'startling lack of attention' in the recent literature to the social, political and economic context of the relationships between health and inequalities in socio-economic status or income. He urges more examination of the causes of these inequalities, especially neoliberal (market-dominated) political doctrines and their impact on both inequality and social cohesion. Thus his focus is more limited than mine here, although it does bear on the cultural trends discussed in the next section.

To argue that the 'social determinants of health' literature downplays culture is not to claim that epidemiology has totally ignored its study. Indeed, one of the more curious aspects of the current situation is that the neglect occurs despite the existing evidence of its importance. Examples of influential research into the health effects of culture, including Western culture, are: the work of Marmot and his colleagues on the negative effect of exposure to Western influence on coronary heart disease in Japanese (Corin 1994, 1995); Wolf and Bruhn's long study of the role of social cohesion and egalitarianism in explaining unusually low mortality rates, especially from heart disease, in the small town of Roseto in Pennsylvania (Amick et al. 1995, pp 6–7; Wilkinson 1996a, pp 116–18); and the Stirling County Study, a classic study in psychiatric epidemiology by Leighton and his colleagues, which showed that social disintegration, as measured by the degree of consensus about values, meaning and shared sentiments, was directly related to the prevalence of psychiatric disorders (Corin, 1994, 1995; Amick et al. 1995, p 6).

So evidence of cultural influences on health exists, but much of this research dates back to the 1950s, 1960s and 1970s, and is overshadowed by the emphasis in contemporary research on socio-economic inequalities. Nowhere in the recent literature on the social determinants of health, to my knowledge, is there a detailed discussion of the characteristics of modern Western culture and their implications for health and well-being. These will be considered in the following sections.

Cultural trends

There are many patterns and trends in Western culture that we might expect to be significant to health. Cultural factors interact closely with structural social and economic factors, both as causes and effects. At one level, inequality and whether it increases or decreases could be said to be a consequence of culture, specifically the values reflected in public policy. However, cultural qualities may also act on health in other ways.

A vast literature exists on the nature of modern Western society and its culture, ranging from the works of the great 19th century social philosophers and sociologists such as de Tocqueville, Weber, Marx and Durkheim, to contemporary social theorists such as Habermas, Bourdieu, Beck and Giddens. I am not going to attempt to discuss Western culture within the context of this literature. While drawing partly on this work (and making some specific refer-

ences to it), I am basing what follows largely on my own analysis and observations, and on the more popular debate about modern life.

Several cultural qualities are widely considered to characterise Western culture (although they are not necessarily confined to it, and are, in fact, becoming increasingly global in their influence). I am not suggesting these qualities exert a uniform effect on everyone, regardless of gender, class and ethnicity; or that individuals are cultural sponges, passively absorbing cultural influences, rather than interacting actively with these factors; or that there is not a variety of subcultures marked by sometimes very different values, meanings and beliefs. Nevertheless, I believe the trends in these qualities are historically important and their effects pervasive, including on the health and well-being of populations. Here are a few 'isms' of modern Western culture:

Consumerism: Consumerism (often equated with materialism) refers to a lifestyle characterised by the acquisition and consumption of goods and services produced in the market economy. The trend in consumerism is broadly reflected in growth in per capita gross domestic product or GDP (about 60% of which is derived from private consumption). By this measure, consumerism has increased about five-fold in Australia and many other Western nations in the past 100 years.

Individualism: Individualism is a defining characteristic of Western nations, often contrasted with the collectivism of Eastern societies. Individualism places the individual, rather than the community or group, at the centre of a framework of values, norms and beliefs. It is exemplified by the former British Prime Minister, Margaret Thatcher's famous comment: 'There is no such thing as Society. There are individual men and women, and there are families.' (The reference to families is often omitted when this remark is quoted.)

Economism: Many might equate economism with capitalism, economic rationalism or neoliberalism. However, I use the term to embrace more than an ideological faith in free markets. It refers to a tendency to view the world through the prism of economics: to regard human society as an economic system, and to believe that choice is, or should be, based primarily on economic considerations. Again, GDP growth probably provides some sort of proxy measure of the trend in economism. A good example of economism is the Australian Prime Minister John Howard's statement in a speech to a 1998 World Economic Forum dinner that: 'The overriding aim of our agenda is to deliver Australia an annual (economic) growth rate of over four percent on average during the decade to 2010'.

Postmodernism: This includes a suite of related cultural qualities that characterise contemporary society. Postmodernity, or late modernity, is marked by the loss of grand narratives, universal truths and unifying creeds. Its characteristics include relativism, pluralism, ambiguity, ambivalence, transience, fragmentation and contingency. Postmodern life is episodic, uncertain, flexible and reflexive. Meaning in life is no longer a social given, but is individually chosen, or constructed, from a proliferation of options.

All these cultural qualities are interrelated, and interact: economism with consumerism, consumerism with individualism, individualism with postmodernism, for example. In a review of Zygmunt Bauman's *Life in fragments: essays in postmodern morality* (1995), Elliott, also a scholar of postmodernity, says that while postmodernism is identified with the political Left, it is much less obvious that it is itself a radical concern:

What has happened in so-called postmodern society is the collapse of core community values and ethical foundations, and the reorganisation of everyday cultural life within the ideological structures of the globalised capitalist economy itself. From this angle, the advent of postmodernism – with its deconstruction of metaphysical foundations, its dazzling globalisation of social institutions, its reifying of high-tech, and its cult of hedonism – fits hand in glove with the imperatives of a market logic in which everything goes but nothing much counts (1995).

