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Richard Eckersley responds: Culture can be studied at both large and small scales.

The cultures of scientific disciplines are like the cultures of societies: so ingrained that they appear to be the natural and right way to look at the world. Disciplines see things differently; they draw on different conceptual frameworks and approaches, which yield different evidence and interpretations.

I immediately identified with Glass's account of why epidemiology has neglected culture.[1] It provides, I think, a strong intellectual buttress for my arguments. Janes and Dressler are gracious enough to applaud my attempts to integrate culture into the social determinants of health, but have, as anthropologists, serious reservations about how I have gone about it. Let me respond to some of these concerns.

Firstly, both attribute to me a more homogeneous or monolithic model of culture than I propose. I fully accept that culture is a fuzzy, complex, dynamic, multifaceted thing, variably distributed, locally influenced and intimately connected to history, politics, economics and other social factors. I focus on two key defined and measurable qualities, materialism (or consumerism) and individualism. In my book, *Well & Good*, I discuss a number of other 'isms' of Western culture.[2]

Faced with the 'mess' of culture, Janes and Dressler want us to focus on the details of population patterning and distribution, individual and group differences, and culture as local knowledge, and to explore culture's health impacts at this level.[3,4] I have no difficulty with this approach – and, I thought, acknowledged it in my paper (much of my evidence drew on individual differences). But I don't agree that this is the only way to study culture.

Instead of 'zeroing in', we can also draw back – far enough to discern the 'large' effects of culture on populations, for all its fuzziness, complexity and variability. This seems especially important given the globalising nature of the social, economic and cultural forces shaping life today. We can draw an analogy with climate change. The anthropological view would seem to suggest that because the impacts of global warming will vary according to a range of regional and local factors, it can only be studied at these levels. Obviously, this is not the case.

In offering their evidence based on studies of different ethnic groups to support their perspective, Janes and Dressler fail to address my evidence – drawn from epidemiology, psychology and sociology. Anthropologists might dismiss notions that whole societies can be characterised by a few dominant cultural themes, but qualities such as materialism and individualism (or individualization) are common themes in psychological and sociological research.

If what Janes and Dressler say is true, what are we to make of the observation that in the new world countries of the United States, Canada, Australia and New Zealand male youth suicide rates rose from almost identical levels in the 1950s through the 1960s to the 1990s, when they peaked and began to fall in all four countries?[5,6] Or, as I mention in the paper, the strong correlations found between youth suicide rates in Western nations and several different measures of individualism, but not other cultural, social or economic factors?[5]

Several new studies show what is at stake. Results of the 2001-2003 US National Comorbidity Survey Replication show almost a half of Americans will experience a clinical mental disorder during their lives, while over a quarter will suffer a disorder in any one year.[7,8] The risk increases for successive generations; those aged 18 to 29 have an estimated lifetime risk four times that of those aged 60 and over. The researchers say the prevalence and risk estimates are conservative, and the lifetime risk in younger cohorts underestimated by the method used in calculating lifetime risk. They examine whether the increased risk in these cohorts is real or a methodological artifact (a common question raised about such findings) and suggest it is 'at least partly' due to substantive rather than methodological factors.[7]

Challenging the usual focus on structural changes in the economy and family, a new UK study of comparable surveys conducted in 1974, 1986 and 1999 found that mental health problems among adolescents increased for both girls and boys and across all social classes and family types, suggesting changes in these areas are not the main reasons for the rising trends.[9] Recent US studies suggest that children in rich families, a little researched group, may be more likely than other children to suffer substance use problems, anxiety and depression.[10] Two possible explanations are given: excessive pressures to achieve and isolation from parents, both physical and emotional (factors exacerbated by materialism and individualism, I'd argue, as well as affluence). The researchers say that comparative studies of rich and poor youth reveal 'more similarities than differences in their adjustment patterns and socialisation processes'.[11]

Then there is the evidence of people's perceptions of quality of life in Western nations. Surveys in the United States and Australia show many people are concerned about the materialism, greed and selfishness they believe drive society today, underlie social ills, and threaten their children's future.[2] We yearn for a better balance in our lives, believing that when it comes to things like individual freedom and material abundance, we don't seem 'to know where to stop' or now have 'too much of a good thing'.

For example, a study of 'middle Australia' found that a half of those surveyed felt quality of life was falling, with the most common reasons given being, in order: too much greed and consumerism; the breakdown in community and social life; too much pressure on families, parents and marriages; falling living standards; and employers demanding too much.[12] Most people believed family life was changing for the worse, citing the breakdown of traditional values; too much consumerism and pressure to get more money and buy things; a breakdown of communication between family members; and greater isolation of families from extended family networks and the community.

Janes wonders why I don't talk about capitalism and leave culture out of it. But to blame capitalism is too limited; it lets too many of us off the hook. The cultural liberalisation of the 1960s and 70s, not just capitalism, has contributed to Western notions of individual freedom and personal gratification.[2] [Cultures have been said to exert a pervasive but diffuse influence on actions, providing the underlying assumptions of an entire way of life, while ideologies exert a powerful, clearly articulated, but more restricted, basis for social action.[13]]

Dressler says I present a 'West versus the rest' argument, but my main focus was on changes in Western culture over time, not a comparison with other cultures. To the extent that this comparison is implied by what I say about universal values, I am referring broadly to the moral systems of other societies (as reflected, for example, in major religions and philosophical writings), not necessarily to how other peoples lived.[2]

Both Janes and Dressler state my approach does not allow us to make the 'essential links from the cultural, to the individual, to the biological' (Dressler), or to say how culture 'manages to get into the body' (Janes). Yet I did precisely this, if briefly, drawing on the epidemiological literature on how psychosocial processes and behavioural and physiological pathways link social conditions to health outcomes. Finally, contrary to what both say in conclusion, my paper does what they say needs to be done in terms of the challenges we must address and the questions that need to be asked about the role of culture in health. If that was not clear, then I thank them for making it so.

Interdisciplinary divides can be incredibly difficult to span. In a current multidisciplinary project on young people's potential and wellbeing, my co-authors and I not only can't agree on key issues, we have even had trouble agreeing on how to disagree.[14] But it is important that scientists persevere in this endeavour. Science will never give us clear-cut solutions to complex human problems, but synthesis does enhance, or enlarge, the contributions it can make.

My own work attempts to bridge disciplines with the aim of contributing both to a better scientific understanding of the world, and to public and political debate about social directions and futures. I want to inject the issues of culture, health and wellbeing into an escalating contest between two worldviews: material progress, which is dominant and gives priority to economic growth and wealth creation as the basis for making life better, and sustainable development, which seeks a better balance of environmental, social and economic goals and objectives to achieve the same end.[2]

The key challenge of sustainable development has usually been seen as reconciling the requirements of the economy – growth – with the requirements of the natural environment – conservation and sustainable resource use. However, our increasing understanding of the social determinants of health can shift this perspective, making an important contribution to working towards sustainability. It provides a means of integrating different priorities by allowing them to be measured against a common goal or benchmark: improving human wellbeing.

References

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