to environments that move uncomfortably fast or slow, we tend to treat them as personal, internal states of mind. When the environment of college students was experimentally sped up so that they could not maintain the pace, they also began to show irritability and the inability to function (Kastenbaum, 1971). Retirement and institutionalization lead people to experience “standard” time as irrelevant, thus atrophying time-related coping skills and contributing to behavior that may be incorrectly interpreted as evidence of senility.

An important relationship exists between time and health. The standard ways of socially scheduling activity often conflict with one’s personal pace or biological rhythms. A sharp discrepancy between the two will have an impact on one’s health. Scientists studying sleep and sleep disorders note the tension between the sociocultural organization of time and the rhythms of our bodies (Klinkenborg, 1997). Such a split between social time and our ability to keep up is prevalent in time-pressured, production-oriented societies.

In a society as productive as ours, a shorter workweek with longer breaks, more flexible hours, and less time-pressured work should not be impossible. Despite two-day weekends and labor-saving devices, we seem to live in a world that is more time pressured than past societies and many present ones.

SUMMARY

Material environments and our interactions with them affect our bodies. Symbolic and social factors, however, may also influence bodies through neurohormonal and other physical changes, which in turn may even mediate the interaction between our bodies and the physical environments they inhabit.

Stress is not merely in the eyes of the beholder, nor are the ways in which people handle stressors merely a matter of our individual resourcefulness. The economic organization of a society, the various social pressures—such as time pressures—to which its members are subjected, and their membership in sociological categories such as class, race, ethnicity, gender, and age are very important considerations. In the next chapter, we continue to explore these ideas by looking at the emotional aspects of social relationships, power, and health.

Researchers placed blood pressure and pulse monitors on participants in one study and correlated the changes in these stress indicators with activities and social pressures throughout the day. The case of one hospital administrative aide exemplifies workplace stress.

“Her peak reading at the office—a diastolic pressure of 77—came in the morning when she was mediating a dispute between two secretaries. She hit this level again just before lunch when she was in that perennial secretarial bind: politely taking orders from someone who annoys you.

In this case, it was a patient, a tense, well-dressed suburban matron convinced that something was wrong with her despite repeated tests showing she was healthy. At that moment, there were two real emergencies going on—doctors were rushing in and out of the office to consult about a woman near death on an operating table, and a cardiac patient from another hospital needed to be transferred by helicopter to the medical center. In the midst of all this, Collins spent 15 minutes negotiating appointments for the matron; her diastolic pressure peaking and her pulse hitting 90.”


• Social Support and Health
  The Quality of Social Support
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• Social Interaction in Dramaturgical Perspective
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  Dramaturgical Stress and Health
Humans' biological makeup, as Chapter 4 shows, makes them open to influences from the social environment, including relationships with other people. The importance of social relationships for health is demonstrated by studies that find loss of a spouse or intimate friend leads to risk of coronary problems (Pilisuk and Parks, 1986: 33), lowered immunity (Bartrop et al., 1977), or death (Engel, 1971). Mourning and separation from loved ones can affect levels of stress hormones (Pilisuk and Parks, 1986: 45). The absence of social support can affect immune competence. Strong relationships with others can increase resilience against illness (Fonagy, 1996: 128). Although the withdrawal of social support or a diminished quality of social relationships can have a sickening impact on us, social bonds also have the potential to heal us.

Social support is one source of the individual's sense of empowerment. It may seem strange and perhaps a bit clinical to think of our relationships with lovers, family, friends, and fellow workers or students in terms of power, yet social ties can serve as nests that hold us up or keep us from falling when we are threatened. They function as sources of information and emotional or other kinds of aid and as mirrors that help reflect messages of self-affirmation back to us. Just as a fetus needs a womb to receive nourishment, shelter, warmth, and life support, human beings do not function effectively as isolated individuals.

Social support is a general term for the many different resources that aid persons in times of crisis and help them cope with life. Social relationships empower individuals by making them feel they are part of a larger social order. They are also a source of self-validation and a sense of personal security (Pilisuk and Parks, 1986). As symbols of those relationships, physical contact and intimacy can be empowering. Other people can remind us that we are alive and have someone to lean on and depend on when necessary. They can enhance our sense of security and self-confidence. Emotional support is one of the most important ways that social support empowers individuals (House, 1981).