There are other cultural factors and trends besides these: for example, *secularism* – not so much the decline of religious belief, but its exclusion from large parts of private and public life; and *pessimism* – the foreboding many people feel about humanity's future, even while they remain optimistic about their own lives. Yet other cultural trends might be described as countervailing: *feminism* – not just the movement for gender equality, but also the greater recognition and expression of the 'feminine' in human nature; *environmentalism* – the shift from an ethic of ignorance and exploitation of the natural environment to one of awareness and conservation; and *universalism* – the growing consciousness of other peoples, our affects on each other, and our obligations to each other. So there is profound conflict as well as powerful synergy between contemporary cultural forces in Western societies.

All these cultural trends have benefits to health and well-being: consumerism has contributed to making our lives safer and more comfortable; individualism has enhanced human rights, self-determination and political participation; economism has increased economic efficiency and productivity; postmodernism is associated with greater tolerance and diversity; secularism has helped to loosen the chains of bigotry and dogma; feminism has enhanced the status of women and given them more control over their lives; even pessimism, if it does not destroy hope, can be an incentive to change. Both environmentalism and universalism are prerequisites for a sustainable and harmonious planetary existence.

In a commentary on the paper by Coburn (2000) on the role of neoliberalism in health inequalities, Hertzman (2000) lists several factors that he suggests might explain why health is continuing to improve despite the growing influence of neoliberal economics. These include growing social tolerance, diversity, pluralism and flexibility: 'an end to the social respectability of religious, gender, ethnic, and racial discrimination . . . a general loosening of social norms and behavioural expectations and an increase in the range of lifestyles which are considered socially acceptable'. These changes, he says, may increase the level of 'psychosocial equality' in society (so, again, the focus remains on inequality).

Yet taken too far, too fast, and together, the cultural forces I have discussed also present risks to health and well-being. This is especially true of consumerism, individualism, economism and postmodernism, as we shall see, but problems arise even where the essential cultural direction is positive. For example, feminism, in the transitional stages, creates a conflict of roles and goals for both women and men, and can be influenced by other cultural forces such as economism and individualism (that is, these affect how the equality feminism seeks is defined). Environmental consciousness, pitted against the cultural power of consumerism, can produce a sense of despondency and futility.

The conflicts and contradictions include a tension between cultural ideal and social reality. While modern Western societies can be characterised as offering excessive choice and

freedom, it is also the case that these can be illusory. Social constraints remain, and in some cases are increasing, whether these concern having sex or driving cars (both powerful symbols of freedom which are highly prescribed by rules and realities), or class and privilege (which still substantially define opportunity). Furthermore, the postmodern ideal is really a Trojan horse for the social promotion of *particular* choices and values. Western societies present a façade of virtually unlimited freedom that disguises a powerful preference shaped by cultural forces such as consumerism and economism. The media are a potent source of this tension. For all the cultural celebration of autonomy and self-realisation, never before have people lived so little within their own lives; never before have our images of social realities been so filtered and distorted. While cultures are rarely, if ever, completely internally consistent, modern Western culture is deeply incoherent.

One critical consequence of the cultural trends of consumerism, individualism, economism, postmodernism (and secularism) has been their effect on moral values. Values provide the framework for deciding what is important, true, right and good, and so have a central role in defining relationships and meanings. Most societies have tended to reinforce values that emphasise social obligations and self-restraint and discourage those that promote self-indulgence and anti-social behaviour (Campbell 1975; Funkhouser 1989; Ridley 1996). 'We define virtue almost exclusively as pro-social behaviour, and vice as anti-social behaviour', Ridley (1996, p 6) observes in his analysis of human nature and society, *The origins of virtue*. This is not to argue that other societies have always been paragons of virtue, or that they did not often deal brutally with 'out' groups, or that 'pro-social' values such as conformity and deference to authority do not have costs when they, too, are taken too far and become blind obedience. There is also an important distinction to be made between abstract values and the often highly prescribed and proscribed behaviours into which they are socially translated.

Social virtues serve to maintain a balance – always dynamic, always shifting – between individual needs and freedom, and social stability and order. The 13th-century theologian, St Thomas Aquinas, listed the seven deadly sins as pride (self-centredness), envy, avarice (greed), wrath (anger, violence), gluttony, sloth (laziness, apathy) and lust; the seven cardinal virtues as faith, hope, charity (compassion), prudence (good sense), temperance (moderation), fortitude (courage, perseverance) and religion (spirituality). Other values widely regarded as virtues include patience, honesty, fidelity and forgiveness. Virtues, then, are concerned with building and maintaining strong, harmonious personal relationships and social attachments, and the strength to endure adversity. Vices, on the other hand, are about the unrestrained satisfaction of individual wants and desires, or the capitulation to human weaknesses.

