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RANK AND HEALTH: A CONCEPTUAL DISCUSSION OF SUBJECTIVE HEALTH AND PSYCHOLOGICAL PERCEPTIONS OF SOCIAL STATUS

PIERRE MORIN, Process Work Institute, Portland, Oregon, USA

ABSTRACT *The social dimensions of health and illness have been studied extensively from a materialistic angle. The nonmaterial or subjective factors of social experience affecting health have only recently received some attention. This paper introduces a new multidimensional concept of rank, which includes social dimensions as well as nonmaterially based elements of emotional, psychological, and spiritual strength. It proposes that rank is an important addition to the current literature of socioeconomic inequality and health and examines its relevance for the discussion of how social status inequalities affect people's global health. It suggests that rank as a signifier of power contributes to feelings of powerlessness and leads to worsened health outcomes. This paper suggests that perceived rank may play a role in the socioeconomic status (SES) effect on self-reported health. It presents a new conceptual and therapeutic model to address issues of rank-based discrimination in health care. Copyright © 2006 John Wiley & Sons, Ltd.*

Key words: rank, subjective health, SES, marginalization, power, Process Work

INTRODUCTION

Health can be defined in many ways and the description of health encompasses objective factors, subjective experiences and their somatic, mental, and social dimensions. This article's general inquiry is about constituents of health and the role of psychosocial factors in influencing health and creating health disparities. More specifically, this conceptual discussion focuses on the part that psychological perception of social status, dominance, or rank plays in affecting subjective health. The primary objective of this paper is the specification and operationalization of an expanded concept of rank and the demonstration of its association with subjective health. The inclusion of both material and nonmaterial dimensions to the study of socioeconomic inequality and health is believed to be an important addition to the current literature. Further, it introduces

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the reader to a new conceptual and therapeutic model for addressing rank-based discrimination.

RANK

Human status hierarchies are complex and involve social and individual processes. The nature of our social relations is influenced by various strategies that involve dominance, prestige and privilege, processes of inclusion or exclusion, and material equality. Social and psychological wellbeing are closely connected and our social world affects psychological, behavioral, and health outcomes. As individuals we face the problem of negotiating our social world. We compare ourselves in relation to others and our self-evaluation shapes our psychological atmosphere and guides our behavior. We use skin color, gender, sexual orientation, religion, culture and social status to qualify a person's diversity and to discriminate and marginalize some over others. Psychological literature, concentrating on the individual, often ignores the effect of this process of social differentiation and power differences down the various social hierarchies. On the other hand, the sociological literature that addresses issues of social stratification usually ignores its interaction with individual psychology. The concept of rank brings individual and society together in an attempt to increase our awareness of the ways in which individual psychology interacts with sociological processes. Rank (Mindell, 1995; Fuller, 2003) reflects the underlying power differences of the many hierarchies we use on a daily basis to compare ourselves. Rank entitles and it limits. It is a source of pride, shame and humiliation. As a signifier of power it acquires its constructive and destructive effects. Rank incorporates collective dimensions like 'social capital' (Putnam et al., 1993; Putnam, 2000), social status differences, material inequality, and dominance and prestige hierarchies as well as individual self-evaluative processes that contribute to self-esteem, respect or dignity, aggression, and psychological and physical health. Mindell's (1995) definition of rank further adds a person's perception of his or her psychological and spiritual powers to the perception of material power conferred by his or her social standing. Thus, a broad operational definition of rank includes a conscious or unconscious, social or personal ability or power emerging from areas of socio-cultural influence, personal psychology, and/or spiritual ties.

From this perspective socio-cultural power is only one dimension of power within many. Mindell (1995) describes various ways in which power may be experienced. He differentiates between distinct dimensions of personal power and rank: social, psychological, relational, transpersonal or spiritual, and contextual rank. His operational definition of rank includes subjective views of social status and emotional, psychological, and spiritual power. Particular social characteristics, such as race, gender, age, sexual orientation, health, and physical attributes, provide individuals with a set of social rank and privileges. Furthermore, personal history and psychology equip individuals with another kind of psychological or emotional rank that influences the sum of their rank and privileges.

The expanded concept of rank (Mindell, 1995) is an analytic framework that integrates individual and collective factors of social comparison and materially and nonmaterially based notions of rank and privilege. It has the advantage of including the various aspects into a single framework. Rank reflects the psychological interpretation of social conditions as well as the cognitive appraisal of individual powers.

