A SOCIOLOGICAL PERSPECTIVE ON HEALTH, ILLNESS, AND THE BODY

"Individuals who enjoy good health rightly think of themselves as fortunate: But luck has little to do with the broad patterns of disease and mortality that prevail in each society. The striking variations in health conditions among countries and cultural groups reflect differences in social and physical environments. And increasingly, the forces that shape health patterns are set in motion by human activities and decisions. Indeed, in creating its way of life, each society creates its way of death." [emphasis added]


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When we think of health and illness, we usually think of eating properly and other healthy habits, of institutions such as hospitals, and of health professionals such as doctors and nurses. Although we may be dimly aware that health has its social dimensions, we may not think of health as a topic for social scientists.

Sociological analysis emphasizes that the occurrence of illness is not random. Different kinds of societies produce different patterns of illness and death. As Eckholm's statement on the preceding page shows, our material social and cultural way of life is linked with our way of death. The sociology of health and illness studies such issues as how social and cultural factors influence health and people's perceptions of health and healing, and how healing is done in different societies. Social structures and cultural practices have concrete consequences for people's lives.

We like to think that a newborn infant is as yet untouched by these abstract forces and has possibilities for health limited only by the child's genetic makeup. Even at birth, however, these abstract forces have begun to inscribe themselves on the baby's body. The very life chances of this infant, including the probabilities that she will live, be well, acquire the skills for success in her culture, and achieve and maintain that success, are powerfully influenced by all of the social circumstances and forces she will encounter throughout her life. In short, the baby's life chances, including possibilities for health and long life or sickness and death, are shaped or constructed by society itself.

The baby's birth weight, for example, is influenced by her mother's diet, which in turn is partly a product of her society, her culture, and her social class. Other features of the mother's social context have direct consequences for the newborn's health, including the mother's smoking or drug habits, the housing and sanitary conditions in which the infant is born, and the like. Later, whether the baby is a victim of cholera, bubonic plague, schistosomiasis, or lead poisoning depends on public health measures taken in her environment. What other factors in the baby's home life and environment will shape her sense of self and self-esteem, and her ability to cope with stress and manage her environment? As she matures, how will her gender, race, ethnicity, and social class influence her life chances?

Later in life, her experiences as a worker will place her in various physical environments and social relationships that will affect her health. Her culture will shape what she likes to eat, how she experiences stress, whether she drinks alcohol, and how she feels about her body. How she experiences the process of giving birth will be shaped by her culture's meanings of childbirth as well as by the social context of birth, such as whether it takes place in a hospital under the supervision of an obstetrician trained in Western notions of pregnancy as a medical problem.

The infant is born into a social structure and culture that also powerfully influence what will be considered illness and how that illness will be treated. When this person gets sick, social forces play an important role in determining her chances of becoming well. How does she decide when she is sick and needs help? If she is sick, for example with a bad cold, how will others respond? If she develops multiple sclerosis, how will the attitudes and responses of others, and the quality of her social and physical environment affect her very life chances? What will happen if she develops a stigmatizing illness, such as leprosy or AIDS?

What resources are available to her in dealing with her needs when ill? If she approaches the medical system for help, how does she pay for it? How do her social class, age, race, and ability to pay influence the quality of her medical care? How does the institutional context of her medical care (for example, a public versus a for-profit private hospital, or a nursing home compared to a hospice or home care) help determine its quality? In addition to the quality of life, even the quality of death is linked with such social contexts.

Medical systems involve concrete organizations that reflect the economic interests of such groups as doctors and other professionals, insurance companies, pharmaceutical industries, manufacturers of medical equipment, hospitals, research organizations, government agencies, and medical schools. They all compete for resources, influence policy, and try to set health care and research agendas. Health care systems differ greatly from society to society in how they define and meet the needs of individual citizens. The baby's life chances are intimately intertwined, therefore, with these seemingly remote social organizations.

The fates of individual bodies are thus linked to the workings of the social body. A person's life chances are neither some deterministic fate nor a purely accidental, random result. Rather, a person's chances for illness and successful recovery are very much the result of specifiable social arrangements, which are in turn products of human volition and indeed deliberate policy choices made by identifiable groups and individuals. In large part, illness, death, health, and well-being are socially produced.