Modern Western culture undermines, even reverses, traditional (or universal) values. Thus most consumption today (beyond meeting basic needs) is located within the vices, little within the virtues. We cannot quarantine other aspects of life from the moral consequences of ever-increasing consumption. The results of this cultural shift include not so much a collapse of personal morality, but its blurring into ambivalence and conflict. Individuals are encouraged to make themselves the centre of their moral universe, to assess everything – from personal relationships to paying taxes – in terms of 'what's in it for me?'. This promotes a preoccupation with personal expectations that keep rising, and with wants that are never sated

because new ones keep being created. As consumerism reaches increasingly beyond the acquisition of things to the enhancement of the person, the goal of marketing becomes not only to make people dissatisfied with what they have, but also with who they are.

Economism is important to values because economics is amoral – that is, it is not concerned with the morality of the choices consumers make to maximise their utility or satisfaction. The more economic choices govern people's lives, the more marginalised moral considerations become. Money itself becomes the dominant value. Social status is ever-more narrowly defined in terms of income and wealth, and the 'opportunity costs' of spending time on things other than making money grow (Csikszentmihalyi 1999). The risks of postmodernism include the trivialisation of conviction and commitment by an 'anything goes' morality: a belief that values are just a matter of personal opinion, and that one set of values is no better or worse than another. Values cease to require any external validation or to have any authority or reference beyond the individual and the moment.

Surveys suggest a deep tension between people's professed values and the lifestyle promoted by modern Western societies (Eckersley 1999, 2000a, 2000b). Traditional sources of moral guidance such as religion, although weakened, no doubt fuel this tension, as would other cultural trends such as environmentalism and universalism. Many people are concerned about the greed, excess and materialism they believe drive society today, underlie social ills, and threaten their children's future. They yearn for a better balance in their lives, believing that when it comes to things like freedom and material abundance, they don't seem 'to know where to stop' or now have 'too much of a good thing'. People perceive a widening gulf between private and public morality, between their own standards and those reflected by institutions such as the media, government and business, even religion. This produces a growing sense of alienation and disengagement, a rising cynicism about social institutions and their roles.

As Durkheim (1970, pp 361–92) observed in his seminal sociological study of suicide a century ago, a crucial function of social institutions such as the family and religion is to bind individuals to society, to keep 'a firmer grip' on them and to draw them out of their 'state of moral isolation'. 'Man cannot become attached to higher aims and submit to a rule if he sees nothing above him to which he belongs', Durkheim (1970, p 389) writes. 'To free him from all social pressure is to abandon him to himself and demoralise him.' While he focused on social structures, Durkheim saw clearly the distinction between material and moral causes of despair, noting (in the language of an earlier time):

If more suicides occur today than formerly, this is not because, to maintain ourselves, we have to make more painful efforts, nor that our legitimate needs are less satisfied, but because we no longer know the limits of legitimate needs nor perceive the direction of our efforts . . . The maladjustment from which we suffer does not exist because the objective causes of suffering have increased in number or intensity; it bears witness not to greater economic poverty, but to an alarming poverty of morality (1970, pp 386–7).

The cultural qualities I have discussed, while pervasive, can show gender and socio-economic differences in their expression and impact. Thus while Western culture promotes a view of the self as individualistic, autonomous and independent of others and social influences,

this may be truer of men than of women, for whom the self is more likely to be construed as interdependent, with others considered part of the self (Cross and Madson 1997). The gender differences in self-construal might, however, be narrowing under the influence of contemporary cultural trends.

In terms of socio-economic differences, consumerism and economism, for example, would cause most stress among low-income groups because of the emphasis they place on money and material well-being. Less obvious is the evidence of a social gradient in postmodern qualities, which also illustrates how culture can accentuate disadvantage. Elchardus (1991, 1994) has shown that the attitudes associated with the 'cultural flexibility' that characterises post-modernity – religious and philosophical indifference, a 'here-and-now' hedonism and an individualism that extends well beyond emancipation from traditional restrictions – are negatively correlated with education and occupation. Cultural flexibility is related to low educational levels, high risk of unemployment, low occupational status, and low degrees of autonomy on the job. Elchardus (1994) criticises the linking of cultural flexibility to a 'progressive vision of individualisation', saying it has resulted in 'a somewhat shameful legitimization of increases in uncertainty and unpredictability in the life of the poor and socially weak'.

Cultural flexibility . . . seems to be a form of withdrawal of commitment and emotion from a social order in which one is losing out. Such a reaction cannot really be considered a form of resistance, let alone revolt, for its very form makes organised action unlikely. Cultural flexibility rather seems to be the meek acceptance of the flexibilisation of one's life for the purposes of economic efficiency and organisational control (Elchardus 1991, p 721).

In summary, modern Western culture, its strengths and benefits notwithstanding, displays several characteristics that have the potential to harm health and well-being. These include: its promotion of anti-social values; the moral ambivalence and confusion arising from its openness and its inherent contradictions; and the tension generated between cultural ideals and social realities. Cultural influences can interact with structural conditions to modify their social effects.

Well-being

The importance of culture to health and well-being emerges more clearly from the research into psychological well-being than it does from epidemiological studies on health. There is very little cross-referencing between this mainly psychological literature and social epidemiology. A significant body of research concerns subjective well-being. In several important respects, this research supports the psychosocial perspective on health inequalities. However, it also reveals some interesting differences between health and well-being. Subjective well-being is not a single construct, but comprises three distinct and to some extent independent dimensions: a cognitive aspect; life satisfaction; and pleasant and unpleasant affect (moods and emotions) (Myers and Diener 1995; Wearing and Headey 1998; Diener et al. 1999). It differs from the concept of 'health' in excluding physical health and in including positive emotions; it is thus less focused on illness and disease (both physical and mental).