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RANK AND SELF-ESTEEM; INTERNALIZED AND EXTERNALIZED RANK

Paradoxically there seems to be no evidence of a social gradient in self-esteem (Elmer, 2001). Low social status does not seem to undermine people's self-esteem. Wilkinson (2005) argues that the questionnaires used for measuring self-esteem fail to recognize the social patterning of self-esteem. Marginalized people experience life as a continuous challenge to their dignity that they have to defend and protect themselves against. 'So important is a sense of pride and self-worth that instead of passively succumbing to social definitions of inferiority, we have to defend against them' (Wilkinson, 2005, 159). Mindell (1995) argues that some people have a lot of psychological power while having few social privileges. Some people from marginalized groups who survive social abuse may acquire a different power. Through their daily confrontation with marginalization and discrimination, they may succeed in gaining awareness of and pride in their individual roots.

Jones (2000) showed that participants' subjective experience of social standing can strongly differ from the outside perception of a third person. Individuals whom one would place in a low social rank perceived themselves with more rank. Others with a different sense of themselves might rank their social standing lower than what others would grant them. The actually felt externalized social rank competes with an internal sense of strength and power that one has in the various areas of socio-cultural comparison. There is a projected outer process of categorization on a continuum of center and margin and an inner stratification of one's social standing. The concept of rank allows us to differentiate between people's own experience and how they think *others* see and treat them. It lets us ask people whether they think others marginalize them, whether other people treat them as if they were inferior. We can see how evaluative social comparisons lead to social anxiety, shame, depression and individual vulnerability to our social environment.

In the next section the focus will be on how individuals' perceptions of their rank and how their marginalization history can contribute to feelings of powerlessness and influence their sense of a coherent and meaningful life. Rank as a signifier of power creates stress, raises basal cortisol levels, affects the individuals' health-related behaviors and leads to worsened health outcomes. Many psychological variables are regarded as a matter of individual differences in traits and personal circumstances. The concept of rank implies that people's psychological and physiological states are socially structured by the impact of inequality on our emotional and psychological life.

RANK AND HEALTH

Explanations of how rank inequality affects people's health demand a comprehensive model that encompasses the multiple ways in which people's health is shaped. Closer reflection is needed to the different processes that come with people's material and psychological or emotional powers when investigating differences in health. There are fundamental causes of health differences among individuals and communities, rooted in the socio-cultural and normative dimensions that justify marginalizing some over others. The topic of health and rank touches upon individual and collective processes and upon subjective perceptions of social dynamics, as well as objective elements of social status. Both the role of individual and collective determinants and the importance of subjective and objective effects animates current academic controversy. At an

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individual level distinctions are drawn between associations based on psychological measures and those related to social conditions. The role of psychology is discussed in contrast with the role of exposures to determined risk factors and hazardous behaviors.

INDIVIDUAL RANK AND HEALTH

The social dimensions of health and illness have been extensively studied from a materialistic angle (for example, material conditions like diet, housing, exercise, environmental pollutants or access to health care) (Anderson and Armstead, 1995). Other studies have shown a correlation between life expectancy and various measures of socioeconomic status (SES) (Wilkinson, 1992). Marmot's (1986) Whitehall Study of British civil servants uncovered an obvious gradient in mortality and morbidity from top to bottom of the social hierarchy. This gradient could not be explained solely by the common materialistic interpretation of the correlation between SES and health. The authors concluded that something correlated with *hierarchy per se*, which powerfully influences health. Something in the nature of inequality itself appears responsible for SES disparities in mortality and morbidity. Eachus et al. (1999) and Brekke et al. (2002) found an additional SES gradient for illness severity and the severity of pain experience. They speak of the 'double suffering' of the less affluent. Individuals on the lower rungs of society not only suffer more illness but also greater symptom intensity. Orpana and Lemyre (2004) found that exposure to psychosocial stressors was associated with poor self-reported health, above and beyond adjusting for SES. These studies are suggesting stress or the ability to cope with stress as the biological pathway through which rank or hierarchy factors influence health. In addition to material causes they point to nonmaterial or subjective factors of social experience affecting health.

