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## **Is modern Western culture a health hazard?**

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### Key messages

- Cultural factors such as materialism and individualism are underestimated determinants of population health and wellbeing in Western societies.
- Evidence links cultural factors, via psychosocial pathways, to psychological wellbeing, and wellbeing, through behavioural and physiological pathways, to physical health.
- An important and growing cost of our modern way of life is ‘cultural fraud’: the promotion of images and ideals of ‘the good life’ that serve the economy but do not meet psychological needs or reflect social realities.



## **Epidemiology, health and culture**

The cultures of societies are under-estimated determinants of their population health and wellbeing. This is as true of modern Western culture, including its defining qualities of materialism and individualism, as it is of other cultures. This paper draws on evidence from a range of disciplines to argue that materialism and individualism are detrimental to health and wellbeing through their impacts on psychosocial factors such as personal control and social support.

The focus of the resurgent scientific and political interest in the effects of the social environment on health has been on socio-economic inequalities in health – especially those associated with income inequality. Two developments strengthen the case for paying more attention to the role of culture in health. The first is that, at the population level, the role of income inequality has become less clear, with recent research challenging the view that it is a major determinant of population health differences.<sup>1-3</sup> Instead it suggests that population health is the product of a complex interaction of history, culture, politics, economics and the status of women and ethnic groups<sup>4</sup>; and that we need, in particular, a better appreciation of how broad indicators of social and economic conditions are related to the levels and social distribution of major risk factors for particular health outcomes.<sup>3</sup>

The second development is a general acceptance that psychosocial factors are a significant pathway by which inequality and other social determinants affect health, and that perceptions and emotions are important to health outcomes.<sup>2,4</sup> This position is now common ground between those who believe that sources of health inequalities are primarily, or fundamentally, material - resulting from differences in material exposures and experiences – and those who argue their sources are psychosocial – stemming from people's position in the social hierarchy and their perceptions of relative disadvantage.<sup>2</sup>

Psychosocial processes involve interactions between social conditions and individual psychology and behaviour,<sup>5</sup> and are associated with (in their negative forms) stress, depression, anxiety, isolation, insecurity, hostility and lack of control over one's life.<sup>6,7</sup> Whether psychosocial factors affect health only (or principally) through health-related behaviours, or also act via direct effects on the neuroendocrine and immune systems, remains contested, but this does not affect the case for taking culture into account. Once we allow a role in health for psychosocial factors and for perceptions, expectations and emotions, then cultural factors have to be considered because culture influences these things.<sup>8</sup>

Epidemiology understands 'culture' mainly in terms of 'subcultures' or 'difference', especially ethnic and racial, and so, usually, as one dimension of socio-economic status.<sup>9-</sup><sup>11</sup> Culture in the broader sense of the dominant or defining culture of a society has been given scant attention in the recent social determinants literature.<sup>12</sup> Of the many books and reports on the subject published over the past two decades, only a few give cultural

determinants more than a passing mention. (The exceptions include the works of Corin on culture in general,<sup>10,11</sup> and my own work on modern Western culture in particular.<sup>12,13</sup>)

Generally speaking, the influence of culture (in this broad sense) on health and wellbeing has been seen as distal and diffuse, pervasive but unspecified.<sup>12</sup> Yet it seems plausible, if not self-evident, that cultural characteristics such as materialism or individualism can have as important an impact on psychosocial factors such as social support and personal control as socio-economic inequality – perhaps even more important.

Marmot and Wilkinson, in noting the relationship between income inequality and social affiliation, suggest there is a ‘culture of inequality’ that is more aggressive, less connected, more violent and less trusting.<sup>7</sup> Singh-Manoux and Marmot take this cultural perspective further in suggesting that socialisation provides a mechanism for integrating the cultural, behavioural, structural and material explanations of social inequalities.<sup>14</sup> Socialisation is the process of transferring attitudes, beliefs and behaviours between and within generations, the means by which societies shape patterns of behaviour and being that then affect health. Drawing on Bourdieu’s concept of ‘habitus’, they argue that social structures become embodied as schemes of perception that provide individuals with class-dependent and predisposed ways of thinking, feeling and acting, which are then reproduced.