Subjective well-being, which is often loosely equated with happiness, is, like health, positively correlated with control, optimism and social support (unless otherwise indicated, much of what follows on subjective well-being is taken from: Myers and Diener 1995; Wearing and Headey 1998; Diener et al. 1999; Diener 2000; Myers 2000). It is also positively correlated with extroversion, and negatively with neuroticism. It is associated with self-esteem, which, however, does not seem to be important to health (Taylor and Seeman 1999). The significance of self-esteem to well-being is culturally variable, which might help to explain this discrepancy.

Looking at other factors, being married and religious enhances well-being. So does the ability to adapt, to set goals and progress towards them, and viewing the world as understandable, controllable and meaningful. These qualities are interrelated. Meaning in life is strongly related to well-being (more so to its positive dimensions than its negative) and is, in turn, related to self-transcendent values, strong religious beliefs, membership of groups, dedication to a cause and clear life goals (Zika and Chamberlain 1992). Diener and Suh (1997) note that the central elements of well-being are based on people's most important values and goals: subjective well-being 'is most likely to be experienced when people work for and make progress towards personal goals that derive from their important values'. Goal conflict or ambivalence, on the other hand, is associated with diminished well-being (Diener et al. 1999).

The most interesting findings on subjective well-being, compared to health, concern its relationship to income. As with health, there are income gradients between and within populations: average well-being is higher in rich countries than in poor (although this may also be due to factors other than wealth, such as literacy, democracy and equality), and within countries, the rich have more of it than the poor. As with health, the biggest gains in well-being with rising income come at low-income levels, and taper off at higher levels. Increased income appears to matter when it helps people meet basic needs; beyond that, the relationship becomes more complex.

Neither in comparisons between nor within countries, however, is the gradient in well-being as pronounced as it is with health. In contrast to the wide disparities between rich and poor countries in life expectancy, Cummins (1998) has demonstrated the uniformity in population estimates of life satisfaction. When life satisfaction is measured as a percentage of the scale maximum, the population average for countries across all major geographic regions is about 70% with a standard deviation (SD) of 5% (for Western nations, the average is about 75%, SD 2.5%). Within countries, only in the poorest is income a good indicator of well-being; in most nations the correlation is small, and even the very rich are only slightly happier than the average person (figure 4.2).

Another striking difference between health and well-being is that while health, as measured by mortality and life expectancy, has improved steadily over past decades, well-being has not, at least not in developed nations. The proportion of people in developed societies who are happy or satisfied with their lives has remained stable over the past several decades (50 years in the US), even though they have become, on average, much richer. Indeed, one of the most striking findings of research into subjective well-being is the often small correlation with objective resources and conditions. One recent estimate is that external circumstances account for only about 15% of the variance in subjective well-being (Diener et al. 1999, Diener 2000).

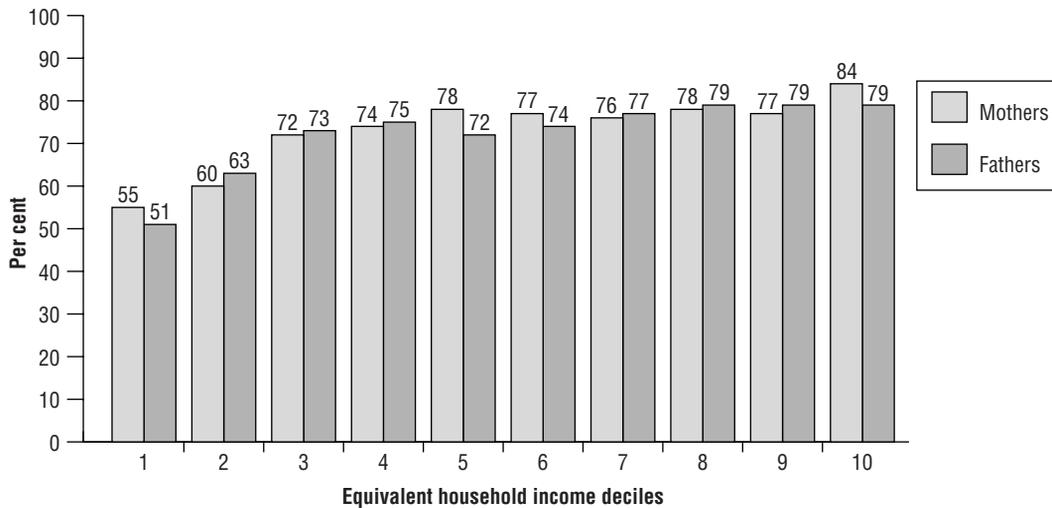


Figure 4.2 Australians' life satisfaction by income, 1991-2

Notes: Figures represent the proportion of parents in each income decile scoring 7-9 on a nine-point scale of life satisfaction. The survey involved parents with at least one child under 20 in nine urban and two rural areas (N = ~ 8,500). Equivalent household income refers to combined incomes of parents and children over 15, expressed as a percentage of the Henderson Poverty Line.