This support may involve touch. Because many measures of social support use paper-and-pencil methods such as questionnaires, human touch has not been adequately investigated as a medium of emotional support. Giving social support may involve subtle cues like body language and tone of voice, which often go unnoticed by the researcher-observer (Pilisuk and Parks, 1986: 39). Although the effects of social contact may not be mentally perceived, nonetheless they may have an impact on our bodies. For example, a nurse's touch can affect the blood pressure of even a comatose patient (Lynch, 1979). Under the stress of electric shocks, dogs who were petted responded to these stressors with fewer pathological consequences than animals who were not touched. Similarly, rabbits on a high-fat diet that were not touched were more likely to develop heart disease than those that were cuddled and petted (Marmot and Mustard, 1994). Rats handled during infancy recovered from stress neurohormonally, more rapidly than non-touched rats; indeed, non-handled rats may age more rapidly (Berkman et al., 2000). Social support also reduced the stress of lower status in monkeys (Shively et al., 1999). Animal experiments should be used cautiously when generalizing to humans, but these studies do suggest that nonverbal aspects of social relationships may have health consequences.

Social support may have physical benefits by preventing the loss of self-esteem and aiding a sense of mastery (Pearlin, 1983). Social support empowers by giving individuals a sense that they are valued, esteemed, cared for, and belong to a network of mutual obligation. These are primarily emotional functions, but social support also serves instrumental purpose. A person's support networks often provide useful information and material resources (such as financial aid) as well as other help (Levin and Idler, 1981). Support can also encourage recovery from an illness, for example, by encouraging a family member to do therapeutic exercises. Other social networks also promote such health habits as regular exercise, good eating habits, and adequate sleep.

In the classic study Suicide, Durkheim ([1897]1951) found a relationship between rates of suicide and the degree to which individuals were integrated into their group, which he measured with indicators such as divorce rates. Thus, a group with high rates of divorce should show a high rate of suicide. Conversely, a more integrated group should have a lower rate. Durkheim was the first social scientist to demonstrate that suicide was not simply an individual psychological issue but also to some extent a social and cultural phenomenon influenced by such factors as the strength of social bonds (see Berkman et al., 2000). Much of the literature on social support and health follows in this tradition by making similar associations between social isolation and poor health. We must also consider

1Durkheim also recognized that groups fostering too much integration could encourage what he called "altruistic suicide," such as the deaths of Japanese kamikaze pilots who crashed their planes into Allied warships during World War II.
the possibility of a reverse causal relationship; that is, poor health may lead to social isolation (House et al., 1988).

Social isolation itself can be stressful. Some research indicates that low integration into social networks (or low social cohesion) contributes to poor health, even when significant stressors are absent (Gore, 1978: 158). In a comprehensive study of a large population in Alameda County, California, Berkman and Syme (1979) measured four types of social contact: (1) marriage partners, (2) close friends and relatives, (3) members of a church, and (4) informal or formal associations. Persons who had contacts with any of these groups evidenced lower mortality rates than those who did not. The authors of this study recognized the problem of causal direction: Does illness cause a person to withdraw and others to withdraw from that person, or does social isolation generate sickness? Therefore, they analyzed groups with every kind of health status and found that, even among those who were sick, persons with higher levels of social contact had lower mortality rates. Persons with extensive social connections were likely to smoke and drink less, and to eat and sleep more regularly than those with few social connections. This finding suggests that social relationships also protect health by encouraging good health habits (Wallston et al., 1983).

Another study found that neither high stress nor lack of support, in and of themselves, increased pregnancy complications. When major stressors were combined with a low degree of social support, however, there were significantly higher numbers of complications. Women who had high stress and high levels of social support experienced fewer difficulties than those who had a lot of stressful events but not much support. When the levels of stress were low, the absence of social support did not have a notable impact on complications (Nuckolls et al., 1972). Most research finds social support to be either a primary causal factor in determining health or a mediating factor, which may protect the person from the full impact of the stressor. Over the last two decades of the twentieth century, 13 large prospective cohort studies in the United States and several other developed countries demonstrated that people who are isolated and disconnected from others are disproportionately likely to die earlier (see Berkman and Glass, 2000, for a review of this literature).

The Quality of Social Support

Lynch (1979) argues that social isolation can both contribute to coronary heart disease and adversely affect a person’s recovery from a heart attack. Lynch emphasized that social contact (or what he calls “dialogue”) is of chief importance for health. Corroboration of his thesis comes from studies that find mortality rates are considerably lower among married persons than among those who are single or formerly married. Between 1970 and 1988 in Poland, changes in death rates among married men and women were low, but they were substantially higher among divorced men and women. A similar pattern was found in Hungary, where the highest increases in death rates were among widows (Wilkinson, 1996: 123–124). Likewise, death rates from such diseases as cirrhosis of the liver, tuberculosis, and pneumonia are higher for those who are not married (Levin and Idler, 1981; Lynch, 1979). Although such evidence is in line with our cultural assumptions about the importance of family life, it must be interpreted cautiously. Marital status tells us nothing about the quality of social contact. Many people are formally married but psychologically live alone and feel isolated from each other, whereas divorced and other single people may participate in rich social lives. Unhappy marital relationships can cause greater health risk than can the absence of a partner (Kiecolt-Glaser and Glaser, 1991: 860–861).