THE SOCIAL CONSTRUCTION OF THE BODY

To construct is to make or build something. Clearly, societies do not literally make or produce bodies, but they can influence, shape, and misshape them. Just as an artist can mold clay to construct an object (which is constrained by the physical properties of the clay), social groups and the cultures they share can shape members' bodies. Obvious examples of cultural shaping of the human body include the foot binding practiced in traditional Chinese society, the cradle boards used to shape infants' heads among the Kwakiutl Indians, the stays and corsets worn by nineteenth-century middle-class European and American women, and the high heels and pierced earrings favored today. Similarly, having to live in a polluted environment or to sit at a desk, to work on an assembly line, or to bend over all day in a mine shaft are examples of social conditions that can indirectly shape the body and in turn the body's health.

A biologist illustrates the physical consequences of social practices:

If a society puts half its children in dresses and skirts but warns them not to move in ways that reveal their underpants, while putting the other half in jeans and overalls and encouraging them to climb trees and play ball and other active outdoor games; if
later, during adolescence, the half that has worn trousers is exorted to “eat like a growing boy” while the half in skirts is warned to watch its weight and not get fat; if the half in jeans trots around in sneakers or boots, while the half in skirts totters about on spike heels, then these two groups of people will be biologically as well as socially different. Their muscles will be different, as will their reflexes, posture, arms, legs and feet, hand-eye coordination, spatial perception, and so on. They will also be biologically different if, as adults, they spend eight hours a day sitting in front of a visual display terminal or work on a construction job or in a mine. (Hubbard, cited in Vines, 1993: 93–94).

Those things that happen to human bodies are closely related to the working and anatomy of the social body. Illness is not merely a physical experience but also a social experience. The sick body is not simply a closed container, encased in skin, that has been invaded by germs or traumatic blows; rather, it is open and connected to the world that surrounds it. Thus, the human body is open to the social body. Similarly, our material (or physical) environment, such as the urban landscape, the workplace, or our foods, are influenced by our culture, social structure, and relationships. And these, in turn, influence our bodies.

THE SOCIAL CONSTRUCTION OF IDEAS ABOUT THE BODY

Ideas, too, are constructions. Every society has many levels of shared ideas and practices regarding bodies: What is defined as healthy and beautiful in one society might be considered unhealthily fat and ugly in another; what is seen as thin and lean in one group might be defined as sickly in another. Aging may also be defined as a process to be either conquered, feared, accepted, or revered. Likewise, some societies picture the body as working like a machine, whereas others see it as a spiritual vessel.

Health Beliefs and Practices

Because they are social constructions, our ideas of the body and its health and illness are influenced by both our culture and our social position, such as class or gender. Both cultural and social structural factors are important in understanding people's behavior and health. People act as they do not only because of their beliefs about health (the cultural aspects) but also because of structural aspects, such as how power is distributed and relationships are organized. Thus, although we conceptually distinguish cultural and social structural aspects, in actuality they overlap.

Culture is the beliefs, values, practices, and material objects shared by a people. Culture includes such elements as language, beliefs about the universe and the nature of good and evil, ideals such as justice or freedom, and more mundane considerations such as what constitutes appropriate food, dress, and manners. It also encompasses objects that a people produce and share. Cooking utensils, automobiles, plays, cemeteries, blueprints, crucifixes, tools, musical scores, and flags are among the items that represent cultural values and notions.

How do our cultural conceptions of a person's physical abilities affect those abilities? In our society, we used to believe that women were unable to carry heavy objects. Although biology contributes somewhat to women's physical abilities, so do cultural ideas. In a patriarchal society, women's expectations that they will be weak, together with the experience of being treated as weak because of their social status, have a self-fulfilling result: Women do not become strong. Culture can affect health by shaping behaviors, such as diet, or by influencing how people change their environments, which in turn affects their health (Brown and Inhorn, 1990).

Social structure (or social organization) is the relatively stable, ongoing pattern of social interaction. In a particular society, recognizable patterns of interaction are appropriate to different social positions and relationships, such as parent-child, supervisor-employee, teacher-student, and friend-friend. Behavior in these relationships is regulated through a number of mechanisms, including social control and shared cultural values. Various persons in social relationships occupy different social statuses. These relationships are often part of larger social organizational contexts; for example, the supervisor and employee positions may be part of a business corporation.

One feature of social structure is how it is stratified. People can be stratified or ranked according to such dimensions as class, ethnicity, age, and gender. Socioeconomic status (SES), or social class, is often measured by income, occupation, or wealth. A person's social location in socioeconomic stratification influences how much power the individual has to manage his or her body and external environment. Socioeconomic position can be used analytically to understand the social location and power of neighborhoods and communities, as well as individuals (Lynch and Kaplan, 2000).

Other determinants of power affect health. The particular position of power we occupy in our family (for example, child or parent) and our gender, race, and ethnicity are also all important factors. Ever health status (being chronically ill, for instance) determines the stressors to which we are exposed and the coping resources available to us.