Source: Australian Living Standards Survey, 1991-92, Australian Institute of Family Studies, Melbourne; personal communication with Ruth Weston.

In a recent review of research on subjective well-being, Diener et al. (1999) conclude that there is no simple answer to what causes happiness. Instead, there is a complex interplay between genes and environment: between life events and circumstances, culture, personality, goals and various adaptation and coping strategies. The evidence suggests that people adjust goals and expectations and use illusions and rationalisations to maintain over time a relatively stable, and positive, rating of life satisfaction and happiness. This characteristic of subjective well-being might explain the key differences with health, despite the similarities in their social determinants. It might also explain why, despite the apparent links between health and emotions, the relationship between health and subjective well-being is not clear-cut: subjective well-being correlates strongly with self-reported health, but only weakly with objective health (Diener et al. 1999).

All in all, the literature on subjective well-being paints a pretty positive picture: most people are mostly happy and satisfied most of the time. However, there is a range of evidence that suggests a positive bias in the results of happiness and life satisfaction surveys (Eckersley 2000b, 2001). For example, while Australians' overall life satisfaction has remained relatively stable over the past two decades, their satisfaction with many of the life domains that are important to life satisfaction – friends, family, community, freedom – has declined (figure 4.3) (Jones 1999). And when people are asked about social conditions, rather than about their own lives, responses are more negative: in 1999, only a quarter of adult Australians believed overall

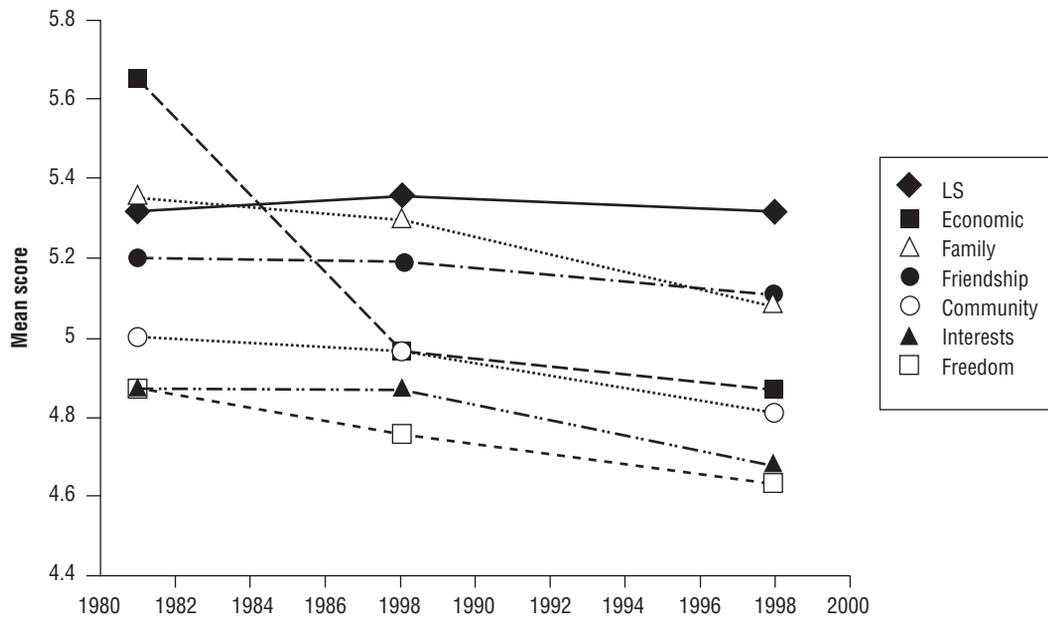


Figure 4.3 Australians' satisfaction with their 'life as a whole' (LS) and various life domains, 1981–98

Notes: Scores are based on a 7-point scale, terrible (1) to delighted (7). Domain scores are means of responses to a range of items in each of the domains of: economic circumstances and well-being (job, income, standard of living, housing); family (time, adult relationships, responsibilities); friendship and respect (love, acceptance, inclusion, honesty, kindness); community (as a place to live, safety, schools, health services); life's interests and diversity (enjoyment, sex, fun, challenge, spare time); and freedom (pressure, relaxation, sleep, independence, privacy). Data are based on a national sample of 1,000 Australians aged 18 and over.

Source: based on data from Jones 1999.

quality of life in Australia was improving and the same proportion that the 1990s were the decade of highest quality of life (Eckersley 1999, 2000a, 2000b).

If qualities such as meaning, goals and values are important to well-being, then so is culture. Drawing on cross-cultural studies of happiness, Diener et al. (1999) conclude: '... culture can have a profound effect on the causes of happiness by influencing the goals people pursue as well as the resources available to attain goals'.

People for whom 'extrinsic goals' such as fame, fortune and glamour are a priority in life experience more anxiety and depression and lower overall well-being than people oriented towards 'intrinsic goals' of close relationships, self-acceptance and contributing to the community (Kasser and Ryan 1993, 1996; Kasser 2000). People with extrinsic goals tend to have shorter relationships with friends and lovers, and relationships characterised more by jealousy and less by trust and caring. Materialistic values are positively correlated with social alienation (Khanna and Kasser, in preparation; personal communication with Tim Kasser, Knox College, Illinois), with depression, anxiety and anger, and negatively correlated with life satisfaction

(Saunders and Munro 2000). While these correlations do not prove that materialism and related values cause a deterioration in well-being, they do suggest their cultural promotion is not conducive to it. The cause–effect relationship is likely to be complex and two-way.

