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The Implications that a Co-Constitution of Mind and Modern Western Culture May Have for Health: An Evaluation of the Concept of Control

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A fundamental tenet of cultural psychology is the co-constitution of mind and culture. This essay undertakes to elucidate the implications for health that such a tenet has within our modern Western culture, through an evaluation of the concept of control. A sociological account of our individualist, capitalist and consumerist culture is proffered, outlining the fluid nature of what has been termed "liquid modernity" and the implications this has for one's identity. In particular, the role that control may play in the etiology or exacerbation of depression, anorexia nervosa and health outcome discrepancies across the social hierarchy – known as the "status syndrome". Contemporary Western culture may be seen to have a largely deleterious effect on health: It may contribute to depression and anorexia albeit having a positive effect on the health of those at the top of the social hierarchy through its propagation of the status syndrome.

Keywords: culture, identity, depression, status syndrome, anorexia nervosa

Un principe fondamental en psychologie culturelle est la fusion entre esprit et culture. Cet essai tente de soutirer les impacts potentiels qu'un tel principe peut avoir au sein d'une société occidentale moderne, et ce à travers l'évaluation du concept de contrôle. Un inventaire sociologique de notre culture individualiste, capitaliste et consommatrice est offerte, dépeignant la nature fluide de ce qui a été conceptualisé comme étant de la « modernité liquide » ainsi que ses implications sur l'identité. Notamment, le rôle du contrôle dans l'étiologie ou l'expression de la dépression, l'anorexie mentale et autres conséquences dû à une hiérarchie sociale : le syndrome du statut. La culture occidentale contemporaine semble avoir des effets corrupteurs sur la santé : elle contribue potentiellement à la dépression et à l'anorexie, bien qu'elle ait une influence positive sur la santé des individus hautement classés dans la hiérarchie sociale à travers la diffusion du syndrome du statut.

Mots-clés : culture, identité, dépression, syndrome du statut, anorexie

"People are the same wherever you go" sing Paul McCartney and Stevie Wonder in their song "Ebony and Ivory". Shweder (1990) posits that this line sums up a core assumption within general psychology. Namely, that there is an innate and universal processing mechanisms inherent in human beings. Cultural psychology refutes this, asserting that humans, including such processing mechanisms, are indelibly linked to, and shaped by, their sociocultural environments. Indeed, cultural psychology is premised on this, "the principal of intentional or constituted worlds", which asserts that humans and sociocultural environments "interpenetrate each other's identity and cannot be analytically disjoined" (Shweder, 1990, p. 1). In an attempt to address invalid generalisations about purportedly universal human psychological functioning based on one particular population, namely the contemporary Western White middle class, the theorizing of this principal has tended to focus on cultures outside this population (Shweder & Sullivan, 1993).

Going against this trend and aiming to supplement it, the present undertaking endeavours to delineate the implications that this co-constitution of mind and culture has for health within our Western modern, "first world" culture. It aims to do so through an examination of the concept of control that pervades this culture. Therein, it proffers an atypical verification of

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the co-constitution of mind and culture. Thus, this discussion extends beyond prior literature which has tended to be strictly delimited by a particular paradigm; either mainstream clinical psychology or cultural psychology (MacLachlan, 1997). In contrast, the current undertaking serves to instantiate the relational metatheoretical principals which emphasize the interrelated and interdependent nature of cultural psychology and clinical psychology (Overton, 2007; Overton & Ennis, 2006; Ryder, Ban, & Chentsova-Dutton, 2011). This means that concepts such as that of control exist not only at, for instance, the psychological level investigated within clinical psychology but also at other levels of analysis, such as the sociocultural. In order to illustrate this transmission across the levels of analysis, the pertinent characteristics of this modern culture and their effect on one's identity will be discussed, followed by an explanation of the implications this may have for health. The current endeavour is likely to be better served by an in-depth analysis of a limited number of exemplars of control rather than a gleaning over of many. Hence, this explanation of health ramifications will centre on the role of control in depression, anorexia nervosa and in fostering health outcome discrepancies across the social hierarchy, known as the "status syndrome" (Marmot, 2004).

"Liquid Modern" Culture and Identity

Sociologist Zygmunt Bauman (2000) terms our modern Western culture "liquid modernity". "Liquid" referring to the fluid, continually changing quality that characterizes the individualist, consumerist and capitalist move of contemporary Western culture away from the more static, institutionalized and collective culture of preceding decades. Bauman explains that in these preceding Panoptical times (following from Bentham's Panopticon, epochs in which there was a reachable and knowable observer or authority), such as the Victorian era, there was a mutual engagement between the observer and the observed in society. This is embodied in the central role that work played in people's lives: Work was fundamental to one's identity since it was a means of fulfilment (Baumeister, 1987). For instance, a wealthy patron would commission a piece of work which served as an outlet for the creativity and passion of the craftsman. In our Post-Panoptical age, however, this mutual engagement between authority and citizens has ceased. The authority is now unreachable and fluid as in the case of the "absentee landlords" of modern day globalization. Or, as Harris (1981) affirms, in the case of the increasingly impersonal relations that now characterise producer -consumer relations. This engenders apathy in both parties owing to the lack of ongoing social bonds, which adds to the cumulative effect of contemporary culture described by Drucker as "no more salvation by society" (Bauman, 2000, p. 30). Gilles Lipovetsky (2005) explicates this further, asserting that this tide of modernity has resulted in the dismantling of the normative and protective collective networks and institutions which were previously central to people's identity (see also Baumeister, 1987; Danziger, 1997). Jung surmised that the modern day failure and abandonment of religion, for instance, deprives the individual access to the fixed answers to problems interpreting the self, as well as the secure moral base which religion offers (Jung, 1971).