In understanding health and illness, cultural aspects to consider might include people’s eating and hygienic practices and their ideas about health, illness, and healing. By contrast, structural elements might include a person's position and relationships in the workplace, family, and medical settings, as well as such social status indicators as gender, race, age, and class.

Both scientific and nonscientific ideas about health, illness, and the body are the result of social construction, as are the facts we assemble as evidence for our ideas about the world. All descriptions, including medical descriptions, are constructions in that they include some information and exclude other information. Similarly, definitions of health are social constructions. For example, the International Dictionary of Medicine and Biology defines health as "a state of well-being of an organism or part of one, characterized by normal function and unattended by disease" (Becker, 1986: v. 2, 1270). This definition delineates well-being only in terms of bodily functioning and the absence of disease. But are we necessarily healthy if we
simply lack disease? And are all diseases necessarily unhealthy? Is it healthy to function under all (however miserable) conditions? Why should functioning be such an important criterion? Is it because our society places so much cultural emphasis on certain forms of functioning?

The Medical Model

Our culture derives many of its ideas about the body from the Western biomedical model. A sociological perspective on health and illness, however, does not take this model as truth. Rather, the medical ideas of the body and its diseases are also seen as socially constructed realities that are subject to social biases and limitations. Biomedical ideas are based on a number of historical assumptions about the body and ways of knowing about the body; the following are some of these historically created assumptions that have become embedded in the Western medical model. Chapter 9 develops these concepts in more detail.

One biomedical assumption is mind-body dualism. The medical model assumes a clear dichotomy between the mind and the body; physical diseases are presumed to be located solely within the body. As a result, biomedicine tries to understand and treat the body in isolation from other aspects of the person inhabiting it. The history of Western medical science suggests several of the sources of this image of the body as separate from mind or spirit.

Not only does the medical model dichotomize body and mind, but it also assumes that illness can be reduced to disordered bodily (biochemical or neurophysiological) functions. This physical reductionism excludes social, psychological, and behavioral dimensions of illness. One result is that medicine sees disease as localized in the individual body. Such conceptions prevent the medical model from conceiving of the social body or how aspects of the individual's social or emotional life might affect physical health. Thus, medicine generally ignores social conditions contributing to illness or promoting healing.

A related assumption of the biomedical model is what Dubos (1959) called the doctrine of specific etiology. This belief holds that each disease is caused by a specific, potentially identifiable agent. The history of Western medicine shows both the fruitfulness and the limitations of this assumption. Dubos noted that although the doctrine of specific etiology has led to important theoretical and practical achievements, it has rarely provided a complete account of the causation of disease. An adequate understanding of illness etiology must include broader factors, such as nutrition, stress, and metabolic states, which affect the individual's susceptibility to infection. As noted in Chapter 2, the search for specific illness-producing agents works relatively well in dealing with infectious diseases but is too simplistic to explain the causes of complex chronic illnesses. Also, as Dubos observed, this approach often results in a quest for the "magic bullet" to "shoot and kill" the disease, producing an overreliance on pharmaceuticals in the "armamentarium" (stock of "weapons") of the modern physician.

The machine metaphor is another implicit assumption in the medical model. Accordingly, the body is a complex biochemical machine, and disease is the malfunctioning of some constituent mechanism (such as a "breakdown" of the heart). Other cultures use other metaphors; for example, ancient Egyptian societies used the image of a river, and Chinese tradition refers to the balance of elemental forces (yin and yang) of the earth (Osberson and AmaraSingham, 1981). In combination with the assumption of mind-body dualism, the machine metaphor further encouraged the notion that the physician could "repair" one part in isolation from the rest (Berliner, 1975).

Partly as a product of the machine metaphor and the quest for mastery, the Western medical model also conceptualizes the body as the proper object of regimen and control (Foucault, 1979), again emphasizing the responsibility of the individual to exercise this control in order to maintain or restore health. This assumption meshes with other values, resulting in the medical and social emphasis on such standardized body disciplines as diets, exercise programs, routines of hygiene, and even sexual activity (Turner, 1984: 157–203).

THE CENTRALITY OF POWER IN THE SOCIOLOGY OF HEALTH AND ILLNESS

One of the unifying themes of this text is the social construction of both ideas about the body and the body itself. In this process, power and control play an important role. In the most general sense, power is the ability to get what we want and to get things done.