Despite the positive correlation between personal control and well-being, individualism, considered more broadly, has been associated with diminished well-being, especially when taken to the extreme (although in cross-country studies, individualism correlates positively with happiness [Veenhoven 1999]). Seligman (1990) argues that one necessary condition for meaning is the attachment to something larger than the self, and the larger that entity, the more meaning people can derive: ‘The self, to put it another way, is a very poor site for meaning’. Schwartz (2000) says that individual autonomy and self-determination can become excessive, and freedom experienced as ‘a kind of tyranny’. Twenge (2000), in reporting large increases (about one standard deviation) in anxiety and neuroticism in children and college students in the US between the 1950s and 1990s, links the rise to lower social connectedness and higher environmental threat (fear of crime, AIDS etc.), both of which, she says, stem from increasing individualism and freedom; economic factors such as unemployment and poverty seem not to be involved.

Baumeister and Leary (1995) argue that a need to belong is a fundamental human motivation: humans have ‘a pervasive drive to form and maintain at least a minimum quantity of lasting, positive, and significant interpersonal relationships’. In a wide-ranging literature review, they show that there are multiple links between the need to belong and cognitive processes, emotional patterns, behavioural responses and health and well-being. ‘The desire for interpersonal attachment may well be one of the most far-reaching and integrative constructs currently available to understand human nature.’ Baumeister and Leary suggest that the ‘belongingness’ hypothesis could help psychology recover from the challenge posed by ‘cultural materialism’, with its assumption that human culture is shaped primarily by economic needs and opportunities, and so should be analysed with reference to economic causes.

The importance of values emerges in a cross-national study by Halpern (2001) of the relationships between crime and values, social trust and inequality. He found that tolerance for a set of ‘materially self-interested’ attitudes – like keeping something you’ve found, lying in your own interest, or cheating at tax – was higher in men, younger people, larger cities, and had increased over time, mirroring patterns of criminal offending. These self-interested values were also found to be statistically associated with crime victimisation rates at the national level. Inequality and social trust did not have fully independent relationships with victimisation rates, but were conditional on the prevalent values of society. Thus inequality *per se* was only modestly associated with higher crime, ‘but when it occurs in societies that are characterised by high levels of self-interested values then its effects become more pronounced’.

Thus this mainly psychological literature challenges social epidemiology’s narrow emphasis on structural factors, especially inequality. It also generally supports the validity and legitimacy of ‘traditional’ or universal values in terms of their benefits to well-being. In contrast, several of the defining characteristics of modern Western culture would appear, on the basis of the research evidence, to be harmful to well-being through their influence on values, goals, expectations, meaning and belonging.

Young people's health and well-being

Like the psychological literature on well-being, the sociological literature on late-modernity and post-modernity also offers a marked difference to the dominant epidemiological emphasis on socio-economic inequality. Again, there is little reference to this work in the social determinants literature. Postmodern scholarship focuses much more on the cultural qualities of contemporary life and the ways in which these qualities are closely intertwined with structural changes in the family, work and education, but not necessarily with inequality.

Furlong and Cartmel (1997a, 1997b, pp 65–81), drawing on the work of influential writers like Beck and Giddens, examined the extent to which the health risks faced by young people (in Britain) reflected traditional inequalities. They concluded that while many of the health risks encountered by young people were still differentially distributed along the lines of class and gender, 'the processes of individualisation, coupled with the stress which develops out of uncertain transitional outcomes, have implications for the health of all young people' (Furlong and Cartmel 1997b). In particular, 'the protraction and desequencing of youth transitions have had a negative impact on young people's mental health'.

Furlong and Cartmel describe the increased sources of stress 'which stem from the unpredictable nature of life in high modernity'. These include the ongoing sense of doubt, the heightened sense of insecurity, the increased feelings of risk and uncertainty, and the lack of clear frames of reference that mark young people's world today. While traditional forms of inequality remain, even young people from privileged social backgrounds worry about failure and the uncertainty surrounding their future. Conversely, those from disadvantaged backgrounds may feel that the risks they face are personal and individual rather than structural and collective.

Young people's health and well-being are important to understanding the social determinants of health for several reasons. One is the 'life-course' dimension of social influences on health, which emphasises the importance to later health of developmental stages and transition points from before birth to adulthood. These can make young people particularly vulnerable to social effects. Also, they have, generally speaking, yet to experience the health outcomes of long-term, degenerative biological processes associated with diseases such as heart disease, stroke and cancer.

Rates of psychosocial disorders among young people have risen since World War II in almost all developed countries (Rutter and Smith, 1995). These disorders include drug abuse, crime, depression and suicidal behaviour. The rise in suicide among young males has been a striking feature of these trends, with some countries, including Australia and New Zealand, showing more than a three-fold increase in suicide rates among males aged 15–24 (figure 4.4), and a more recent rise in males 25–39 (Cantor et al. 2000). The increase in suicide is despite the reduced lethality of suicide attempts over recent decades because of developments such as safer pharmaceutical drugs and better intensive-care medical technologies (which would have particularly affected suicide rates among women, who are more likely than men to attempt suicide and to use less fatal means).