Social support is also important in the workplace, where it buffers work-related stress (Hibbard and Pope, 1993; House, 1981; Waxler-Morrison et al., 1991). A study of NASA workers found that good work relationships protected them from the effects of such stress (Caplan, 1972). Unemployment can have negative health effects, but social support may buffer them by offering a sense of empowerment. A longitudinal study of men who were laid off from work found that those with higher degrees of social support reported fewer symptoms of illness and showed lower levels of cholesterol (Gore, 1978).

Further investigation is needed on how particular organizational forms encourage or discourage social support. For example, how do cultural factors, such as an emphasis on competitiveness and individualism, affect the possibility for supportive relationships in the workplace? Pilisuk and Parks (1986: 59) observed “social currents of careerism, autonomy, mobility, privacy and achievement that disrupt our traditional roots and ties also make difficult the continuity of new bonds.” Not only do we need further research on how social support may be health promoting, but also we need to examine how control over work conditions (and other institutional settings) makes social support possible.

A Critical Appraisal of Social Support

Much of the social support literature makes several assumptions that are problematic. First, social support should not be treated as a stable, constant factor; levels of social support do not necessarily remain the same over time. Second, stressful events (stressors) and social support are not independent factors, but rather interact with each other (Atkinson et al., 1986). Just as social support may protect a person against a stressor (such as unemployment), so too may a stressor (such as unemployment) affect levels of social support. For example, a spouse’s unemployment may put a strain on the entire family relationship and thereby reduce the support given by family members. High levels of kin involvement and family leadership have been associated with high blood pressure among low-income people. For those with more economic resources, such family involvement and status have been linked with low blood pressure (Corin, 1994: 107–108).

The main failing of social support research is its blindness to the larger contexts of power relationships in which social support takes place (see Berkman et al., 2000). For example, people in economic need may have difficulties with their social networks. Their social and economic powerlessness may strain their social networks, and may also limit their access to supportive social relationships.
need to address the health problems exacerbated by coping difficulties and limits to social support created by societal structures outside the private sphere (Wadsworth, 1996: 165).

Studies of social support make little mention of class and power. For example, how do controls in the workplace affect social support as well as self-esteem and self-mastery? How does the distribution of power in existing social networks such as families affect social support? How do institutional structures under capitalism generate competitiveness, individualism, and social mobility that make social support difficult? Social support can be a means of empowering the individual, but it exists in social and cultural environments that often reduce its quality and availability. The research emphasis on social support should not blind us to the many other ways these social environments can disempower individuals, making it more difficult for them to control their own bodies and well-being (see Carpenter, 2000).

Social Inequality, Support, and Health

Evidence from animal studies indicates that physiological changes, some of which contribute to illness, are associated with subordinate status. When the social status of an animal is altered, these physiological patterns change (Weiner, 1992: 176). Obviously, relationships between top-ranking baboons and bottom bananas (as studied, for instance, by Sapolsky, 1982, 1989, 1990) are in many ways unlike those between office worker and boss. The “underlying threat among humans is not of being bitten so much as that of economic sanctions like losing your job or missing promotion” (Wilkinson, 1996: 196).

Human relationships are more complex and involve symbolic aspects. We are creatures capable of reflecting on our situation. Thus, unlike other creatures, we can dramatize insults and injustices in our minds—either playing them down or dramatically enhancing them. The very process of talking to ourselves and others about events can function to minimize or dramatize their significance. Animal studies can suggest some ways by which social status affects human bodies (Evans, Hodge, and Pless, 1994). A number of similarities exist in the way risk factors for coronary heart disease are affected by social status both among baboons and humans (Brunner, 1996; Wilkinson, 1996: 195). The activities involved in establishing and maintaining hierarchies—such as activities of social control—may have physical consequences for humans and other animals (Weiner, 1992: 195).