Braverman (1974) presents the modern day division of labour as further evidence of this dismantling of protective societal institutions. He explains that in modernity each worker's job has become so repetitive that it has become meaningless. They cannot identify or take pleasure in the finished good. What's more, they cannot garner, as they once did, a sense of fulfilment from their work, something which has ramifications for their identity. These ramifications are constituted by a shift in motivation. Namely, from an intrinsic motivation to perform well, gain satisfaction and, indeed, fulfilment to a purely extrinsic motivation. As such, in modernity, one's potential in work is conceived of in terms of advancement or prestige. Furthermore, as Baumeister comments, fulfilment "for many seems to be a matter of pleasant sensations… (and of) hedonistic self indulgence" (Baumeister, 1987, p.6), something which is exacerbated by the individualist and consumerist ideals of contemporary culture and is almost the antithesis to the sense of fulfilment rooted in community and dialogical, collective identity which prevailed in bygone eras.

Thus, in our liquid modernity, without the bedrock of the protective societal networks and collective institutions which characterised previous epochs, individualism has come to be pervasive. This is evident in the shift towards a more self-orientated and individualised conception of identity. As such, the responsibility for success or failure and health or illness now lies solely with the individual.

Depression

It is due to this individualism that contemporary Western culture may be seen to shape and reinforce an external conceptualisation of mental ill-health, one

of the most ubiquitous examples being that of depression (Leader, 2009). Modern Western culture may be seen to foster a conception of depression as a biomedical disease. That is, as something external to the sufferer that needs to be controlled. This objectification of depression may be exacerbated by the consumerist underpinnings of our contemporary Western culture, in which patients may be encouraged to become passive recipients and consumers of healthcare: exerting control over their condition through the use of medications (Aujoulat, Marcolongo, Bonadiman, & Deccache, 2008; Livingston, 2004). As Cleland (1987) asserts, this is evidenced in the occurrence of social iatrogenesis in modern Western societies. This describes the process through which Western biomedicine fosters a morbid society preoccupied with disease which, in turn, encourages people to become consumers of curative and preventative medicine. However, in a attempt to combat and move beyond such passive patient roles, health care providers are now increasingly employing patient care models focused on 'activating' patients to become more responsible for their health care and more knowledgeable about, and committed to, their treatment (for e.g., Steele's model of patient empowerment: Steele, Blackwell, Gutman, & Jackson, 1987; numerous models of patient coping: Schmitz, Saile, & Nilges, 1996; Turk & Rudy, 1990; see also Aujoulat, d'Hoore, & Deccache, 2007).

This instantiates a vital addendum for this theoretical discussion in its entirety; namely, that the intention is not to posit that cultural factors penetrates uniformly and unaltered to the individual mind, as an initial reading of social iatrogenesis or indeed cultural psychology might suggest. Rather, the present undertaking presupposes that we are not such 'cultural dopes' (e.g., Danziger, 1997) in that, following the tenets of Shweder's conception of cultural psychology (e.g., Shweder, 1990), we actively interpret and modulate culture prior to identifying with or internalising aspects of it. This occurs not only on an individual level but also, for instance, through theoretical models of patient care.

Although the patient care models described above endeavour to oppose and repudiate cultural factors, such as social iatrogenesis, which encourage the passive patient role, several theorists argue that they fall short in this regard and do not adequately empower patients due to their inherent emphasis on an offensive effort to maintain a high level of illness control (Aujoulat, Marcolongo, Bonadiman, & Deccache, 2008; Salmon & Hall, 2003; Tilden, Charman, Sharples, & Fosbury, 2005). These models encourage patients to master medical knowledge relevant to their illness in order to exert and maintain control over the symptomatology associated with their illness. In the case of chronic ill-health, which often includes depression (e.g, Constantino, Lembke, Fischer, & Arnow, 2006; Kocsis et al., 2003), this truculent and persistent attempt at bolstering control has been shown to have adverse implications for patient outcomes and adjustment; being related to decreased functioning, social interaction and support seeking as well as adherence to medical recommendations. Most pertinent in the present context is the convergent conclusion reached by several researchers; that these deleterious consequences are related to the objectification of illness that is a concomitant of the offensive pursuit of control which characterizes many of these models (Aujoulat et al., 2008; Salmon et al., 2003; Tilden et al., 2005). Hence, whilst contemporary biomedical models of patient care attempt to curtail sociocultural factors, which encourage a passive patient role, these models are often unsuccessful and may inadvertently contribute to an objectified conception of disease, including depression.

The individualism and concomitant individualised conception of identity that characterise liquid modern culture may be seen to also contribute to an objectified conceptualisation of depression. This centres on the notion that, as explicated above, the responsibility for health lies solely with the individual. Hence, there may be a pressure to view depression in an objectified, biomedical manner and as something under one's own control: Depression is seen as a medical disease to be treated in a congruently medical fashion, namely with anti-depressants.

Anti-stigma organisations, such as the National Alliance for the Mentally Ill (NAMI), also contribute to this, positing that a biomedical conceptualisation of mental illness serves to reduce the stigma that sufferers encounter. In line with this, their informational brochure begins "Like diabetes and heart disease, major depression is a serious medical illness that is quite common" (NAMI, 2002, p. 3). Likening depression to these largely biological ailments (not to mention terming it a 'medical illness') propagates a view of depression as an objective biomedical condition and thus condones a congruent, purely medical treatment. Moreover, pharmaceutical companies such as Zoloft, often present only the neurobiological etiological mechanisms to consumers, and insurance companies urge patients to first consult general practitioners if they

feel they may be experiencing depression. This is more likely to result in the cheapest treatment option of anti-depressants compared with seeing a psychiatrist or psychologist, who is more likely to advocate for more costly psychotherapeutic interventions. Thus, this would cut down the costs of the insurance company (Goldstein & Rosselli, 2003), but also implicitly endorsing the control of depression through medication.