Blum et al. (2000) found in a study of US high school students (years 7–12), that while some risk behaviours appeared to be more common among some groups of young people, demographic factors did not predict risk behaviours well. Race/ethnicity, income and family

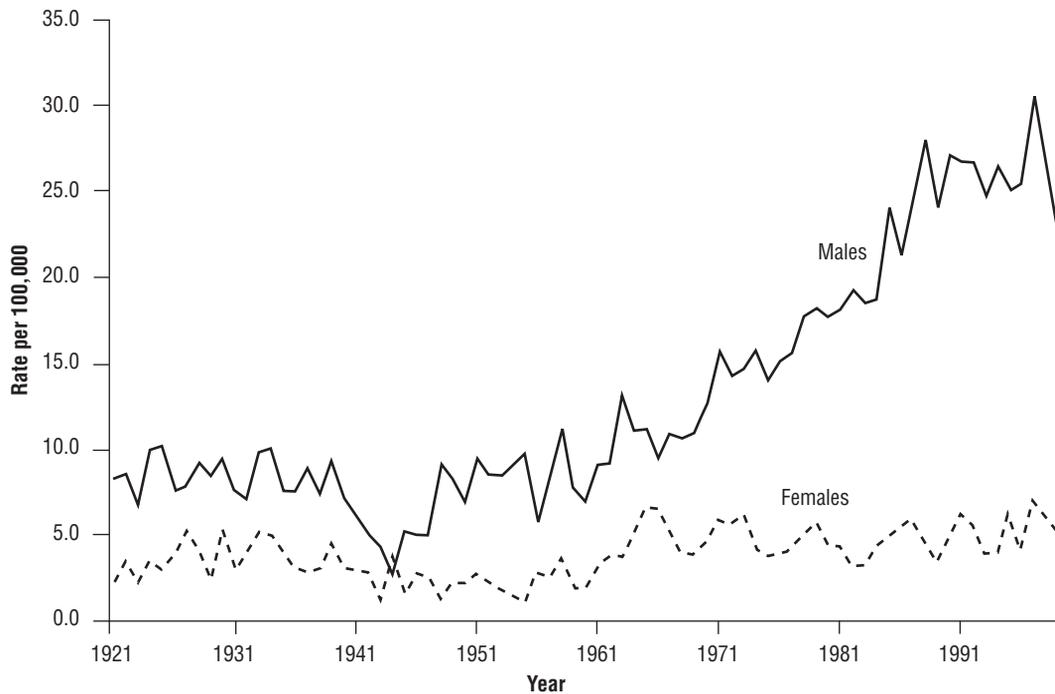


Figure 4.4 Youth suicide in Australia, 1921–99, males and females aged 15–24

Notes: Rates are aged-adjusted using the 1991 Australian population; the peak in 1997 is partly a data artefact, as may be the fall in 1999; the dip in male rates during World War II is at least partly a data artefact.

Source: National Injury Surveillance Unit, Australian Institute of Health and Welfare, using source data provided by the Australian Bureau of Statistics.

structure together explained no more than 10% of the variance in each of five risk behaviours – cigarette smoking, alcohol use, involvement with violence, suicidal thoughts or attempts and sexual intercourse – among younger adolescents, and no more than 7% among older youths. They caution that highlighting group differences runs ‘a high risk of building our interventions on variables that are not amenable to change’ and, even if they were, ‘would not significantly alter behavioural outcomes’.

In a major review, Rutter and Smith (1995, pp 782–808) say that, to a large extent, finding causal explanations of the increases in psychosocial disorder among young people ‘remains a project for the future’. However, they regard as unlikely several popular explanations for the trends, such as social disadvantage, inequality and unemployment (although these can be associated with disorder at an individual level). More likely explanations include: family conflict and break-up; increased expectations and individualism; and changes in adolescent transitions (in particular, the emergence of a youth culture that isolates young people from adults and increases peer group influence; more tension between dependence and autonomy; and more romantic relationship breakdowns among young people).

Rutter and Smith call for, among other things, further investigation of the theory that shifts in moral concepts and values are among the causes of increased psychosocial disorder. They note, in particular, 'the shift towards individualistic values, the increasing emphasis on self-realisation and fulfilment, and the consequent rise in expectations'. My own analysis of rising rates of psychosocial problems among young people has also focused on their cultural roots and young people's vulnerability to the failure of modern Western culture to provide, using Corin's words, adequate 'webs of meaning' that frame 'the way people locate themselves within the world, perceive the world, and behave in it' (Eckersley 1993, 1995, 1998b).

In a recent ecological study, I examined statistical associations between youth suicide rates in developed nations and 32 socio-economic and cultural variables (Eckersley and Dear, in press). Male youth suicide rates were positively correlated with several measures of individualism, including personal freedom and control. For females, the correlations were positive but in only one instance significant. Both male youth suicide and individualism were negatively correlated with older people's sense of parental duty (it is 'parents' duty is to do their best for their children even at the expense of their own well-being'). Correlations between suicide and other possibly relevant cultural variables – including tolerance of suicide, belief in God and national pride – were not significant. Nor was there a significant correlation between suicide rates and any of the socio-economic variables including divorce, poverty, youth unemployment and income inequality.