It has been argued that there is a relationship between the distribution of power in a society (such as levels of economic equality or inequality), levels and quality of social support, and health (see Berkman et al., 2000). Once societies have gone through an epidemiological transition (see Chapter 2) and most of their members have an adequate minimum material standard of living, then psychological factors (such as lack of social support and stress) become more important as determinants in disease (Wilkinson, 1999a; Williams, 2000, 2001). Some evidence links U.S. income distribution, social cohesion, and mortality (Kennedy et al., 1996). Both economic stressors and social support tend to be socially distributed by class: “It’s as simple as that. If you are poor, you have more stress and less
manage the impressions one makes on others, and particularly by struggling to keep up social appearances that are inconsistent with deeply held feelings and conceptions about oneself.

A significant part of performing in social life involves managing our own and other people’s emotions. Everyday situations call for appropriate emotions and feelings as well as appropriate displays of emotions. Many skills of self-presentation thus require what Hochschild (1983) calls emotion work—the activities through which we manage our own and other people’s emotions. Emotion work involves repressing displays of undesirable or inappropriate emotions and evoking appropriate ones. For example, it is considered improper to laugh during a funeral. What does one do to keep from displaying such inappropriate emotions? One might try to think of something sad, engaging in emotion work to both appear to have the proper demeanor and to “feel” the appropriate emotions.

Performing is part of all social life, so some dramaturgical stress is inevitable. Societies such as ours, however, exacerbate dramaturgical stress because the manipulation of appearances and emotions is an important skill and a highly complex and self-conscious act. Not only are emotions and bodily expressions highly controlled, but also the activity of manipulating appearances is itself stressful (Elias, 1978: 1994). It takes energy to constrain feelings and actions and to manage emotional communication while monitoring that of others. Self-presentation and role playing, together with the emotion work required by these roles, can be dramaturgically stressful (Williams and Bendelow, 1996: 41). Under certain social conditions stress becomes particularly intense and chronic, promoting illness.

**Dramaturgical Stress and Social Inequality**

Dramaturgical stress is heightened when a person’s performance in a given situation is inconsistent with his or her concept of self (Cockerham, 1978: 49). Stress may be generated by “the task of managing an estrangement between self and feeling and between self and display” (Hochschild, 1983: 13). Considerable pressure may come from the effort to protect and to control emotional information. Actors in subordinate social statuses (that is, those with less power) may be more likely to encounter such stressful situations and lack the dramaturgical resources to cope with them.

As noted in Chapter 4, some actors are in social positions that make them particularly vulnerable to stress: those who occupy subordinate positions in various institutional contexts (such as school, family, or work), members of minority groups, and those whose identities are potentially stigmatized (disabled or gay people, for instance). Actors in subordinate positions may lack status shields (Hochschild, 1983) to protect their sense of self (Freund, 1998). Lower-status individuals often lack such dramaturgical resources, leaving their very selves vulnerable to attacks by those in power (Williams and Bendelow, 1996). For example,
institutional rules protect teachers from having their authority, character, or competence challenged in class, whereas students lack such status shields.\textsuperscript{3}

Inability to protect the boundaries of self and to counter the intrusion of others may lead to depression and anxiety. Individuals' social positions determine their resources for protecting their self-concepts and for controlling how they experience themselves. Subordinate status, combined with social controls that prevail in a situation (such as a service job that demands emotion work), require intense feelings to be suppressed, denied, or relegated to another sphere (such as family). Persons in subordinate status are thus especially vulnerable to dramaturgical stress, and the stress is intensified by their powerlessness in the face of controls and demands of others (Williams, 2001). Box 5.1 illustrates how degrading work and demands to be cheerfully deferential compound the physical distress of "menial" laborers.

The social organization of time and space influences our emotion work and dramaturgical competence, the availability of "backstage"\textsuperscript{4} respites, and our levels of security about our psychological space, and hence levels of dramaturgical stress. Having to interact in the same physical space with coworkers, bosses, or family members, we are less likely to express disruptive emotions there. "Physical containment may support emotional containment" (Newton, 1995: 84).

Box 5.1

Social Inequality and Dramaturgical Stress: Not-so-"Merry-Maids"

Author Barbara Ehrenreich spent several months doing low-wage service work, trying to learn how it was possible for women driven off welfare to live and support their families on wages barely above the federally mandated minimum. One of the jobs she took was with a housecleaning service:

"Maddy assigns me to do the kitchen floor. OK, except that Mrs. W. is in the kitchen, so I have to go down on my hands and knees practically at her feet. No, we don't have sponge mops like the one I use in my own house; the hands-and-knees approach is a definite selling point for corporate cleaning services like The Maids. 'We clean floors the old-fashioned way—on our hands and knees!' (author's emphasis), the brochure for a competing firm boasts... A mop and a full bucket of hot soapy water would not only get a floor cleaner but would be a lot more dignified for the person who does the cleaning. But it is this primal posture of submission—and of what is ultimately anal accessibility—that seems to gratify the consumers of maid services.