The discourse utilized by organisations such as NAMI and Zooloft resonates with phrases like 'suffering from a depression' and 'struck by a depression' which permeate modern discourse. This appears to substantiate the impact that this objectification has on the individual's conceptualisation of depression and therefore (since the two are interrelated; e.g., Gammell & Stoppard, 1999) treatment outcomes. This impact is further evidenced by the fact that in 1997 patients suffering through depression were 4.8 times more likely to be prescribed an antidepressant than in 1987 (Olfson et al., 2002). Further, there was a 10.9% decrease in the percentage of patients who received psychotherapy to treat their depression during the same period (Wyatt & Livson, 1994). Thus, although following the tenets of cultural psychology—specifically, the existential uncertainty principal—individuals within a culture are 'active agents' in their meaning making, interpretation and identification with aspects of their culture (e.g., Shweder, 1990). Thus, modern Western culture, overall, appears to be shaping the individual's conceptualisation of depression. Namely, shaping it through endorsing an objectified, biomedical conception of the disorder.

One might argue (as for e.g., NAMI, 2002 does) that this external and objectified conceptualisation of depression may be adaptive in that it reduces the potential threat to the self by placing depression outside the subject, much akin to the disembodiment of limbs which are afflicted with chronic pain. These patients often replace possessive adjectives with definite articles - referring to afflicted limbs as 'the leg' or 'the back' (MacLachlan, 2004). However, while rehabilitation in chronic pain is related to when the offending limb is reintegrated into the self concept (once again becoming 'my hands' versus 'the hands'; MacLachlan, 2004), this is not the case with depression, when it is conceptualised as external to the sufferer. At no point in such interventions is the patient encouraged to incorporate their depression as part of them. Rather, viewing depression as exogenous facilitates the biomedical approach, i.e., physicians treating an 'it' rather than a 'you' (MacLachlan, 2004). While this may be helpful for surgeons or immunologists, excising a tumour or fighting a bacterial infection, it may not be as adaptive as in the case of chronic pain but may, in fact, be ill founded in the case of depression (Anderson, 1993).

Psychiatrist Gordon Livingston contends that this objectification of depression and truculent attempt at bolstering control is counterproductive to overcoming the experience of depression. Rather, he asserts that empowerment of patients is paramount, in which depression is conceptualised as part of their own experience, as opposed to an external pathogen or disease which invades the body (Livingston, 2004). Gullestad, a psychoanalyst, expresses this concisely in her recommendation that patients be encouraged to "own his/her affective state… (such that the) feeling of hopelessness can be integrated into the individual's self representation - as part of the me experience" (Gullestad, 2003, p. 4). As alluded to earlier, research into chronic illness (ill-health which persists for 6 months or longer) substantiates this with patients who accept the uncontrollability inherent in such ill-health as opposed to those to truculently attempting to bolster control, progressing to an acceptance of the 'ill' aspects of the self and significantly greater adjustment outcomes (Adams, Pill, & Jones, 1997; Aujoulat et al., 2007; Shapiro, Astin, Shapiro, Robitshek, & Shapiro, 2011; Tilden et al., 2005).

Psychological research similarly validates this assertion. Several researchers contend that the objectification of depression reduces patients' beliefs regarding their ability to help themselves as well as their general health seeking behaviour (Keen, 2000; Szasz, 1961). In a prospective study of women diagnosed with depression, Gammell and Stoppard (1999) found that a biomedical conceptualisation of depression does not allow individuals to take control of their life situation, decreasing help-seeking behaviours and fostering their view of depression as something over which they had little power, controlled only by their medication (see Sayce, 2000, for a review of similar findings). Thus, Western cultural ideals may be seen to propagate an objectification of depression, as something over which one must forcibly exert control, oftentimes through medication. This, however, may ultimately be disempowering and, therefore, a deficient and counterproductive treatment for this now endemic (e.g., World Health Organisation, 2012) phenomenon.

Furthermore, when the objectified conception of depression as something which one should control (e.g., Leader, 2009) is coupled with the individualism and "dominating ideal of happy life'" (Gullestad, 2003, p. 7) that pervade contemporary Western culture, depression is seen, perhaps, as a failure. That is, firstly a failure of the individual sufferer to capitalise on the opportunities available to him or her, which our liquid modernity espouse as the source of happiness (Bauman, 2000). Secondly, a failure to maintain control which individualist and consumerist Western culture offers through anti-depressant medications (Leader, 2009). As a result, sadness and mourning have come to be seen as neither 'normal' nor healthy but rather as abnormal phenomena (Gullestad, 2003). This has a deleterious effect for two reasons. Firstly, sadness is indeed 'normal' and, what's more, mourning may be essential for healthy grieving (Freud, 1917; Maples, 1998). Secondly, it fosters the understanding of health as a dichotomy and not, as it rightly is, a continuum (MacLachlan, 1997). From this stems a certain stigma and shame with falling into the "ill" category (e.g., Maples, 1998), which further exacerbates depression.