COMMUNITY RANK AND HEALTH

Social ordering in human societies is associated with gradients of disease. Wilkinson (1996, 1999) demonstrated that egalitarian communities, states, and countries with small income differences tend to be healthier. Characteristics of social cohesiveness, social trust, active community participation, or the general quality of social relations correlate with income distribution and influence the overall health status of the community (Kawachi, 1999). People with strong social networks, for instance, have a mortality rate that is half or a third that of people with weak social links (House et al., 1988; Berkman, 1995). A study of 38 US states showed that income inequality and mortality were reflected in the degree of distrust people expressed, in the extent of organizational membership and community participation of the population.

Social status disparities, and the way communities deal with and respond to them – in the form of hierarchical power relations or some forms of egalitarian cooperation – have a huge impact on health. The way individuals, communities, states, and nations handle rank and hierarchy directly reflects the quality of their social relations and health (Putnam et al., 1993; Williams et al., 1995; Kawachi et al., 1997). Wilkinson (1996) proposed that the level and quality of social ties or mutual cooperation in a society may explain why some countries have healthier populations than others. Income inequality is thought to create a sense of injustice and dissatisfaction, accompanied by a damaging state of physiological arousal and stress. It is individuals' perceptions of their social standing relative to others or their relative income that is believed to be more important than

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their absolute income. Hence, the experience of relative poverty or low rank and the affronts to personal dignity that it represents have psychosomatic effects. Processes of harmful social comparisons and psychological perceptions triggered by relative deprivation explain the importance of social status in its effect on health (Kawachi et al., 1999).

SUBJECTIVE RANK

Community-level events have their effects on individual health and wellbeing through interpersonal and intergroup behaviors. Despite substantial research that relates objective indicators of SES to health, there is limited work on subjective experience of social status and health. Psychological variables associated with the experience of stress and adversity (Taylor and Seeman, 1999) and exposure to psychosocial stressors (Orpana and Lemyre, 2004) have been discussed to mediate the impact of SES on health. Socio-emotional distress, pessimism, locus of control, and imbalance between life demands and capacity for decision-making and control (job-strain-model), have been linked to both SES and worse health outcomes (Adler and Ostrove, 1999; Cohen et al., 1999; Taylor and Seeman, 1999). The subjective experience of social standing (for example, one's perception of social class, gender, ethnicity) and its consequences on health have only recently been studied in medical literature. Adler et al. (2000), using a simple drawing of a social ladder on which respondents had to place themselves, showed that self-ratings of subjective social status were more consistently and strongly related to psychological functioning and health-related factors (self-reported health, heart rate, sleep latency, body fat distribution, and cortisol habituation to repeated stress) than objective indicators of social status. In a followup of the Whitehall II study, which included the ladder of subjective social standing, subjective status not only showed more of a gradient than objective SES measures, but the effect of occupational grade became non-significant once subjective status was included. Further, the association of subjective status and physical health remained significant even when depression was controlled for (MacArthur and MacArthur, 2001). The authors' conclusion was that psychological perceptions of social status may be an independent contributor to the SES-health gradient. These results have been replicated in various studies that relate psychological perceptions of social status to mental and physical health outcomes (Adler et al., 2000; Goodman et al., 2001; Singh-Manoux et al., 2003; Operario et al., 2004; Hu et al., 2005). They emphasize the importance of subjective factors for the relationship between SES and *global* health. Hence, the cognitive or psychological averaging of standard markers of socio-economic conditions and the different processes behind material and emotional powers need closer attention when investigating differences in global health (Bartley et al., 2004).

Adler et al. (2000) developed a *community* rank ladder to determine people's standing or rank within social groups (such as religious or local communities) and to detect individuals who may not have high social standing in terms of income, occupation, or education but may have some compensating rank within their communities. In a study of adolescents, community ladder rankings were more strongly associated with health than the subjective social status rankings (Goodman et al., 2001). Besides that, no other study has yet used an expanded concept of rank that includes materially and nonmaterially based dimensions of rank, to analyse the influence of subjective rank on health.