I don't know, but Mrs. W.'s floor is hard—stone, I think, or at least a stone-like substance—and we have no knee pads with us today... So here I am on my knees, working my way around the room like some fanatical penitent crawling... when I realize that Mrs. W. is staring at me fixedly... She's... watching that I don't leave out some stray square inch, and when I rise painfully to my feet again, blinking through the sweat, she says, 'Could you just scrub the floor in the entryway while you're at it?"  


Humans in subordinate social positions are particularly vulnerable to dramaturgical stress, not only because they often face heightened and conflicting emotional demands, but also they lack resources and options for coping or resisting. Williams and Bendelow (1996: 41) observe, "Less powerful people, therefore, face a structurally in-built handicap in managing social and emotional information and this handicap may, in turn, contribute to existential fear, anxiety and neurophysiological perturbation."

Stressful Social Interactions

Because dramaturgical stress is linked with structural factors, especially social status, it is likely to be a feature of regular social interaction in which social stratification and power are embedded in social relationships.

Work

In corporate and bureaucratic jobs, a great deal of control over the presentation of self is an important part of a person's work skills. Manners and politeness become tools for the efficient and effective accomplishment of work (Mumford, 1963: 139). In postindustrial economies, the proportion of jobs providing service has increased. Occupations involving selling (salesclerk, stockbroker, for instance) or providing emotional services such as friendliness or reassurance
(nurse, flight attendant) have increased dramatically (Hochschild, 1983). These service jobs demand elaborate skills in self-presentation and in managing one’s emotions (both of which entail emotion work).

According to Hochschild (1983), emotional labor is the active effort to change one’s emotional expression and experience, required as a part of one’s work in order to interact with clients, customers, or others within the work hierarchy. Psychologist Eric Fromm (1965: 268) observed:

If you do not smile you are judged lacking in a “pleasing personality” and you need to have a pleasing personality if you want to sell your services whether as a waitress, a salesman or a physician. Only those at the bottom of the social pyramid, who sell nothing but their physical labor, and those at the very top do not need to be particularly pleasant.

In his description of bureaucratic white-collar workers, Mills (1956: xvii) noted that the management of one’s personality had increasingly become an essential work skill “of commercial relevance and required for the more efficient and profitable distribution of goods and services.” Demand for pleasing personalities, particularly in the face of job conditions that are anything but pleasing, can be highly stressful and often require workers to deny their emotional responses. A study of bank employees found that when the emotional and physical appearances demanded of workers conflicted with their own sense of self, they began to experience self-artificiality. Bureaucratized structures, particularly those with commercial goals, are most likely to produce this tension between the public face and private self (Karasek and Theorell, 1990: 33). The rude customer who “is always right,” the demand for geniality in the face of social isolation within the office, the interpersonal competitiveness, and the hierarchical pressures all produce dramaturgical stress in the workplace (Freund, 1982, 1998). Box 5.2 illustrates how emotional labor is linked with dramaturgical stress.

Much of the burden of emotional labor falls on women. Women increasingly do “second shifts” of emotional labor, at work and at home (Hochschild, 1989). Emotional “second shifts” can result in overload. Research shows that women’s well-being at work can be influenced by the demands of stressful emotion work at home (Wharton, 1999).

Emotion work entails more than merely assuming a smiling mask, because that might appear insincere. Rather one must convince oneself, to some extent, that one’s angry reaction is not valid. Hochschild (1983) describes how flight attendants are taught to see the nasty customer as a victim and one’s own angry response as unnecessary. They were expected to convince themselves that they felt something other than what they were feeling. Such invalidation of one’s emotions may have long-term health consequences, especially as the split between what one feels and what one shows may become automatic, no longer a temporary mask that one assumes voluntarily (see Williams, 2000). Emotional labor need not be very stressful or alienating; in fact, sometimes, it can be a source of job satisfaction.

**Box 5.2: Emotional Labor and Dramaturgical Stress—Problems for Paralegals**

“I was trying to be pleasant, pay attention and take notes [while the witness was talking]. Not an easy feat, [because] I felt like I was next to a human time bomb [the attorney].”

Whenever a lawyer is angry about something, the paralegal is liable to be the recipient of that anger—even when the fault lies elsewhere. . . . Law firms recognize this aspect of the job; they specifically seek to hire legal assistants who can deal gracefully with irate attorneys. . . . Being pleasant or cheerful is an attitude paralegals are expected to convey while trying to accomplish other aspects of their jobs.