However, we can also think of such processes as going beyond matters of class; socialisation reproduces lifestyles and identities, not just social differences in them. A culture of individualism and materialism could also produce those attributes of a culture of inequality. In other words, these developments in thinking about inequality in essentially cultural terms invite a broader consideration of cultural factors as determinants of health.

The neglect of culture is surprising in some respects, but not others. It is surprising given that some of the earlier social epidemiological research – for example, the work by Marmot and Syme in the 1970s on the effects of exposure to Western influence on heart disease in ethnic Japanese<sup>15,16</sup> - pointed to its significance. It is unsurprising in that cultures tend to be ‘transparent’ or ‘invisible’ to those living within them because they comprise deeply internalised assumptions and beliefs, making their effects hard to discern. As Corin says, cultural influences are always easier to identify in unfamiliar societies.<sup>10</sup> Our own cultures appear to constitute a natural order that is not itself an object of study. This impression, she says, is an ‘unsupported ethnocentric illusion’.

Another reason for underestimating the role of culture is the extent to which its impacts are ‘refracted’ through a host of other, more specific influences, including a person’s personal circumstances and temperament (this is also true of other distal determinants of health). In other words, changes that affect everyone can, nevertheless, affect people differently and contribute to specific problems that only some experience.

A third explanation is that culture is a much debated and contested subject, defined and used in many different ways in different disciplines and even within the same discipline.

Culture, as I use the term here, refers to the language and accumulated knowledge, beliefs, assumptions and values that are passed between individuals, groups and generations<sup>17</sup>; a system of meanings and symbols that shape how people see the world and their place in it and give meaning to personal and collective experience<sup>11</sup>; or, more simply, as the knowledge we must possess to function adequately in society.<sup>18</sup>

In discussing the effects of modern Western culture on health, I do not mean to suggest that culture exerts a uniform effect on everyone, regardless of gender, class and ethnicity; or that individuals passively absorb cultural influences, rather than interacting actively with them; or that there is not a variety of subcultures marked by sometimes very different values, meanings and beliefs. To rephrase Ehrlich's comments about genes: cultures do not shout commands to us about our behaviour, they whisper suggestions (although, as I will show, the whispers are loud and persistent).<sup>19</sup>

My arguments about culture and health draw mainly on the sociological, psychological and epidemiological literatures. While this analysis differs in its scope and focus from anthropological perspectives, it is, I believe, conceptually consistent with those perspectives. For example, Dressler and his colleagues argue that individuals possess cultural models that derive both from their own biographies and from the collective or shared understandings that form the traditions of their society.<sup>18</sup> These models reflect a 'cultural consensus' about the way the world works, but this consensus is not complete and can be contested, even bitterly so. 'Cultural consonance' is the extent to which individuals reveal in their own beliefs and behaviour the cultural consensus (with one focus of research being the association between cultural consonance and disease risk).

It follows that, just as inequality can be studied at both population and individual levels, so too can culture. It can be measured as differences between societies (reflecting differences in cultural consensus), or as differences between individuals and groups within a society (reflecting degrees of cultural consonance). Some societies are more materialistic or individualistic than others (even among Western nations), and some individuals and groups within any one society will reveal these qualities more than others. Thus the evidence I draw on relates to both individual-level and population-level effects of culture.

Culture may help to explain health differences within societies in several ways. As already noted, they could arise from variations in cultural characteristics between individuals and groups. Culture could also influence levels of inequality – for example, through the part individualism plays in market-oriented, or neo-liberal, political doctrines that are associated with greater inequality. It might also interact with socio-economic status to moderate or amplify its health effects - for example, materialism and individualism might accentuate the costs of being poor or of low social status by making money more important to social position and weakening social bonds and group identity. However, culture's role is perhaps more important in explaining health differences among societies, or changes in a population's health (or, more accurately, health potential) over time. (As the novelist L. P. Hartley famously said in *The Go-Between*: 'The past is a foreign country: they do things differently there'.)

This paper is an exercise in multidisciplinary synthesis.<sup>13</sup> Rather than improving our understanding of the world by creating new knowledge, as empirical research does, synthesis seeks to improve understanding by bringing together existing knowledge from different disciplines. I acknowledge that: there is a lack of research in many areas I discuss; much of the research remains in its infancy (many of the associations are correlational and do not prove causation); the interplay between social factors and individual behaviours is both subtle and complex; and cultural influences, with their intangible, subjective qualities, are difficult to measure. Given these limitations, the evidence is often indirect and circumstantial, and the arguments are to some extent theoretical and speculative, intended to stimulate greater research interest in the topic.