Power is a ubiquitous factor in our daily lives. It both enables us to accomplish tasks (such as to get enough food) and constrains the number and types of possibilities open to us. This text emphasizes the relationship between health and power, such as the power of workers over their work pace; the power of people to control the quality of their physical environments; the power of various groups or societies to shape health policy or to deliver what they consider healing; the power of people of different statuses to control, receive, and understand information vital to their well-being; and the power of the mass media to shape ideas about food and fitness. In addition to these objective manifestations of power, we also subjectively experience power. Our sense of personal empowerment—a feeling that we can handle stressful situations, for instance—is important to health and well-being and strongly related to our ability to manage our environment and feel safe and secure in it. The power of individuals is not simply personal but also usually has a social basis.

The concept of social power in particular implies that the will of one individual or group can prevail over that of others. Our statuses (such as age and social class) in society determine the resources available for the exercise of power. For example, if I own a business and control its resources, I can decide how they will be used; generally, I have power in my workplace and have more resources to enforce my will than do the workers in my business. Often our experiences deal not with overt power or control but relative, implicit power. For example, if I feel in control of my family life, I thus feel able to resist others’ attempts to wrest control, whether by direct confrontation or by
subtle manipulation. For this reason, power is typically enhanced when its exercise is accepted as legitimate. Likewise, when people do not recognize that power is being exercised, they may submit to control unwillingly and unknowingly. Concepts like "social status" and "social control" thus are significant in understanding the relationship between power and the body. Control refers to the exercise of power in a particular situation. Like a sense of empowerment, control is related to our ability to manage our environment and to feel safe and secure in it.

**Social control** may be defined as those ways in which a society assures itself of its members' proper and respectable behavior, appearances, productivity, and contributions. Social control assures the relatively smooth functioning of the social order and the maintenance of hierarchical relationships such as class.

This control may rely on violence, force, persuasion, and/or manipulation. Internalized forms of control, such as individual conscience, are far more subtle and effective means of assuring uniformity. The standards by which people learn to measure themselves are another way in which society uses the social self as a means of control. Social organizations also use their control of information to maintain power. For example, the regulation that workers have to punch a time clock is a device for assuring work attendance. Social control measures also affect those who are in power, as when they become their own slave drivers.

**THE PERSPECTIVE OF THIS TEXT**

Although our focus is sociological, we have drawn from many other disciplines and subdisciplines, such as medical sociology, medical anthropology and economics, socio- and psychophysiology, sociology and anthropology of the body, sociology of health and illness, social psychology, history, philosophy of the body, and ethics. Each has its separate focus, and persons contributing to one discipline are often unaware of related work in other fields. We emphasize synthesizing work from several disciplines to achieve a more holistic appreciation of health and illness that views healing and prevention in the broadest sense: The body is not treated as a self-enclosed machine, and health and illness are understood in their social, cultural, and historical contexts.

A holistic perspective is necessary, but difficult because it requires us to go beyond the rigid separations of concepts about the body, mind, and society. As Scheper-Hughes and Lock (1986: 137) wrote:

We are without a language with which to address mind-body-society interactions, and so are left hanging in mid-air, suspended in hypnoses that testify to the radical disconnectedness of our thoughts. We resort to such fragmented concepts as the biosocial, the psychosomatic, the psychosocial, the somatossocial, as feeble ways of expressing the complex and myriad ways that our minds speak to us through our bodies, and the ways in which society is inscribed on the expectant canvas of our flesh and bones, blood and guts.

We stress the interactions of mind, body, and society, and the importance of symbols and subjective experience in understanding health and illness. The narrow focus and unifactorial models of disease characterizing much of modern medicine and some of the sociology of health and illness deflect attention from the social issues implied by persisting inequalities in health status within most modern societies (Comaroff, 1982: 61), as well as the yet greater gaps of inequality between so-called developed and less developed nations. A critical sociology, thus, emphasizes the interconnected factors of social inequality, power, and social control in producing both illness and health.

**SUMMARY**

This text on the sociology of health and illness deals with the social construction of bodies, with an emphasis on how power shapes this construction. How cultural and social-structural factors and central power relationships influence us physically and how we perceive, care for, maintain, and "repair" our bodies constitute the major questions to be addressed. Our perspective is holistic, emphasizing the interpenetration of mind, body, and society.

The first part, Chapters 2 through 5, deals primarily with the ways in which society and culture affect physical functioning, and the material environments in which people exist. The second part, Chapters 6 through 9, emphasizes people's experience of their own and others' bodies, especially social aspects of the illness experience. The last part, Chapters 10 through 12, examines social and cultural factors in the medical systems' treatment of sick persons, and the political economy of health care in the United States.