“Sometimes I think she [the law firm’s personnel director] thinks smiling is supposed to be part of my job.”


This is not the case, however, when workers lack autonomy or control over their work (Wharton, 1999).

**Race and Ethnicity** Over 30 years ago, Franz Fanon, the Algerian psychiatrist, wrote about the connections between racial and colonial domination and psychological and physical well-being. In the following passage, he linked muscular tension and illness in Algerians to their powerlessness in the face of French colonial authority:

This particular form of pathology (generalized muscular contraction) had already called forth attention before the revolution began. But the doctors described it by portraying it as a congenital stigma of the native, an original part of his nervous system where it was stated, it was possible to find the proof of a predominance of the extra-pyramidal system in the native. The contracture is in fact simply the postural accompaniment to the native’s reticence and the expression in muscular form of his rigidity and his refusal with regard to colonial authority. (Fanon, 1963: 293)

Because it was not possible for the colonized Algerians to express anger openly toward colonial authority, it was held in, but manifested itself in the form of muscular tension. Note also that the effects of a social problem (colonial rule) were viewed by the colonial doctors as an inherited, individual problem. The individual could not leave the social space of a racist encounter and thus expressed somatically the resistance that could not be shown openly. The particular form and distribution of muscular tensions throughout the body represented how the body was used to create an impermeable boundary between self and other. This muscular armoring keeps the other and their claims on one out of one’s psychological space.
Geographical variations in levels of disrespect, prejudice, and racism have been linked to high mortality rates in African Americans (Kennedy et al., 1999). Racism may promote illnesses, such as hypertension, which is prevalent among African Americans. Their elevated rates of hypertension cannot be explained simply by diet or genetics (Johnson and Gant, 1996). One study of African American women concluded that face-to-face encounters with racist provocation can affect cardiovascular reactivity (for example, heart rate, blood pressure). Cardiovascular reactivity increased more among those individuals who were able to speak during a racist provocation compared to those who were simply listening, but support from another person in responding to the provocation helped reduce reactivity (McNeilly et al., 1995). Another study showed that black women who responded actively to unfair treatment were less likely to have high blood pressure than women who held their responses “inside” themselves (Krieger and Fee, 1994).

Similarly, African American males may be exposed to more anger-provoking encounters with arbitrary authority (in regard to housing, employment, and the law, for instance) than other groups, but they cannot express their anger. The suppression of their emotional responses might well contribute to their greater incidence of hypertension (Johnson and Gant, 1996). Socialization to suppress hostility may be especially high among upwardly mobile, upper-lower-class persons, who emphasize the importance of politeness and respect higher-status people (Harburg et al., 1973). One study, comparing hypertensive African Americans with those with normal blood pressure, described those with hypertension as humble, docile, sober, serious, and controlled (Johnson and Gant, 1996: 98). The demand that one always be polite and civil—no matter how rude someone else may be—represents a form of social control. Strict control over anger is a norm in our society (Elias, 1994; Stearns and Stearns, 1986).

Sexual Orientation Those who must cope with a social stigma by concealing their identity under a cloak of normal appearances face special stresses. For example, in our society widespread homophobia (fear of homosexuality) pressures homosexuals to hide their true selves in order to perform according to social expectations; however, trying to pass as heterosexuals may cause considerable distress. For example, in our society widespread homophobia (fear of homosexuality) pressures homosexuals to hide their true selves in order to perform according to social expectations; however, trying to pass as heterosexuals may cause considerable distress. The family does have a dimension to its place in the stress process that sets it apart from occupations, however. It is, of course, a major reservoir of problems and tribulations. Multiple facets of marital relations, parent-child encounters, and the transitional points along the family life cycle have been viewed as fertile ground out of which stress can grow. It is likely, too, to be an arena in which problems generated elsewhere are transplanted. But the family domain, unlike occupation, is also the place where the wounds that people incur outside are most likely to be healed. The family is truly many things to its members: it is commonly an active and rich source of pain, and it is just as commonly where people turn to find relief from pain. In the stress process, it stands in a uniquely pivotal position.

Visible lesbians are treated as outcasts or queers. They are ignored, fantasized about, and played with. Lesbians are subject to verbal and physical harassment. Closeted lesbians live in fear of being found out. A lesbian’s family may be a source of stress for her as coming out to one’s family can often mean risking anger, pain or exile. Drifting apart from one’s family may be the result of not coming out. (O’Donnel, 1978: 14)

“Closets” are the refuge of the powerless, but the use of this refuge has its price. “Closets are a health hazard” was a slogan first used by the physicians marching in the 1981 Gay Freedom Day Parade in San Francisco.