An alternative argument could be made that the increased incidence of depression over the last few years (e.g., WHO, 2012) is the cause of the rise in anti -depressant prescription, rather than liquid modern and biomedical-endorsing cultures. This is being based on the fact that these are legitimate, or simply ubiquitous, treatment methods. The debate on anti-depressants is vast and intricate to the extent that a valid discussion is beyond the scope of the current undertaking. That said, given that it underscores some of the arguments presented here, it seems germane enough to necessitate a brief discussion. It appears to me that, at present, the evidence against anti-depressants as a valid treatment method is growing at a far greater rate than that which endorses them and that an increasing number of researchers in the area are concluding that they are not an adequate way of addressing depression (Lesch, 2004; Silberg, Maes, & Eaves, 2010; see also Fournier et al., 2010 for a meta-analysis of anti-depressant efficacy). Darian Leader, for instance, points out that the empirical research affirming the efficacy of anti-depressants (based on the elucidation of the biological underpinnings of the disorder) receives an inordinate amount of funding relative to that which investigates the efficacy of psychotherapeutic interventions, owing to the support of the pharmaceutical industry (Leader, 2009). Further, many theorists refute such research in favour of the view that biological underpinnings are not causal but rather the embodiment or result of broader psychological or psychosocial issues (Leonard & Myint, 2009; Ströhle & Holsboer, 2003; Wolkowitz, Burke, Epel, & Reus 2009). This rebuke of overly reductionist theorizing is expressed concisely by statistician Lee Cronbach. He refers to researchers who are determined to find unidirectional causal relationships which they view as perfectly adequate, thereby neglecting our subjective experience of the world, as "…Flat Earth folk (who) seek to bury any complex hypothesis with an empirical bulldozer" (Cronbach, 1982, p. 70). Thus, it seems prudent to suggest that the sharp rise in the prescription of anti-depressants may not be fully accounted for by the increase in incidence of depression since it's clear that there are a number of researchers and practitioners who question the legitimacy of their use as a treatment method. This, I would suggest, appears to bolster the role that modern Western culture may play in the proliferation of antidepressants and the concomitant biomedical conceptualisation of depression.

And so, through the Western consumerist and individualist cultural ideals and endorsement of the biomedical model, individuals suffering through depression may be seen to have taken on a passive role and thus lack the empowerment that may be vital for treatment. When one couples this with mourning and sadness oftentimes being socially unacceptable in contemporary Western culture, one can see how this cultural context may contribute to rise of depression to the title of second greatest contributor to the 'global burden of disease' (e.g., WHO, 2012).

Anorexia Nervosa

Western culture's individualism, such that it deems all success or failure the sole product of one's ability to capitalize, or not, on the opportunities available in one's environment, may exert influence over not only a person's ability to rise from 'rags to riches' but also their health, as seen above in relation to depression. In conjunction with other facets of our modern culture, this individualism may also be seen to contribute to another form of ill-health, namely anorexia nervosa. Here an addendum is necessary: I do not wish to posit that culture is the sole determinant of eating disorders, rather that it may be one of a number of etiological factors or perhaps a factor that exacerbates the suffering of those experiencing an eating disorder.

Consultant psychiatrist Aisling Campbell asserts that both empirical research (e.g., Surgenor, Horn, &

Hudson, 2003; Tiggemann & Raven, 1998) and her own clinical experience concur in suggesting that anorexia nervosa may result from a need to control some aspect of one's experience (Campbell, 2008). Indeed, when one considers the criteria for the diagnosis of the disorder, it is apparent that a need for control may contribute to some or all of these characteristics: less than 85% of normal/expected weight; intense fear of weight gain; inaccurate view or experience of body shape; disturbance to the normal rhythm of the menstrual cycle (American Psychiatric Association, 2000). This is particularly relevant when other areas of an individual's life seem uncontrollable, for example, following the collapse of a relationship or career.

The account of Aine Crowley, an artist who previously experienced anorexia, harrowingly substantiates this through the diary entries she kept during that period of her life (Crowley, 2008). During her first year of art college she explains that she was determined "to prove to myself and others that I was not wasting my time in art college". And so she began to work ferociously at her studies in order to achieve this and to gain control of her life. However, her new work ethic resulted in her beginning to skip meals and lose weight, culminating in a diagnosis of anorexia nervous. At first, she refused to face her diagnosis, insisting she "had this overwhelming feeling of control over everything…I was being independent I didn't need anyone to nurse me" (Crowley, 2008, p. 148). Nearly a year later, however, the opposite was the case: "I've no control over anything anymore. Even my health isn't in my hands" (Crowley, 2008, p. 161). Here we see how the individualistic cultural ideals of control and success may pressure an individual to achieve these ideals in their own lives. Such control, however, may not be beneficial but, as in this case, spurious and destructive.

Bordo (1993) delineates the nuances of this relationship between anorexia and the ideals that contemporary culture fosters. She points out that one must look not only at the cultural ideal of control but also the circumscribing manner in which feminity is constructed in contemporary discourses and hence the effect it may have on the identity of the modern woman. In the nineteenth century, feminity was constructed through certain personality traits or behaviours, namely delicacy, sexual passivity and capricious emotionality. With the advent of the television and movie industries in the twentieth century, however, the construction of feminity has come to be prescribed more and more through visual means. In our image-obsessed culture, feminity is now primarily constructed not through personality characteristics but bodily discourse: images stipulating the clothing, body shape and facial expressions that constitute the "modern woman" (Bordo, 1993).

This 'modern woman' is, as Bordo describes, "a double bind": a construction that affirms contradictorily ideals and directives (Bordo, 1993, p. 313). This contradiction comprises, on the one hand, the domestic conception of feminity that our modern Western culture still endorses. That is, a robust sexual division of labour in which women are confined to the home and have fewer chances to aqcuire more prostegious positions in the workplace. On the other hand, in order to legitimize their access to the modern professional arena, women must also master the 'masculine' values of that arena–discipline, emotional reservedness and control.