### **Materialism and individualism**

The psychological and sociological literatures suggest powerful effects of culture on psychological wellbeing. Take materialism, by which I mean attaching importance or priority to money and possessions (and so broadly equate here with consumerism), and which underpins consumption-based economies. Many psychological studies have shown that materialism is associated, not with happiness, but with dissatisfaction, depression, anxiety, anger, isolation and alienation.<sup>13,20</sup> Human needs for security and safety, competence and self-worth, connectedness to others, and autonomy and authenticity are relatively unsatisfied when materialistic values predominate.

People for whom ‘extrinsic goals’ such as fame, fortune and glamour are a priority in life experience more anxiety and depression and lower overall wellbeing than people oriented towards ‘intrinsic goals’ of close relationships, self-knowledge and personal growth, and contributing to the community.<sup>13,20</sup> 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.

As materialism reaches increasingly beyond the acquisition of things to the enhancement of the person, the goal of marketing becomes not only to make us dissatisfied with what we have, but also with who we are. As it seeks evermore ways to colonise our consciousness, the market both fosters and exploits the restless, insatiable expectation that there must be more to life. In short, the more materialistic we are, the poorer our quality of life.

Individualism, by which I mean placing the individual at the centre of a framework of values, norms and beliefs and celebrating personal freedom and choice, is another cultural quality with profound significance for wellbeing, but here the evidence is contradictory. Wellbeing is associated with several qualities that individualistic societies should encourage, notably personal control and self-esteem;<sup>12,13</sup> individualism is, after all, supposed to be about freeing us to live the lives we want. Historically, individualisation has been a progressive force, loosening the chains of religious dogma, class oppression and gender and ethnic discrimination, and so associated with a liberation of human potential.

However, just as the reality of commitment differs from the ideal, so the reality of freedom differs from its ideal, especially when it is taken too far or is misinterpreted. Sociologists note that individualisation has transformed identity from a 'given' into 'task'; it has replaced determination of social standing with, in Bauman's words, 'compulsive and obligatory self-determination'.<sup>21</sup> The individualised life is a fate, not a choice; we can't choose not to play the game.

This process has had a range of consequences: a heightened sense of risk, uncertainty and insecurity; a lack of clear frames of reference; a rise in personal expectations, coupled with a perception that the onus of success lies with the individual, despite the continuing importance of social disadvantage and privilege; a surfeit or excess of freedom and choice, which is experienced as a threat or tyranny.<sup>22-25</sup> To cite Bauman again, there is 'a nasty fly of impotence in the ointment of freedom', an impotence that is all the more upsetting in view of the empowerment that freedom was expected to deliver.<sup>21</sup>

Psychology offers at least two mechanisms by which individualism not only reduces social connectedness and support, but also diminishes personal control. First, Twenge has argued that a lack of control over one's life can be part of a defensive strategy to maintain self-esteem.<sup>26</sup> The modern individual needs high self-esteem and one way to maintain that high self-esteem is to believe that the things that threaten it are beyond the one's control.

Secondly, building on the work of Ryan and his colleagues,<sup>27</sup> I have suggested that Western individualism confuses autonomy (the ability to act according to our internalised values and beliefs) with independence (not being reliant on or influenced by others).<sup>13</sup> Someone who holds collectivist values is behaving autonomously, but not independently, when acting in the interests of the group. (Or, to put it somewhat differently, 'thinking *for* ourselves' has been redefined as 'thinking *of* ourselves'.)

The confusion of autonomy with independence encourages a perception by individuals that they are separate from others and the environment in which they live, and so from the very things that affect their lives. The more narrowly and separately the self is defined, the greater the likelihood that the personal influences and social forces acting on us are experienced as external and alien. The creation of a 'separate self' could be a major dynamic in modern life, impacting on everything from citizenship and social trust, cohesion and engagement, to the intimacy of friendships and the quality of family life. So the issue here is not just a matter of the changed relationship between the individual (as an entity) and society, but of the way in which the individual self is construed. In other words, the result is not only increased objective isolation, but also more subjective loneliness (even in company or within relationships); out of regard for privacy – our own and others' – we may fail to seek support when we need it, or hesitate to offer it to others when we should.