The interpretation of these findings is by no means clear-cut. Given other positive correlations, including between individualism and happiness, health and life satisfaction, the findings could suggest that suicide rises as life gets better (see Barber 2001, for an articulation of this view). However, taking into account possible cultural differences in survey responses and the broad context of young people's well-being today – especially the lack of evidence of any increase in overall happiness and the evidence of increasing psychological distress and disturbance that affect a substantial proportion of young people (Eckersley 1998b, 2001) – I believe it is more likely that the results reflect a failure of Western societies to provide appropriate sites or sources of social identity and attachment, and, conversely, a tendency to promote false expectations of individual freedom and autonomy.

Interpreted this way, the findings support Durkheim's theory that suicide is associated with a weakening of social cohesion, a failure of society to integrate the individual, as already discussed (Durkheim 1970). Individualism could impact on youth suicide through its effect on specific social institutions and functions, such as the family and child-rearing, as suggested by the negative correlation between parental duty and both youth suicide and individualism. However, its effects may go further than this. Western societies – and some more than others – may be taking individualism to the point where it can become more broadly dysfunctional – to society and the individual (perhaps especially males, because of gender differences in constructing the self as independent or interdependent). In other words, these societies are promoting a cultural norm of personal autonomy that is unrealistic, unattainable or otherwise inappropriate. They project images and raise expectations of virtually unrestrained individual freedom, choice and opportunity, and of the happiness these qualities are supposed to deliver, which bear increasingly less resemblance to psychological and social realities.

My discussion of the health effects of cultural factors has focused largely on psychological

health and well-being, where the impacts are most obvious. In recent years, health authorities have become more aware of the importance of mental illness to population health and well-being. This recognition has been associated with the development of new measures of disability, allowing researchers to move beyond mortality rates in assessing the burden of disease. Measured in terms of both disability and death (disability-adjusted life years or DALYs), psychiatric conditions, including depression, accounted for 23% of the disease burden in high-income countries in 1998, compared to 18% for heart disease and 15% for cancers (World Health Organization 1999). In the global ranking of disease burden, major depression is projected to rise from fourth in 1990 to second in 2020 (Murray and Lopez 1996). A psychosocial theory of health suggests the impacts of culture extend to physical health.

Conclusion

This analysis has highlighted the importance of exploring cultural influences in seeking to understand the social determinants of health and well-being – not just socio-economic factors such as inequality. It suggests cultural changes can amplify or moderate the health impact of inequality – that is, an increase or decrease in health inequalities is not necessarily due to a change in socio-economic gradients. It also indicates that cultural changes could impact on health quite independently of socio-economic factors. In particular, I have emphasised the ways in which key features of Western culture can jeopardise the personal, social and spiritual relationships and certainties that are crucial to well-being.

There are several significant implications of the analysis. Health inequalities may be due in part to differences within populations in cultural factors such as the orientation and congruence of values and goals, at both individual and group levels. These may or may not be associated with structural factors. Also, the social factors that most influence health differences within populations (ie, contribute to health inequalities) may not be the same factors that most influence health over time.

In arguing that defining cultural changes in Western societies pose risks to human health and well-being, I have to acknowledge that, despite these hazards, mortality rates continue to fall and life expectancies to rise. There are several possible explanations for this paradox: the analysis underestimates people's psychological adaptability and resilience; it exaggerates the cultural dangers, relative to cultural benefits to health and well-being; the harm is offset by increasing benefits in other domains of life, such as health care, nutrition and education; the risks to health are mainly of a non-lethal kind, and are more likely to be reflected in rates of chronic illness, especially psychosocial disorders; there are lags between the cultural changes and their life-threatening consequences to health (suicide excepted); and a combination of these reasons. A combination of offsetting benefits, non-lethal risks and lag effects is the most plausible explanation why the impact of cultural change is not more apparent in health status in Australia and other Western nations. We need to bear in mind that death, however much social epidemiology focuses on it, represents only one dimension of health and well-being.

The broader view of the social determinants of health presented here has profound political significance. The implications of socio-economic inequalities in health are serious

enough, but they are relatively easily addressed through, for example, conventional policies for correcting or compensating for these inequalities. Acknowledging important cultural influences on health and well-being, on the other hand, means we need to re-evaluate the entire Western worldview and its values, goals and priorities.

Further Reading

Corin, E 1994, The social and cultural matrix of health and disease, in Evans, R G, Barer, M L & Marmor, T R (Eds), *Why Are Some People Healthy and Others Not? The determinants of health of populations*, Aldine de Gruyter, New York.

– *A valuable review of the epidemiological literature on cultural influences on health.*

Hays, S 1994, Structure and agency and the sticky problem of culture, *Sociological Theory* 12 (1): 57–72.

– *An insightful exploration of the separation of culture and social structure and why it matters.*

Campbell, DT 1975, On the conflicts between biological and social evolution and between psychology and moral tradition, *American Psychologist*, December: 1103–26.

– *Based on a presidential address to the American Psychological Association, a fascinating look at the origins of moral values and the relationship between modern science and religious tradition.*