Family Not all situations that demand a split between self-presentation and feelings are equally stressful. One may more easily distance oneself from work relationships than from intimate, primary group relationships (such as family or loved ones). Pearlin (1983: 6) observed:

Several studies suggest that persons whose families make them feel powerless, force them to surrender their autonomy, or inhibit their displays of anger in response to arbitrary authority will experience subsequent health problems (Doherty and Campbell, 1988; Sagan, 1987; Seligman, 1992).

Noting the high incidence of somatic symptoms among people who live in totalitarian societies, Griffith and Griffith (1994: 55) observe:

In non-totalitarian, Western societies, we find remarkably similar examples of somatic symptoms that have been fostered within micropolitical systems of abusive families, where a child sexually abused at home hides the abuse at school and church, even defending her father as if he were a wonderful parent; or where a wife is physically beaten at home by her husband but hides the abuse even from friends or coworkers, believing that she cannot or should not escape and will only suffer more if she were to disclose.

Thus, micropolitical circumstances (such as marriage and family), like oppressive macropolitical contexts (such as a totalitarian state), may require a distressful containment of feeling that can be expressed only somatically.

Situations in which sexual abuse or gendered violence occur are intensely stressful interactions. Griffith and Griffith (1994: 55–56) present a case of a woman who was sexually abused but had to contain her distress while routinely encountering her abuser in the micropolitical context of the home:

In meeting with Jana alone, however, the story widened. With specific questioning about possible abuse, she told how during the summer, while out of school, she stayed at home with her stepfather on days that her mother worked. When they were alone, the stepfather had sexually fondled her and warned her not to tell anyone. She had not spoken out of fear that she would not be believed, that she would be punished by him, or that the revelation would threaten her mother’s new marriage. She was terrified that he would touch her again but spoke to no one. Instead her body began jerking violently out of control.
Such situations create what the authors describe as “unspeakable dilemmas,” because these women must live with their abuser and dramaturgically conceal their distress. Women with young children, few job skills, and no alternative place to live often feel trapped in abusive situations. Children who are victims of sexual abuse, when seen in emergency rooms, often show symptoms of seizures that are nonepileptic in origin (Griffith and Griffith, 1994: 55). Gendered violence (sexual abuse, rape, domestic violence, or the threat of abuse) attacks the victim’s psychophysical boundaries, sense of self, and security in their world. The threatened person’s feelings often cannot be acknowledged or expressed; they must be dramaturgically hidden.

**Dramaturgical Stress and Health**

As discussed in Chapter 4, certain kinds of prolonged or acute stress can lead to physiological responses and, ultimately, sickness. Dramaturgical stress, affecting body and emotions, may promote illness in a number of ways. Contradictory psychosomatic states are responses to dramaturgical demands and the result of dramaturgical stress. Interviews of patients with “somatoform symptoms” showed the following:

[T]he bodily experience of such a dilemma is that of mobilizing the body for action (e.g., an aggressive emotional posture), while expressing a contradictory emotional posture (e.g., a warm welcoming with smiles and attentive listening, belying privately held seething). In essence, the body receives two conflicting directions for organizing its physiological readiness to act. (Griffith and Griffith, 1994: 61)

These physical symptoms are one way of responding to social situations in which a profound disjunction exists between how one desires to present oneself and a contrary self-presentation, demanded by a social situation in which the actor cannot leave the field. Thus, the body may cope with such a “push me-pull you” situation by expressing somatic symptoms.

Several studies have examined the relationship between the expression of such emotions as anger and physiological responses. In one early experiment, some subjects responded to provocative situations by expressing overt hostility (“anger out”). Persons displaying “anger in” responses were more likely to blame themselves and not express overt hostility. “Anger in” respondents exhibited more extended physical stress reactions than the “anger out” group (Funkenstein et al., 1957). In another experimental situation, anger was induced experimentally by having a colleague arbitrarily harass and insult subjects while they were trying to solve a problem. The subjects’ anger resulted in increases in their blood pressure, but those who could express their hostility by giving the harasser what they believed was a mild electric shock returned to normal blood pressure levels more rapidly. Those who were not allowed to express anger in this fashion continued to show signs of elevated blood pressure long after the harassment had stopped (Hokanson and Burgess, 1962). Such experiments point to how emotion work might influence us physically.