An important means by which individualism and materialism affect wellbeing is through their influence on values.<sup>12,13</sup> Values are a core component of culture, a property of

societies and their people and institutions, as well as of individuals. Like culture more broadly, values have been underestimated in health research because their effects are hard to measure: they are abstract, generic, pervasive, flexible and internalised (just the sort of ‘rules’ complex adaptive systems like human societies need). Values provide the framework for deciding what is important, true, right and good, and have a central role in defining relationships and meanings, and so in determining wellbeing.

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. Virtues 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. ‘We define virtue almost exclusively as pro-social behaviour, and vice as anti-social behaviour’, Ridley observes in his analysis of human nature and society.<sup>28</sup>

Christianity’s seven deadly sins are: pride (vanity, self-centredness), envy, avarice (greed), wrath (anger, violence), gluttony, sloth (laziness, apathy) and lust. Its seven cardinal virtues are faith, hope, charity (compassion), prudence (good sense), temperance (moderation), fortitude (courage, perseverance) and religion (spirituality). Extending this list, Comte-Sponville gives these as ‘the great virtues’: politeness, fidelity, prudence, temperance, courage, justice, generosity, compassion, mercy, gratitude, humility, simplicity, tolerance, purity, gentleness, good faith, humour and, finally, love (which transcends virtue).<sup>29</sup> He says that a virtuous life is not masochistic or puritanical, but a way of living well and finding love and peace.

Modern Western culture undermines, even reverses, universal values and time-tested wisdom.<sup>12,13</sup> The result is not so much a collapse of personal morality, but a loss of moral clarity: a heightened moral ambivalence and ambiguity, a tension or dissonance between our professed values and lifestyles, and a deepening cynicism about social institutions. Without appropriate cultural reinforcement, we find it harder to do what we believe to be ‘good’; it takes more effort. And, conversely, it becomes easier to justify or rationalise bad behaviour. There are positive (reinforcing) feedbacks in the process: anti-social values weaken personal and social ties, which, in turn, reduce the ‘hold’ of a moral code on individuals because these ties give the code its ‘leverage’; they are a source of ‘moral fibre’.

Social perspectives on population health must also take personality into account because new research shows that our personalities are changing in ways that may impact on the psychosocial pathways between social conditions and health. For example, in a series of studies drawing on psychological tests conducted with American children and college students over periods of up to sixty years, Twenge and her colleagues have found large shifts (up to one standard deviation) in scores on a range of personality traits and other psychological qualities.<sup>26,30-34</sup> Twenge says her findings show that broad social trends - not just genes and the family environment, as psychologists have assumed - are important

influences on personality development.<sup>30</sup> She quotes an Arab proverb: ‘Men resemble their times more than they resemble their fathers.’<sup>34</sup>

Twenge and her colleagues found increases in trait anxiety (or neuroticism), self-esteem, extraversion and, in women, assertiveness, while sense of control over life had declined (that is, locus of control had become more external). To give two examples of the extent of these shifts, the average American child in the 1980s reported more anxiety than child psychiatric patients in the 1950s,<sup>30</sup> and the average college student in 2002 felt less control over their lives than 80-90 per cent of college students in 1962.<sup>26</sup> Using a range of indicators (for the anxiety study these included divorce rate, birth rate, women’s age at first marriage, proportion of people living alone, crime rate and youth suicide rate), Twenge links most of these trends to rising individualism and freedom through declining social connectedness and increasing environmental threat. Economic factors such as unemployment and poverty seem not to be involved.

With respect to the negatives, trait anxiety has been associated with depression, suicide attempts, alcohol and drug abuse and poorer physical health;<sup>30</sup> an external locus of control is associated with lower wellbeing, depression, anxiety, poor school achievement, helplessness, ineffective stress management and decreased self-control.<sup>26</sup> The associations of anxiety and lack of control with depression, for example, can be stronger than those between depression and experiences such as parental divorce, domestic violence, relationship break-ups, unemployment and financial hardship.<sup>35</sup>

Turning to the positives, the benefits of high self-esteem to wellbeing are now being questioned and it might itself have costs, including aggression and risk-taking.<sup>13</sup> It may also work against personal control, as already mentioned. And while extraversion is associated with higher wellbeing, its combination with the other personality changes could lead to a more narcissistic or ‘contingent’ self-esteem, which requires constant external validation or affirmation to be sustained.<sup>13,20</sup> This development is consistent with an extrinsic goal orientation that is associated with diminished wellbeing, as noted above.