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RANK AND STRESS

Newer stress theories, for example the concepts of allostatic load (McEwen and Seeman, 1999) and vital exhaustion (Appels et al., 1993), claim that the greater the cumulative adversity relative to advantage over the life course, the higher the probability of chronic disease, disability and premature mortality in later life. Advances in biology have contributed to a better understanding of how stress due to adverse social conditions or low rank 'gets under the skin' to produce health disparities. These nervous and metabolic changes are supposed to mediate the influence of stress on the body. The question arises of how persons of low social status stay resilient in the face of adversity and nevertheless have positive health outcomes. For many people life disadvantage and adversity need not lead to negative health outcomes. Many researchers reoriented their focus therefore on the coping mechanisms. Syme (1991) demonstrated that a perceived sense of control is positively related to better health outcomes. A study of Vietnam veterans demonstrated the role of several post-trauma resilience factors (hardiness, postwar social support, and additional stressful life events) in moderating PTSD symptomatology (King et al., 1998). Components of cumulative advantage or coping resources may come, for example, in the form of positive life circumstances in childhood and over one's personal life course, personal capacities and abilities, the successful realization of expected life transitions (e.g. job transitions, marriage), or having positive evaluations of one's life. These findings led researchers like Hertzman (1999) and the authors Singer and Ryff (1999) to explain the SES-health gradient as an emergent property of the interaction between the developmental status of people and the material and psychosocial conditions they encounter over their life course. They conceptualize health outcome as a product of cumulative adversity and advantage over a lifespan. The effects of this type of chronic psychosocial stress are particularly relevant in rich developed countries. Rising living standards mean that the health effects of material privation, poor living conditions, and lack of basic resources diminish and cumulative effects of chronic stress have much more time to make themselves felt.

SENSE OF COHERENCE

Antonovsky (1979, 1987) explored the origins of health in post-menopausal women who had survived extreme hardship (Holocaust and resettlement to Israel) and its foundation in nonmaterially based dimensions of inner strength. He developed the Sense of Coherence (SOC) construct, a general measure of a person's world view, with which he explained why some people are less likely to be adversely affected by stressful environments and life events than others. Antonovsky stressed the importance of meaningfulness in life and one's perceived control over life circumstances. He viewed the social context as part of one's resistance resources or deficits. His SOC has been shown to be a strong predictor of health outcomes (Kivimaki et al., 2000; Nilsson et al., 2000; Svartvik et al., 2000; Suominen et al., 2001; Zhang et al., 2001). Antonovsky's concept of Sense of Coherence (SOC) (Antonovsky, 1979, 1986 and 1987) postulates a psychological and social transmission of health. In a Canadian study (Wolff and Ratner, 1999) stress and traumatic events in childhood were found to be inversely related to SOC, and social support was positively related. Another study (Torsheim et al., 2001) showed a strong association between SOC and stress in younger adolescents. In this view health is socially embedded (via

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trauma and stress) in the childhood/adolescent period and is psychologically transmitted by learned patterns and meanings that lead to a weak SOC.

Many other factors have been studied that contribute to the burden of psychosocial and health risks, including gender equity (Annandale and Hunt, 2000), race relations and ethnic groups (National Center for Health Statistics, 1998), but there is no unified model that brings these processes of social comparison and marginalization together in a common framework for their impact on health.

In a preliminary study Morin (2002) examined the relationship between self-reported health, subjective rank, Antonovsky's sense of coherence (SOC) and objective socioeconomic status (SES) among 133 participants of chronic body symptom management seminars. For the measure of subjective rank he used Mindell's multidimensional concept of rank. Findings showed that subjective rank was significantly related to self-reported health and explained 31% of the variance in self-reported health. In a multiple regression analysis SOC and objective SES became non-significant predictors once subjective rank was entered. The association of subjective rank and self-reported health remained significant even when objective SES were controlled for.

Morin (2002) suggests that one's sense of feeling well is related to subjective and objective rank but one's perceived rank dominates the effect on self-reported health. The strong relationship between subjective rank and self-reported health over and above the effects of objective measures of social status confirms the hypothesis that perceived rank is more sensitive in predicting health than objective measures of social status. These results are consistent with the assumption that low subjective rank is linked to greater stress by either increasing stress directly or increasing the vulnerability to the effect of stress.

Marginalization and discrimination by sexist, homophobic, and racist structures and policies translate into people's experience of rank and have a direct influence on people's health and wellbeing. Morin's (2002) results show that some of the effects can be compensated for by other individual powers and value orientations. The women in the study, for example, had a realistic view of their social standing and the sexism that affected their external social rank; but nevertheless they were able to report a stronger sense of internal social rank. The results further demonstrate that feelings of being loved and accepted on a community level (through feelings of empowerment and subjective rank) can have an important impact on health. In this view health is socially embedded (via integration and acceptance) over one's life course and is psychologically transmitted by feelings of love and support that lead to a strong subjective rank. Marginalization, discrimination and the abuse of rank have the opposite effect. They are experienced by the victims as an insult to their dignity, lead to a low sense of rank, and contribute to impaired global health and wellbeing.