In line with both the theorizing of Campbell (2008) and firsthand account of Crowley (2008), Bordo (1993) affirms that anorexia often evolves from a relatively benign attempt at self-control, such as dieting. However, this conventional feminine practice may be stretched beyond convention with a discovery of what it feels like to crave and need but yet, through staunchness of will, to 'triumph' over such need. What ensues is the experience of the traditionally 'masculine' values of self-control, expertise and power which now pervade the construction of the modern woman. In the case of anorexia nervosa, this experience is intoxicating and habit-forming to a life threatening extent. Resonating with the sentiment expressed by Aine Crowley (2008), above, another past sufferer of anorexia Aimee Liu, describes the experience as follows: " I need nothing and no one else…I will be master of my own body, if nothing else, I vow" (Liu, 1979, p. 123). Bordo (1993) asserts that this experience is so affecting because, in conjunction, the ideal of slenderness and concomitant exercise and diet regimens offer the insidious illusion of meeting, thorough the body, the contradictory demands of the 'double bind' modern construction of feminity. The attempt at reconciling these incongruent demands of the modern definition of feminity is indeed an illusion since feminity and masculinity have, arguably, always been constructed through a process of mutual exclusion. The modern woman can, and should, exercise the historically male characteristics of control and power. However, when such virtues are forced beyond healthy practice (perhaps attempting to validate entry to the historically patriarchal professional arena) and circumscribed by

impossible ideals of slenderness, it's clear that this 'androgynous' feminity is not a viable possibility for the self.

This modern construction of feminity is, as Brodo describes it, "a parody" (Brodo, 1993, p. 316). However, she explains that in our image-obsessed, contemporary culture we find it increasingly difficult to differentiate between parodies and possibilities for the self (Brodo, 1993). This is harrowingly evidenced in the case of anorexia nervosa. Here, explored as a possibility for the self, the parody exposes itself, becoming "a war that tears the subject in two…a battle between the male and female sides of the self" (Brodo, 1993, p. 316). Anorexia nervosa poignantly demonstrates how liquid modern cultural ideals, particularly of control and the circumscribing modern construction of feminity, may affect an individual's sense of identity, shaping their behaviour and experience to such an extent that they foster ill-health, sometimes to a life threatening degree.

The Status Syndrome

That said, perhaps it may be argued that these individualist cultural ideals of controlling ones destiny, through capitalising on the fact that health or illness is the sole responsibility of the individual, may be beneficial beyond the 'rags to riches' procurement of wealth. Most notably, these ideals have been found to promote health and even extend life, through what Sir Michael Marmot, epidemiologist, terms the status syndrome (Marmot, 2004). Status refers to the outcome of an evaluation that produces differences in respect and prominence (Keltner, Gruenfeld, & Anderson, 2003) and status syndrome to the discrepancies in health outcomes that result from status differentials. Controlling for wealth, it has been demonstrated that people of even marginally higher status live significantly longer than those below them (Marmot, 2004). This includes winners versus nominees of both Academy Awards (Redelmeier & Singh, 2001) and Nobel Prizes (Rablen & Oswald, 2008).

This is further validated by the findings of the Whitehall studies, which examined the relationship between the status differentials and health outcomes of British civil servants (Marmot, 2004). In one of the studies, which examined the relationship over a 25 year period, status was statistically significantly related to morbidity in old age, such that those higher in status live longer and vice versa (Marmot & Shipley, 1996). Mental health is also affected: The reviews of Ghaed and Gallo (2007) and Wolff, Subramanian, Acevedo-Garcia, Weber and Kawachi (2010) both found that increased status leads to a decrease in psychosocial problems, including depression and anxiety. Marmot explains that this effect of status is due to "how much control you have over your life – and the opportunities you have" (Marmot, 2004, p. 2) and the concomitant effect this may have on one's identity: The experience of exerting control of the environment alters one's perception of oneself (Infurna, Gerstorf, Ram, Schupp, & Wagner, 2011).

This sense of control is almost precisely what the abovementioned Western individualist ideals affirm. Therefore, we may infer that these ideals play at least some role in the propagation of the status syndrome. Johnson and Krueger (2005) provide a specific example of the effect of control on physical health amongst monozygotic twins. They found that those twins who shared low income environments also shared health problems, such as heart disease and diabetes. These health problems are shown to be reduced through the alleviation of poverty and concomitant stressors. However, the findings indicate that a comparable reduction in health problems may be achieved through an increased perception of control over one's environment.

Similar to its precursor status, control has been shown to affect both physical and mental health. The research of Arslan, Dilmaç and Hamarta (2009) demonstrates that, amongst university students, stress and anxiety levels are related to the degree of control which the students feel they have over their environment and life events. More specifically, those with a greater sense of control experience less stress and anxiety and vice versa. Numerous studies assert that a similar correlation exists between control and depression (see Gray-Stanley et al., 2010; Hartley, Vance, Elliott, Cuckler, & Berry, 2008; Jones & Riazi, 2011). In line with the assertions made by Marmot (2004), this further substantiates the degree to which one's sense of control may impact upon one's health.

There is a caveat regarding this beneficial impact of Western individualism that I feel should be highlighted. Namely the fact that the inverse is true: People at the bottom of the social status ladder experience ill-health as well as a lack of control (Marmot, 2004). Marmot is optimistic despite this, however. He states that he cannot envisage a society where all are equal, asserting that "all societies will have social rankings; ergo all societies will have

health gradients" (Marmot, 2004, p. 25). Marmot (2004) is optimistic based on the fact that life expectancy across all gradients is increasing, therefore today's bottom social groups could, in the future, have the same health benefits as today's top social groups (Drever & Whitehead, 1997). The extent to which one subscribes to this is a personal matter, which I will not stray into since it is beyond the remit of the present undertaking. What is relevant, nonetheless, is that modern Western cultural ideals of control and individualism affect health through the propagation of the status syndrome.

An argument against the causal role of culture in fostering the status syndrome, and thus a necessary addendum here, is its postulated biological underpinnings - which may be interpreted by some as causal. This centres on the notion that the increased control that those of higher status experience is accompanied by a sense of increased power (an individual's relative capacity to modify others' states by providing or withholding resources or administering punishments; Keltner et al., 2003). The review of Keltner et al. (2003) delineates how research has found that increased power is associated with increased activity within the dopaminergic, reward system of the brain (left frontal cortex and mesolimbic region) and concomitant inhibition of cortisol and norepinephrine systems (right frontal cortex and septohippocampal region), which control the vigilant attention and stress systems.