Most of the associations between culture and wellbeing are correlational, as I have said; they do not prove that materialism, for example, causes a deterioration in wellbeing; it could also work the other way, with unhappier people drawn to materialistic pursuits as a distraction or antidote – as ‘retail therapy’. However, the associations do suggest the cultural promotion of materialism and individualism is not conducive to wellbeing. The causal relationships are likely to be complex and reciprocal, and to involve interactions with other, more specific influences, including genetic and socio-economic factors.

### **Culture’s impacts on health**

Culture’s impacts are most clearly observed in the study of psychological wellbeing, as the above discussion shows. Given this, and epidemiology’s traditional focus on physical disease, it is worth noting the personal and social costs of mental illness. Depression is the leading cause of disability in the world.<sup>36</sup> In the global ranking of the burden of disease, measured in terms of both disability and death, major depression is projected to

rise from fourth in 1990 to second in 2020.<sup>36</sup> In high-income countries, depression and other neuropsychiatric conditions account for more of the disease burden than heart disease or cancer.<sup>37</sup> Suicide, which has been called the mortality of depression, ranks in the ten leading causes of death in these countries.<sup>36</sup>

The extent to which we are falling short of maximising human wellbeing, despite falling mortality and rising life expectancy and material wealth, has been demonstrated in a large study of Americans aged 25-74, which examined mental health not just as the absence of mental illness but as ‘a syndrome of symptoms of positive feelings and positive functioning in life’.<sup>38</sup> The study found that 26 per cent of people were either ‘languishing’, depressed, or both – that is, mentally unhealthy; 57 per cent were moderately mentally healthy – neither mentally ill nor fully mentally healthy; and only 17 per cent of people were ‘flourishing’ – that is, they enjoyed good mental health. (Consistent with other research, older, well-educated, or married people were more likely to be flourishing and less likely to be languishing or depressed.)

When it comes to physical ill-health such as heart disease and cancer, cultural influences are likely to be hard to disentangle from the many other social and personal factors involved, as we have already learned with other distal determinants such as income inequality.<sup>3</sup> These factors include health care: in attempting to measure the health effects of social and cultural determinants, we must take into account the growing role of biomedical advances, which are extending life but, in doing so, may be masking the health effects of the changes in the social conditions in which we live.

Nevertheless, the combined evidence linking culture, via psychosocial pathways, to psychological wellbeing, and wellbeing, through behavioural and physiological pathways, to physical health is, I believe, persuasive. Health authorities now accept that there is strong and consistent evidence for a causal association between depression, social isolation and lack of social support and heart disease; and that the increased risk posed by these factors is of a similar order to that of more conventional risk factors such as smoking, high blood pressure and high cholesterol.<sup>39</sup> Mortality among people who are socially isolated is two to five times higher than for those with strong ties to family, friends and community.<sup>40</sup> Cultural factors, especially materialism or consumerism, are also implicated in adverse social trends such as growing obesity and inactivity, which, in turn, are linked to a wide range of physical health problems including heart disease, diabetes and cancer.<sup>41</sup>

The strength of the subjective – of perceptions, expectations and emotions - in influencing health more broadly is highlighted in an American study (reported in the psychological, not health, literature) that found that older people who had more positive self-perceptions of ageing lived an average 7.5 years longer than those with less positive attitudes.<sup>42</sup> The advantage remained even after age, gender, socio-economic status, loneliness and functional health were taken into account. The study says this effect on longevity is greater than the survival advantages associated in other studies with low blood pressure and cholesterol, not being overweight, not smoking, and exercising. The study notes one likely cause of poor self-perceptions of ageing: ‘socially sanctioned

denigration of the aged'. This is a cultural characteristic of modern Western societies with their adulation of youthfulness (if not youth), a trait promoted by materialism and individualism.

Most of the evidence cited above concerns individual-level health effects of psychosocial and attitudinal factors that culture influences (so making these effects a valid means of assessing the health impacts of culture). Several recent studies have also found population or ecological effects that are attributable to culture. A cross-country study of crime found that tolerance for a set of 'materially self-interested' attitudes – such as 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.<sup>43</sup> These values were also associated with national crime victimisation rates, more strongly so than were social trust and inequality. The relationships of inequality and social trust with crime were conditional on the prevalent values of society; thus inequality per se was only modestly associated with higher crime, but when it occurred in societies that were characterised by high levels of self-interested values its effects became more pronounced.