Perceptions and their first-person subjective character, and all those aspects of experience that are directly knowable only through introspection are thought not to be capable of being analysed in terms of causal relations and, thus, are often marginalized by the objectifying approach of science. Hence, first-person or subjective experiences and people's way of presenting and explaining their difficulties do not receive enough attention in current literature.

In his dissertation Morin (2002) discusses the importance of materially and non-materially based factors of personal empowerment or rank, and their effect on individuals'

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ability to stay healthy. It reports on associations between subjective rank and self-reported health that were found to be stronger than those between objective SES or SOC measures (Antonovsky, 1979 and 1987) and health, and suggests the importance of further research into the subjective, non-material as well as social dimension of health. It also shows that social stratification is not only objectively or materially defined but also based on one's subjective perceptions.

The operational definition of rank as a conscious or unconscious, social or personal ability or power emerging from areas of socio-cultural influence, personal psychology, and/or spiritual ties is broad. Experience of rank encompasses material SES dimensions as well as other less materially based social elements like community integration and self-esteem. It includes perception of social and community standing as well as other psychological values of coping with life, such as self-knowledge, comfort with strong emotions, and the ability to interrelate with others and solve conflicts. In covering psychosocial resources it corresponds with Antonovsky's SOC, and concepts of subjective social status developed by Adler and colleagues (2000). Internal experience of rank is very relevant for people's ability to stay healthy, become resilient, and cope with the challenges of life. Its effect on physical and mental health is matched by the experience of subjective social standing, sense of coherence, depression and fear. Many questions remain to be investigated: for example, how these factors combine and interact and what individual responses need to be taken into account. But the specific questions should not distract from the important fact that people's internal experiences of the external world have an important influence on global health outcomes.

IMPLICATIONS FOR FURTHER STUDIES

Further research is needed to explore the importance of experienced rank to psychological, social, and physiological wellbeing. How can diversity in the experience of being an individual with a specific set of social roles based on gender, sexual orientation, ethnic identity, socioeconomic status, and health at times of changing socio-cultural relations be operationalized in quantitative and qualitative analyses? The analytical framework presented here attempts to take the diversity of people's experience of their social standing into account. The psychosocially integrated concept of rank and its diversification into externalized and internalized components describe a comprehensive model of subjective social status and health. It includes normative processes that have a profound effect on individual health-related behaviors.

Systemic, institutional and individual rank-based discrimination afflicts those of low rank, their sense of dignity, as well as their health and wellbeing. Our communities' belief systems and values, as shown in their judgments of rank, influence the health of individuals and whole groups. Socio-culturally shaped rankist values fortify social injustice, power imbalance, and personal indignity. Rank is a promising concept that may broaden the definition and understanding of social status and health. However, there is little knowledge about possible interventions for countering the unfavorable effects of low rank. Besides structural or political changes, there are no innovative strategies addressing the specific needs of persons with lower rank.

PROCESS WORK

A new conceptual and therapeutic model is needed that forms an original and effective approach in dealing with health disparities

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and social inequities. This new model expands the biological view of health to incorporate interpersonal, social and cultural dimensions. In this view, physiological states become a metaphor for social and cultural processes. They are intrinsically entangled with relational and community aspects that call for a different sort of therapeutic model. Rank awareness, conflict facilitation, process and system psychology, cognitive and behavioral approaches are required to address the embodied or somatized experiences of low rank.

Audergon (2004) describes an awareness and facilitative approach to collective trauma. Based on Mindell's (1995, 2002) Process Work methods, this model stresses that 'the essential resources for an individual, group or community's transformation lie within that individual, group or community and their *interaction*' (Audergon, 2004, p. 29). This interactive and communication-centered model applies to rank-based discrimination and social relations in general. Regarding global health it acknowledges the limitations of a biomedical model of disease and illness. The biomedical paradigm approaches illness as a causal product of somatic processes and stresses the significance of the technical-scientific assumptions and the paternalistic voices of experts. It supports an unequal relationship between healthcare professionals and clients and minimizes the importance of the client's personal and contextually grounded experiences of events and problems. In contrast, the proposed new model acknowledges the tension between objective medical and socio-culturally shaped subjective categorizations of disease processes. It complements the biophysical aspects of current clinical practice with a systemic and interactive view of culturally shaped experiences.