Thus, increased status and concomitants of control and power produces reward rich environments and freedom, characterised by approach related behaviour of attention to rewards and positive affect. On the other hand, a decrease in status results attentional resources being taken up by a hyper-alertness to possible threats. This manifests in chronic hyper-vigilance and inhibition-related behaviours of social constraint that, in sum, often lead to negative emotional states. This, when taken with coherent findings of status/ dominance related health benefits within primates (e.g., Sapolsky, 2005), may imply that we seek out higher status for the rewards imbued by control and power concomitants, as a adaptive mechanism which may contribute, or have contributed, to our evolutionary fitness.

Therefore it may be argued that biological or evolutionary factors contribute to the status syndrome as opposed to Western culture. It would seem more prudent to me, however, to infer that this serves instead to implicate Engel's biopsychosocial model (Engel, 1977). That is, interactions between biology and culture are moderated by an individual's perception and identification with aspects of their culture, and, thus, this produces ramifications for the health of that individual. The neurobiological underpinnings of power may not, therefore, be responsible for us seeking, and indeed revering, status. Rather, they may be concomitants or effects of sociocultural forces. Thus, this may serve as evidence for a plausible addendum to the tenet of cultural psychology that mind and culture are inextricably tied, as it appears that it is not just culture and mind that co-constitute each other but rather it seems that culture, mind and neurobiology are intricately intertwined.

Conclusion

The present review sought to verify a central premise within cultural psychology, that human beings and sociocultural factors co-construct one another, as well as to delineate the implications this premise has for health. In particular, it endeavoured to examine the role that the concept of control may play—through a co-constitution of mind and Western individualist, capitalist and liquid modern culture—in depression, anorexia nervosa and the status syndrome. The salient characteristics of this culture were explicated, amounting to an elucidation of how it has come to shape the currently pervasive sense of identity, nowadays notably more individualized and self-orientated than that which prevailed in bygone eras. Liquid modern culture was evidenced to contribute to an objectified biomedical conception of depression, whereby it is viewed as akin to an external virus or bacterium, which infiltrates the individual leading to depression. The ramifications that this conceptualisation has for patients experiencing depression were then delineated. These illustrate that such a conceptualisation ultimately encourages the patient to be passive in their treatment, relying on pharmacological agents in order to exert control over their condition, as opposed to being active and empowered, which research often affirms is related to overcoming depression. It was then demonstrated that the modern Western cultural ideal of control may be seen to contribute to or exacerbate anorexia nervosa; An effect shown to be further compounded by the contradictory ideals and directives that characterize the construction of the modern women which pervade our liquid modern culture. Lastly it was illustrated that modern Western culture may be seen to have positive effects on health through what is termed the status syndrome, which refers to the significantly better health outcomes

enjoyed by those higher up the social hierarchy. These health benefits were shown to not be accounted for by the concomitant wealth and access to healthcare which those of higher status hold, but rather the increased sense of control they experience, as well as neurobiological factors.

Thus, this review has illustrated that the co-constitution of mind and liquid modern Western culture may be seen to have observable, robust and potent implications for health through the concept of control that it propagates. This discussion therefore also serves to advocate for renewed and greater consideration of cultural factors in health care provision and health policy formation. At a more theoretical level, this review illustrates how the concept of control transcends the level of analysis; for instance, from the neurobiological underpinnings of the status syndrome, to the psychological manifestations in anorexia, and to the sociological facets of liquid modern culture. Moreover, this transmission across levels substantiates not only the co-constitution of mind and culture, but also the interconnectedness of cultural and clinical psychology, which previous work typically characterizes as distinct and unrelated fields (Ryder et al., 2011).

In sum, through an examination of the concept of control, it was shown that this co-constitution of mind and culture has largely adverse implications for health. Thus, I concur with Shweder (2000) in not subscribing to the notion of "our (Westerners) moral superiority over all the rest" (Shweder, 2000, p. 4). We may, at times, like to think of ourselves as an utopian, "first world" culture, one that propels people to uplift themselves. It seems, however, that there is, perhaps, a startling underbelly to our Western culture, that may foster deleterious health implications and to which, in the current author's opinion, theorists, health-care providers and policy makers must not fail to attend.

References

Adams, S., Pill, R., & Jones, A. (1997). Medication, chronic illness and identity: The perspective of people with asthma. *Social Science & Medicine*, *45*, 189-201.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Anderson, T. T. (1993). Review of "Being-in-the-world: A commentary on Heidegger's Being and Time". *Journal of Theoretical and Philosophical Psychology*, *13*, 62-69.

Arslan, C., Dilmaç, B., & Hamarta, E. (2009). Coping with stress and trait anxiety in terms of locus of control: A study with Turkish University students. *Social Behavior and Personality*, *37*, 791-800.

Aujoulat, I., d'Hoore, W., & Deccache, A. (2007). Patient empowerment in theory and practice: Polysemy or cacophony? *Patient Education and Counseling*, *66*, 13-20.

Aujoulat, I., Marcolongo, R., Bonadiman, L., & Deccache, A. (2008). Reconsidering patient empowerment in chronic illness: A critique of models of self-efficacy and bodily control. *Social Science & Medicine*, *66*, 1228-1239.

Bauman, Z. (2000). *Liquid Modernity*. Cambridge, UK: Polity Press.

Baumeister, R. F. (1987). How the self became a problem: A psychological review of historical research. *Journal of Personality and Social Psychology*, *52*, 163-176.

Bordo, S. (1993). *Unbearable weight: Feminism, Western culture, and the body*. Berkeley, CA: University of California Press.