Some evidence links the denial of feelings to coronary heart disease (Karasek and Theorell, 1990: 114). Yet this evidence is by no means unproblematic. Some studies find the inhibition of anger expression to be linked to coronary heart disease; others find the expression of anger to be the link (Engebretson and Stoney, 1995). A study of airline pilots concluded that both those who inhibit their anger a lot and those who often express their anger are prone to have higher levels of cholesterol in their blood than their more moderate colleagues (Engebretson and Stoney, 1995); this finding may account for the apparently conflicting prior evidence. Such studies are suggestive of how one’s presentation of self, emotion work, social interaction, and the body might be linked.

Individuals develop coping strategies in distressful situations, particularly those situations of heightened dramaturgical stress in which a sincere performance that belies distress is demanded. This coping is accomplished by compartmentalizing, by dissociating feelings (separating “gut” feelings from conscious feelings), thereby convincing oneself that “all’s well.” Such dissociation may separate bodily activities of expression and internal functions such as blood pressure—akin to what has been called “schizokinesis.” A person whose demeanor appears “cool” on the exterior, but whose internal response to stress involves such dramatic bodily changes as sharp increase in blood pressure, exemplifies this dissociation (Lynch, 1985). How do social and cultural factors encourage such compartmentalization? A consequence of such splits is emotional false consciousness (Freund, 1990), which occurs when emotion work disrupts the body’s equilibrium and our ability to interpret embodied feelings. Such false consciousness involves a split between bodily expressions and an awareness of internal psychosomatic sensations, on the one hand, and continued heightened physiological reactivity to stressful situations, on the other (Freund, 1990, 1998; Williams and Bendelow, 1996). It is as if the levels of consciousness come to be more or less permanently split between bodily appraisals and cognitive appraisals of situations.

An effective social performance (that is, one that appears sincere) may be accomplished through subjectively redefining relationships and emotional responses to them (Hochschild, 1983, 1989). For example, a flight attendant dealing with a rude customer who refused to abide by smoking rules tried subjectively to convince herself, “I shouldn’t be angry, because it’s not his fault; he may have had a miserable business trip.” Problems arise, however, if feelings are reworked on only one level as consciousness and not also on the level of somatic or body consciousness; this emotion management thus short-circuits the signal function of emotion (Hochschild, 1983). Emotions “lie at the juncture between mind, body, culture and biology and are often considered crucial to our survival by their signal function in relation to danger” (Bendelow and Williams, 1995: 151). Emotion work strategies may seem effective for the short term, but on another level of consciousness continue to produce feelings of insecurity. These feelings are apprehended as free floating because one has redefined the source of the threat out of one’s wide awake consciousness.

In social interaction, people may collectively reproduce emotionally oppressive and distressing situations (Newton, 1995). Indeed, oppressive situations produce
individuals who collude in their own social control to reproduce distressing arrangements. The splitting of emotional consciousness facilitates the smooth functioning of hierarchical relationships, even while they produce distress. Furthermore, chronically disavowing one’s feelings may also blur the boundaries between self and other. By affecting one’s ability to experience social situations clearly, this process makes it harder for the victim of oppressive situations to identify accurately those situations as oppressive.

SUMMARY

In this chapter we continued our discussion of mind, body, and society relationships, emphasizing the role of emotions in social interaction. Some research on social support was critically reviewed. The distribution of power is an important factor in influencing the availability and quality of supportive social relationships. We then looked at some of the stressful aspects of interaction that come from role playing. Those in subordinate social statuses may be more vulnerable to dramaturgical stress and more likely to lack resources to cope with such stress. The chapter concluded with a discussion of dramaturgical stress and health.

"... [P]olitical and entrepreneurial interests are, above all, driving what is to be defined as abnormal today. . . . We are no longer in a mood where normal means average; we are in an era of amelioration, enhancement, and progress through increasing intervention into the ‘mistakes’ of nature. However, in this climate, the environmental, social, and political factors that, rather than genes, contribute to so much disease, are eclipsed, and tend to be removed from professional and public attention. Research in connection with these factors remains relatively underfunded. . . . When, under the guise of health promotion, individual bodies and individual responsibility for health are made the cornerstone of health care, moral responsibility for the occurrence of illness and pathology is often diverted from where it belongs (on perennial problems of inequality, exploitation, poverty, sexism, and racism) and inappropriately placed at the feet of individuals designated as abnormal or at risk of being so because of their biological makeup" [emphasis added].


• Illness as Deviance
  The Sick Role
  The Medicalization of Deviance
  The Medicalization of Moral Authority
  Social Control and Power
  Sickness and Social Dissent

• Problems of Meaning and Order
  The Body as a Symbol
  The Meaning of Affliction