The awareness-based model acknowledges the complex interactions that influence health and wellbeing. Besides individual treatment, it recognizes the many competing subsidiary issues that need to be addressed in a communicative dialog. The issue of rising healthcare costs, for example, is connected with the problem of health disparities and other social injustices. It is likely to increase the pre-existing inequalities and health disparities based on gender, race, age and rank. It might deepen the struggle between what we perceive to be the individual's responsibility in taking care of his or her health and the responsibility of the community to look after its less fortunate and privileged members. Rising costs force us to reflect upon our social values and priorities; what we as a community are willing to support and pay.

COMMUNITY MEETINGS AND OPEN FORUMS

A Process Work model addresses, in addition to all other needs, the power and rank imbalance and the dominance of some cultural values over others. This awareness-based model integrates the awareness of communicative backgrounds that go beyond surface meanings and interfere with the primary purposes of the communication. The communicative backgrounds refer to diverse experiential frameworks that relate to gender, age, class, cultural, and health differences as well as to general differences in perspectives and values. As mentioned above they contribute to power differences and health inequalities. In addition, they are often the source of communication problems and misunderstandings. Community meetings such as Open Forums (Mindell, 2002) serve the function of working with the deep-seated problems of community relationships. Processing issues of rank-based discrimination and resulting feelings of indignity, disrespect, insult and humiliation, combined with diversity awareness and community

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building can lead to renewed hope and healing. In objective medicine things operate by cause and effect, but not so in the world of relationship and communication. Communicative interactions take place in a complex field of forces (contextual, psychological, social, and cultural) governed by an uncertainty principle. Social and cultural beliefs or values and individual feelings and goals create an atmospheric field in which there is a prospective uncertainty as to the outcome of a given communicative interaction. The dynamic interactions among these biological, physical, social, cultural, ethical and emotional elements are unpredictable.

Process-oriented Open Forums seeks to reveal the power of transformation in the problems of the community and people's behavior. In the participants' moment-to-moment experiences lie the answers for the community's problem and the direction for community building. Process Work methods include conceptual and cultural metaphors people live by and allow for a process awareness and interpersonal understanding. They help to tolerate tension and uncertainty, and negotiate meaning for the individual and the community. Process Work addresses intrapersonal, interpersonal and systemic dimensions of health and illness. It asserts that the classic scientific formulation that only reason and objectivism are valid, needs to be extended with an understanding that the human psyche is part of the living system and the objective can not function without the subjective.

Process Work includes societal questions such as rank and privileges and the uncertainty of the many forces influencing community relationships in its methodology. It aims at teaching primary care providers to become communication experts. This role can be shared by internists, general practitioners, psychologist, counselors, case managers and/or chaplains. A process work facilitator has a sophisticated view of the relationship between emotions, social environment, and health. Her communicative approach focuses on awareness of these many influences and supports the flux of the developing process. For her, the mix of probabilities collapses at the point of relationship into a meaningful process. In her understanding, from the indeterminacy of the many forces emerges a co-created meaningful interaction.

Process Work sees itself as an initial step towards a new culture of dialog and communication in healthcare that will help facilitate a co-creative project of reshaping our healthcare and the values it represents. It is an essential new element that hopefully will give rise to increased awareness of rank-based discrimination and global health and help communities develop their own resolutions.

FINAL COMMENTS

It is well known that different individuals experience the same stressful life events in very different ways. However, little is known about the factors that increase or decrease an individual's vulnerability to stress and its effects on health. Subjective rank, a person's perception of his or her standing in society, combined with intrinsic non-materially based personal powers, may by itself be a risk or protective factor. From that perspective, perceived rank is a social and psychological substrate of resilience and power is a definite dimension of physical, emotional and mental health. In this sense, risk factors (for example, health behaviors like cigarette smoking) that have been drawn to explain SES/health relationships can only be considered as concomitant phenomena of the more influential primary factor rank. Furthermore, it is believed that rank rules the distribution of risks and resources and may account for the SES/health gradient that is

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not confined to poverty. In addition to material foundations, what matters is the social environment and the quality of social relations.

REFERENCES

Adler NE, Ostrove JM. Socioeconomic status and health: what we know and what we don't. Annals New York Academy of Sciences 1999; 896: 3–13.