In another cross-country analysis, a colleague and I found strong and positive correlations between national youth suicide rates, especially among men, and several different national indicators of individualism, including a measure of young people's perceived freedom of choice and control over their lives (but which is probably measuring independence, as argued above), but not between suicide and social and economic factors including per capita income, poverty, youth unemployment, inequality and divorce.<sup>44</sup> A study of the association between suicide and deprivation and social fragmentation in British parliamentary constituencies found suicide was more strongly associated with fragmentation than with poverty (other causes of death were also related to fragmentation, but more strongly to deprivation).<sup>45</sup> Fragmentation was measured with indicators of renting, single-person households, unmarried people and mobility, so suggesting at least some influence of individualism.

These findings are consistent with the conclusions of a major international review in 1995 of the evidence on trends in psychosocial problems such as depression, drug abuse, suicidal behaviour and crime among young people in Western nations.<sup>25</sup> It concluded that social disadvantage and inequality were unlikely explanations for the increases in psychosocial disorders. Amongst its recommendations, the review called for further investigation of the theory that shifts in moral concepts and values were among the causes - in particular, 'the shift towards individualistic values, the increasing emphasis on self-realisation and fulfilment, and the consequent rise in expectations'. The review noted that far more effective use could be made of cross-national differences in testing possible explanations.

### **Cultural fraud**

The apparent harm caused by materialism and individualism raises the question of why these qualities persist and even intensify. Both have conferred benefits to health and

wellbeing in the past, but appear now to have passed a threshold where rising costs exceed diminishing benefits.<sup>13</sup> Various forms of institutional practice encourage this cultural ‘overshoot’. Government policy gives priority to sustained economic growth but leaves the content of growth largely to individuals, whose personal consumption makes the largest contribution to economic growth.

This ever-increasing consumption is not natural or inevitable, but culturally ‘manufactured’ by a massive and growing media-marketing complex. For example, big business in the United States spends over US\$1000 billion dollars a year on marketing – about twice what Americans spend annually on education, private and public, from kindergarten through graduate school.<sup>46</sup> This spending includes ‘macromarketing’, the management of the social environment, particularly public policy, to suit the interests of business.

Psychologists who have studied cults and mind control warn that even the brightest and best of us can be recruited or seduced by social situations and conditions to behave in ways that are contrary to our values and dispositions, to engage in actions that are immoral, illegal, irrational and self-destructive.<sup>47</sup> As Zimbardo has said, many agents of mind control ‘ply their trade daily on all of us behind many faces and fronts’; we need to learn how to resist them and to weaken their dominance.<sup>48</sup>

There is evidence that resistance is growing, that increasing numbers of people in Western nations are rejecting this dominant ethic of individual and material self-interest, and are making a comprehensive shift in their worldview, values and way of life as they seek to close the gap between what they believe and how they live.<sup>13</sup> Sociologists are writing of the emergence of a new moral autonomy and the opportunity to be truly moral beings, perhaps for the first time in history,<sup>49</sup> and the creation of new forms of social affiliation through a ‘cooperative or altruistic individualism’.<sup>50</sup> We may, then, be witnessing parallel processes of cultural decay and renewal, a titanic contest as old ways of thinking about ourselves fail, and new ways of being human struggle for definition and acceptance.

Cultures bring order and meaning to our lives. Of all species, we alone require a culture to make life worth living, to give us a sense of purpose, identity and belonging – personally, socially and spiritually – and a framework of values to guide our actions. There may be many cultural paths we can follow in meeting human needs. This is the source of our extraordinary diversity and versatility, but it is also a source of danger: we can lose the path altogether, run off the rails.

One of the most important and growing costs of our modern way of life is ‘cultural fraud’: the promotion of images and ideals of ‘the good life’ that serve the economy but do not meet psychological needs or reflect social realities. To the extent that these images and ideals hold sway over us, they encourage goals and aspirations that are in themselves unhealthy. To the extent that we resist them because they are contrary to our own ethical and social ideals, they are a powerful source of dissonance that is also harmful to health and wellbeing.

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