Braverman, H. (1974). *Labor and monopoly capital: The degradation of work in the twentieth century*. New York: Monthly Review Press.

Campbell, A. (2008). Eating disorders: A psychiatric perspective. In G. Moore-Groarke (Ed.), *In search of thinness. Treating anorexia and bulimia* (pp. 29-73). Dublin, Ireland: Currach Press.

Cleland L. G. (1987). 'RSI': A model of social iatrogenesis. *Medical Journal of Australia, 147*, 236-239.

Constantino, M. J., Lembke, A., Fischer, C., & Arnow, B. A. (2006). Adult depression: Features, burdens, models, and interventions. In T. G. Plante (Ed.), *Abnormal psychology in the 21st century* (pp. 139-166). Connecticut, U.S.A.: Praeger.

Cronbach, L. J. (1982). Prudent aspirations for social inquiry. In W. H. Kruskal (Ed.), *The social sciences: Their nature and uses* (pp. 61-81). Chicago: The University of Chicago Press.

Crowley, A. (2008). My journey. In G. Moore-Groarke (Ed.), *In search of thinness. Treating anorexia and bulimia* (pp. 134-165). Dublin, Ireland: Currach Press.

Danziger, K. (1997). *Naming the Mind: How Psychology found its Language*. UK: Sage.

Drever, F., & Whitehead, M. (Eds.). (1997). *Health inequalities*. London, UK: The Stationery Office.

Engel, G L. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, *196*, 129-136.

Fournier, J. C., DeRubeis, R. J., Hollon, S. D., Dimidjian, S., Amsterdam, J. D., Shelton, R. C., & Fawcett, J. (2010). Antidepressant drug effects and depression severity: A patient-level meta-analysis. *Journal of the American Medical Association*, *303*, 47-53.

Freud, S. (1917). Mourning and melancholia. In *The standard edition of the complete psychological works of Sigmund Freud, Volume XIV (1914-1916): On the history of the psycho-analytic movement, papers on metapsychology and other works* (pp. 237-258). London: Hogarth press: Institute of Psycho-Analysis.

Gammell, D. J., & Stoppard, J. M. (1999). Women's experience of treatment of depression: Medicalization or empowerment? *Canadian Psychology*, *40*, 112-128.

Ghaed, S. G., & Gallo, L. C. (2007). Subjective social status, objective socioeconomic status, and cardiovascular risk in women. *Health Psychology*, *26*, 668-674.

Goldstein, B., & Rosselli, F. (2003). Etiological paradigms of depression: The relationship between perceived causes, empowerment, treatment preferences, and stigma. *Journal of Mental Health*, *12*, 551-563.

Gray-Stanley, J. A., Muramatsu, N. N., Heller, T. T., Hughes, S. S., Johnson, T. P., & Ramirez-Valles, J. J. (2010). Work stress and depression among direct support professionals: The role of work support and locus of control. *Journal of Intellectual Disability Research*, *54*, 749-761.

Gullestad, S. (2003). One depression or many? *Scandinavian Psychoanalytic Review*, *26*, 123-130.

Harris, M. (1981). *America now: The anthropology of a changing culture.* New York: Simon & Schuster.

Hartley, S. M., Vance, D. E., Elliott, T. R., Cuckler, J. M., & Berry, J. W. (2008). Hope, self-efficacy, and functional recovery after knee and hip replacement surgery. *Rehabilitation Psychology*, *53*, 521-529.

Infurna, F. J., Gerstorf, D., Ram, N., Schupp, J., & Wagner, G. G. (2011). Long-term antecedents and outcomes of perceived control. *Psychology and Aging*, *26*, 559-575.

Johnson, W., & Krueger, R. F. (2005). Higher perceived life control decreases genetic variance in physical health: Evidence from a national twin study. *Journal of Personality and Social Psychology*, *88*, 165-173.

Jones, F., & Riazi, A. (2011). Self-efficacy and self-management after stroke: A systematic review. *Disability and Rehabilitation: An International, Multidisciplinary Journal, 33*, 797-810.

Jung, C. G. (1971). The spiritual problem of modern man. In J. Campbell (Ed.), *The portable Jung* (pp. 456-480). New York: Viking.

Keen, E. (2000). *Chemicals for the mind: Psychopharmacology and human consciousness*. Westport, Connecticut: Praeger.

Keltner, D., Gruenfeld, D. H., & Anderson, C. (2003). Power, approach, and inhibition. *Psychological Review*, *110*, 265-284.

Kocsis, J. H., Rush, A. J., Markowitz, J. C., Borian, F., Dunner, D. L., & Koran, L. M. (2003). Continuation treatment of chronic depression: A comparison of nefazodone, cognitive behavioural analysis system of psychotherapy, and their combination. *Psychopharmacology Bulletin, 37,* 73-78.

Leader, D. (2009). *The new black: Mourning, melancholia and depression*. Minneapolis: Greywolf Press.

Leonard, B. E., & Myint, A. (2009). The psychoneuroimmunology of depression. *Human Psychopharmacology: Clinical and Experimental, 24*, 165-175.

Lesch, K. P. (2004). Gene-environment interaction and the genetics of depression. *Journal of Psychiatry and Neuroscience, 29*, 174-184.

Lipovetsky, G (2005). *Hypermodern times*. Cambridge: Polity Press.

Liu, A. (1979). S*olitaire.* New York: Harper and Row.

Livingston, G. (2004). *Too soon old, too late smart*. New York: Marlowe & Company.

MacLachlan, M. (1997). *Culture and health*. Chichester, UK: Wiley.

MacLachlan, M. (2004). *Embodiment: Clinical, critical and cultural perspectives on health and illness.* Maidenhead: Open University Press.

Maples, M. R. (1998). Mental ghosts and the process of grief. *Journal of Personal & Interpersonal Loss*, *3*, 217-231.