Adler NE, Epel ES, Castellazzo G, Ickovics JR. Relationship of subjective and objective social status with psychological and physiological functioning: preliminary data in healthy white women. Health Psychology 2000; 19(6): 586–92.

Anderson NB, Armstead, CA. Toward understanding the association of socioeconomic status and health: a new challenge for the biopsychosocial approach. Psychosomatic Medicine 1995; 57: 213–25.

Annandale E, Hunt K (eds) Gender Inequalities in Health. Buckingham: Open University Press, 2000.

Antonovsky A. Health, Stress and Coping; New Perspectives on Mental and Physical Well-being. San Fransisco: Jossey-Bass, 1979.

Antonovsky A, Sagy S. The development of a sense of coherence and its impact on responses to stress situations. Journal of Social Psychology 1986; 126: 213–25.

Antonovsky A. Unraveling the Mystery of Health. How People Manage Stress and Stay Well. San Francisco: Jossey-Bass, 1987.

Appels A, Falger PRJ, Schouten WGW. Vital Exhaustion as a Risk Indicator for Myocardial Infarction in Women. Journal of Psychosomatic Research 1993; 37: 881–90.

Audergon A. Collective trauma: the nightmare of history. Psychotherapy and Politics International 2004; 2(1): 16–31.

Bartley M, Martikainen P, Shipley M, Marmot M. Gender differences in the relationship of partner's social class to behavioral risk factors and social support in the Whitehall II Study. Social Science and Medicine 2004; 59(9): 1925–36.

Berkman LE. The role of social relations in health promotion. Psychosomatic Medicine 1995; 57: 245–54.

Brekke M, Hjortdahl P, Kvien TK. Severity of musculoskeletal pain: relations to socioeconomic inequality. Social Science and Medicine 2002; 54(2): 221–8.

Cohen S, Kaplan GA, Salonen J. The role of psychological characteristics in the relation between socioeconomic status and perceived health. Journal of Applied Social Psychology 1999; 445–68.

Eachus J, Chan P, Pearson N, Propper C, Davey Smith G. An additional dimension to health inequalities: disease severity and socioeconomic position. Journal of Epidemiology, Community and Health 1999; 53(10): 603–11.

Elmer N. Self-esteem: The Costs and Causes of Low Self-worth. York: Joseph Rowntree Foundation, 2001.

Fuller RW. Somebodies and Nobodies. Overcoming the Abuse of Rank. Gabriola Island, BC: New Society Publishers, 2003.

Goodman E, Adler NE, Kawachi I, Frazier AL, Huang B, Colditz GA. Adolescents' perceptions of social status: development and evaluation of a new indicator. Pediatrics 2001; 108(2): E31.

Hertzman C. The biological embedding of early experience and its effects on health in adulthood. Annals New York Academy of Sciences 1999; 896: 85–95.

House JS, Landis KR, Umberson D. Social relationships and health. Science 1988; 241: 540–5.

Hu P, Adler NE, Goldman N, Weinstein M, Seeman TE. Relationship between subjective social status and measures of health in older Taiwanese persons. Journal of the American Geriatric Society 2005; 53(3): 483–8.

Jones LS. Subjective Experience of Marginality in Psychotherapeutic Interaction. Unpublished Dissertation Manuscript, 2000.

Kawachi I. Social capital and community effects on population and individual health. Annals New York Academy of Sciences 1999; 896: 120–30.

Kawachi I, Kennedy BP, Wilkinson RG. Income Inequality and Health: A Reader. New York: The New York Press, 1999.

King LA, King DW, Fairbank JA, Keane TM, Adams GA. Resilience-recovery factors in post-traumatic stress disorder among female and male Vietnam veterans: hardiness, postwar social support, and additional stressful life events. Journal of Personality and Social Psychology 1998; 74(2): 420–34.

Kivimaki M, Feldt T, Vahtera J, Numi JE. Sense of coherence and health: evidence from two cross-lagged longitudinal samples. Social Science and Medicine 2000; 50(4): 583–97.

DOI: 10.1002/ppi

MacArthur JD, MacArthur CT. Research Network on SES and Health Web Page. Available http://www.macses.ucsf.edu/Research/Psychosocial/notebook/subjective.html, 2001.

Marmot MG. Social inequalities in mortality: the social environment. In RG Wilkinson (ed.) Class and Health: Research and Longitudinal Data. London: Tavistock, 1986.

McEwen BS, Seeman T. Protective and damaging effects of mediators of stress. Elaborating and testing the concepts of allostasis and allostatic load. Annals of the New York Academy of Sciences 1999; 896: 30–47.

Mindell A. Sitting in the Fire: Portland: Lao Tse Press, 1995.

Mindell A. The Deep Democracy of Open Forums: How to Transform Organizations into Communities. Charlottesville VA: Hampton Roads, 2002.

Morin P. Rank and Salutogenesis: A Quantitative and Empirical Study of Self-Rated Health and Perceived Social Status. Unpublished Dissertation Manuscript, 2002.

National Center for Health Statistics. Health, United States, 1998 with Socioeconomic Status and Health Chartbook. Hyattsville MD: USDHHS, 1998.

Nilsson B, Homgren L, Westman G. Sense of coherence in different stages of health and disease in northern Sweden – gender and psychosocial differences. Scandinavian Journal of Primary Health Care 2000; 18(1): 14–20.

Operario D, Adler NE, Williams DR. Subjective social status: reliability and predictive utility for global health. Psychology and Health 2004; 19(2): 237–46.

Orpana HM, Lemyre L. Explaining the social gradient in health in Canada: using the National Population Health Survey to examine the role of stressors. International Journal of Behavioral Medicine 2004; 11(3): 143–51.

Popay J, Williams G, Thomas C, Gatrell G. Theorizing inequalities in health: the place of lay knowledge. Sociology of Health and Illness 1998; 20: 619–44.

Putnam RD. Bowling Alone: The Collapse and Revival of American Community. New York: Simon & Schuster, 2000.

Putnam RD, Leonardi R, Nanetti RY. Making Democracy Work: Civic Traditions in Modern Italy. Princeton: Princeton University Press, 1993.

Singer B, Ryff CD. Hierarchies of life histories and associated health risks. Annals of the New York Academy of Sciences 1999; 896: 96–115.

Singh-Manoux A., Adler NE, Marmot MG. Subjective social status: its determinants and its association with measures of ill-health in the Whitehall II Study. Social Science and Medicine 2003; 56(6): 1321–33.

Suominen S, Helenius H, Blomberg H, Uutela A, Koskenvuo, M. Sense of coherence as a predictor of subjective state of health. Results of 4 years of follow-up of adults. Journal of Psychosomatic Research 2001; 50(2): 77–86.

Svartvik L, Lidfeldt J, Nerbrand C, Samsioe G, Schersten B, Nilsson PM. Dyslipidaemia and impaired well-being in middle-aged women reporting low sense of coherence. The Women's Health in the Lund Area (WHLA) Study. Scandinavian Journal of Primary Health Care 2000; 18(3): 177–82.

Syme SL. Control and health: a personal perspective. Advances 1991; 7(2): 16–27.

Taylor S, Seeman TE. Psychosocial resources and the SES-health relationship. The Annuals of The New York Academy of Sciences 1999; 896: 210–25.

Torsheim T, Aaroe LE, Wold B. Sense of coherence and school-related stress as predictors of subjective health complaints in early adolescence: interactive, indirect or direct relationships? Social Science and Medicine 2001; 53(5): 603–14.

Wilkinson RG. Income Distribution and Life Expectancy. British Medical Journal 1992; 304: 165–8.

Wilkinson RG. Unhealthy Societies: The Afflictions of Inequality. New York: Routledge, 1996.

Wilkinson RG. Health, Hierarchy, and social anxiety. Annals of the New York Academy of Sciences 1999; 896: 48–63.

Wilkinson RG. The Impact of Inequality: How to Make Sick Societies Healthier. New York: The New York Press, 2005.

Williams DR. Socioeconomic differentials in health: a review and redirection. Social Psychology Quarterly 1990; 32: 81–99.

Williams RB, Feaganes J, Barefoot JC. Hostility and death rates in 10 US cities. Psychosomatic Medicine 1995; 57(1): 94.

Wolff AC, Ratner PA. Stress, social support, and sense of coherence. Western Journal of Nursing Research 1999; 21(2): 182–97.

DOI: 10.1002/ppi

Zhang J, Vitaliano PP, Lutgendorf SK, Scanlan JM, Savage MV. Sense of coherence buffers relationships of chronic stress with fasting glucose levels. Journal of Behavioral Medicine 2001; 24(1): 33–55.

Correspondence:
E-mail: pierre@creativehealing.org

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