Marmot M. (2004) *Status syndrome*. London: Bloomsbury.

Marmot, M. G., & Shipley, M. J.. (1996) Do socioeconomic differences in mortality persist after retirement? 25 year follow up of civil servants from the first Whitehall study. *British Medical Journal*, *313*, 1177-1180.

National Alliance for the Mentally Ill. (2002).Understanding major depression. What you need to know about this medical illness [Brochure]. Retrieved 21 Mar 2012 from http://www.nami.org/Template.cfm?Section=By_Illness&template=/ContentManagement/ContentDisplay.cfm&ContentID=88980

Olfson, M., Marcus, S. C., Druss, B., Elinson, L., Tanielian, T., & Pincus, H. A. (2002). National trends in the outpatient treatment of depression. *Journal of the American Medical Association, 287*, 203-209.

Overton, W. F. (2007). A coherent metatheory for dynamic systems: Relational organicism-contextualism. *Human Development*, *50*, 154-159.

Overton, W. F., & Ennis, M. D. (2006). Cognitive-developmental and behavior-analytic theories: Evolving into complementarity. *Human Development*, *49*, 143-172.

Rablen, M. D., & Oswald, A. J. (2008). Mortality and immortality: The Nobel Prize as an experiment into the effect of status upon longevity. *Journal of Health Economics, 27*, 1462-1471.

Redelmeier D. A., & Singh, S. M. (2001) Survival of academy award winning actors and actresses. *Annals of Internal Medicine, 134*, 955-962.

Ryder, A. G., Ban, L. M., & Chentsova-Dutton, Y. E. (2011). Towards a cultural–clinical psychology. *Social and Personality Psychology Compass*, *5*, 960-975.

Salmon, P., & Hall, G. M. (2003). Patient empowerment and control: A psychological discourse in the service of medicine. *Social Science & Medicine*, *57*, 1969-1980.

Sapolsky, R. M. (2005). The influence of social hierarchy on primate health. *Science*, *308*, 648-652.

Sayce, L. (2000). *From psychiatric patient to citizen. Overcoming discrimination and social exclusion.* New York: St. Martin's Press, Inc.

Schmitz, U., Saile, H., & Nilges, P. (1996). Coping with chronic pain: Flexible goal adjustment as an interactive buffer against pain-related distress. *Pain*, *67*, 41-51.

Shapiro, J., Astin, J., Shapiro, S. L., Robitshek, D., & Shapiro, D. H. (2011). Coping with loss of control in the practice of medicine. *Families, Systems, & Health*, *29*, 15-28.

Shweder, R. A. (1990). Cultural psychology: What is it? In J. W. Stigler, R. A. Shweder, & G. Herdt (Eds.), *Cultural psychology: Essays on comparative human development* (pp. 1-46). Cambridge, England: Cambridge University Press.

Shweder, R. A. (2000). Moral Maps, "First World" conceits, and the new Evengelists. In L. E. Harrison & S. P. Huntington (Eds.), *Culture matters. How values shape human processes* (pp.158-177). New York: Basic Books.

Shweder, R. A., & Sullivan, M. A. (1993). Cultural psychology: Who needs it? *Annual Review of Psychology*, *44*, 497-523.

Silberg, J. L., Maes, H., & Eaves, L. J. (2010). Genetic and environmental influences on the transmission of parental depression to children's depression and conduct disturbance: An extended Children of Twins study. *Journal of Child Psychology & Psychiatry*, *51*, 734-744.

Steele, D. J., Blackwell, B., Gutman, M. C., & Jackson, T. C. (1987). Beyond advocacy: A review of the active patient concept. *Patient Education and Counseling*, *10*, 3-23.

Ströhle, A. A., & Holsboer, F. (2003). Stress responsive neurohormones in depression and anxiety. *Pharmacopsychiatry*, *36*, 207-214.

Surgenor, L. J., Horn, J., & Hudson, S. M. (2003). Empirical scrutiny of a familiar narrative: Sense of control in anorexia nervosa. *European Eating Disorders Review*, *11*, 291-305.

Szasz, T. S. (1961). *The myth of mental illness: Foundations of a theory of personal conduct*. New York: Paul B. Hoeber, Inc.

Tiggemann, M., & Raven, M. (1998). Dimensions of control in bulimia and anorexia nervosa: Internal control, desire for control, or fear of losing self-control? *Eating Disorders: The Journal of Treatment & Prevention*, *6*, 65-71.

Tilden, B., Charman, D., Sharples, J., & Fosbury, J. (2005). Identity and adherence in a diabetes patient: Transformations in psychotherapy. *Qualitative Health Research*, *15*, 312-324.

Turk, D. C., & Rudy, T. E. (1990). The robustness of an empirically derived taxonomy of chronic pain patients. *Pain*, *43*, 27-35.

Wolff, L. S., Subramanian, S. V., Acevedo-Garcia, D., Weber, D., & Kawachi, I. (2010). Compared to whom? Subjective social status, self-rated health, and referent group sensitivity in a diverse US sample. *Social Science & Medicine, 70*, 2019-2028.

Wolkowitz, O. M., Burke, H., Epel, E. S., & Reus, V. I. (2009). Glucocorticoids: Mood, memory, and mechanisms. In L. L. Judd & E. M. Sternberg (Eds.), *Glucocorticoids and mood: Clinical manifestations, risk factors and molecular mechanisms* (pp. 19-40). New York: Wiley-Blackwell.

World Health Organisation (WHO). WHO Website. Retrieved 20 Mar 2012 from http://www.who.int/mental_health/management/depression/definition/en/

Wyatt, R. C., & Livson, N. (1994). The not so great divide? Psychologists and psychiatrists take stands on the medical and psychosocial models of mental illness. *Professional Psychology: Research and Practice, 25*, 120-131.

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