chapter 16

The Body and Society: Health and Illness

ON A WARM SUMMER NIGHT, August 7, 2007, Barry Bonds hit the 756th home run of his career, passing Hank Aaron as the all-time Major League Baseball home run leader (Saduharo Oh of the Yomiuri Giants in Japan remains the world record holder with 822 in his career). Hitting a 90-plus-mile-an-hour fastball 400 feet in the air takes a significant amount of power—but also eye–hand coordination, catlike reflexes, and remarkable agility.

Perhaps it also takes drugs. For the last few years of his career, Bonds has been plagued by accusations that he took anabolic steroids to increase his size, bulk, and power. Some have suggested that his record have a permanent asterisk affixed to note that it was not accomplished naturally. Photographs of his early years compared with his later career show a body that has changed as much as Michael Jackson's face over the same amount of time.

The public debate about Bonds's achievement almost inevitably turns on either/or questions: Did he take steroids or not? Did he "really" break the record or not? But to the sociologist, the lines are never as clear. After all, virtually every athlete uses some form of chemical elixir—from Gatorade to surgery—to enhance performance. And steroids may increase size and power, but they do nothing about speed or eye–hand coordination.

There are few things more personal and private than our bodies, and few things that are more shaped by social processes. Our bodies are ourselves, as the women's health handbook told us, but they are also profoundly social.

More than that, these debates indicate something deeply social about our bodies. On the one hand, we may experience them as private possessions, over which we exercise complete control. From childhood, we're taught that no one can touch our bodies without permission and that respecting others means respecting the sanctity of their bodies. That our body is our own property is

the foundation principle of many laws, including all crimes against a person, child abuse, rape laws, and women's reproductive rights.

But on the other hand, our bodies are subject to enormous social control—what we can and cannot do to them, with them, and for them. How we present our bodies; the risks we are permitted to pose to them; the responsibility we bear for injury, disability, or disease—all are subject to social scrutiny and control.

Is the body an individual possession or a social space? To the sociologist, it's both. There are few things more personal and private than our bodies and few things that are more shaped by social processes. Our bodies are ourselves, as the women's health handbook told us, but they are also profoundly social.

The Social Construction of the Body

"I used to hate my body. Now, instead, I hate the forces that conspire to make me hate my body."

When sociologists talk about the body, we do so in three distinct ways. First we discuss the ways in which we construct our identity through our bodies: what we think is beautiful, for example, or the ways we adorn and transform them to fit with cultural norms. Second, we discuss the ways in which our interactions are *embodied*—that is, the ways in which we use our bodies in interacting with others. And, third, we discuss the ways that social institutions use those bodies—in work or family life, for example, disciplining and training bodies to participate in social life (Lorber and Moore, 2007; Weitz, 2002).

The Sociology of Beauty

What we think of as beautiful is less a matter of individual perception and more about ever-shifting cultural standards. Standards of beauty vary enormously from culture to culture, and, within the United States, among different racial and ethnic groups, ages, and even classes. In general, standards of women's beauty vary depending on economic trends and the status of women: When the economy goes up, women's standards become

increasingly "feminine," exaggerating biological differences to suggest that male breadwinners can afford to have their wives stay at home. When women's status rises, men tend to become more interested in their own upper-body muscles, and beards and mustaches increase. In some Islamic cultures, women are believed to be so sexually alluring (and men so unable to control themselves when confronted with temptation) that they wear burkhas, which keep their entire bodies covered.

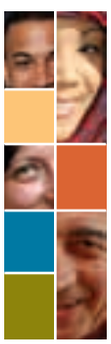
In the United States, women's beauty is placed at such a high premium and the standards of beauty are so narrow that many women feel trapped by what feminist writer Naomi Wolf (1991) called the "beauty myth"—a nearly unreachable cultural ideal of feminine beauty that "uses images of female beauty as a political weapon against women's advancement." By this standard, women are trapped in an endless cycle of cosmetics, beauty aids, diets, and exercise fanaticism (Wolf, 1991, pp. 10, 184; see also Rodin, Silberstein, and Streigel-Moore, 1985; Streigel-Moore, Silberstein, and Rodin, 1986).

Did *you* know?

The first Miss America pageant was held in 1920—the year U.S. women obtained the right to vote.

Weight and Height. The body shape and weight that is considered ideal also varies enormously. And it appears that standards are becoming harder and harder to achieve. For example, in 1954, Miss America was 5' 8" and weighed 132 pounds. Today, the average Miss America contestant still stands 5' 8", but now she weighs just 117 pounds. In 1975, the average female fashion model weighed about 8 percent less than the average American woman; by 1990 that disparity had grown to 23 percent. And though the average American woman today is 5' 4" tall and weighs 140 pounds, the average model is 5' 11" and weighs 117 pounds. Forty-two percent of girls in first through third grades say they want to be thinner, and 81 percent of 10-year-olds are afraid of being fat. Almost half of 9- to 11-year-olds are on diets; by college the percentage has nearly doubled (Gimlin, 2002).

Just as the gap between rich and poor has been growing, so too has the bifurcation between the embodied haves and have-nots. For example, Europeans are getting taller—but Americans are not. Dutch men now average over six feet tall; women average about 5' 8". (American men average 5' 10" and women 5' 4"). Researchers believe



Sociology and our World

White or Wrong?

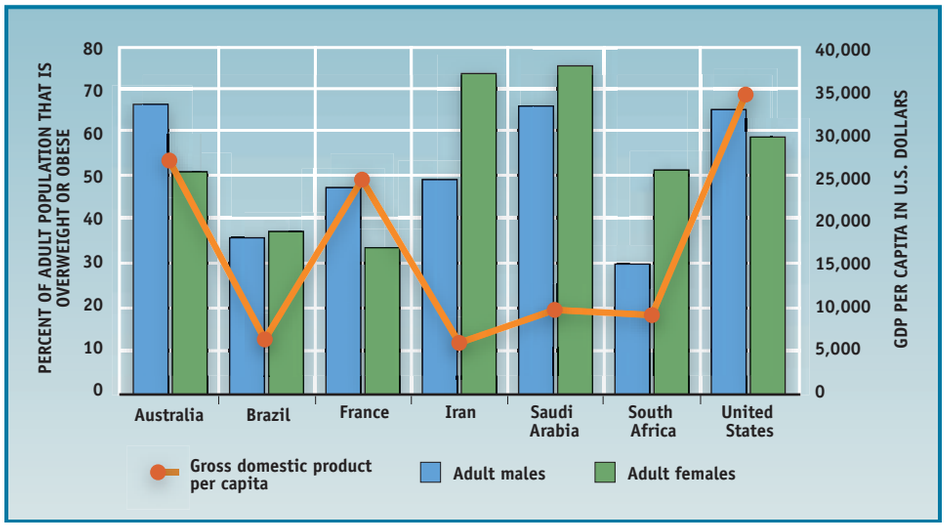
Over the past decade, a whiter skin industry has been flourishing across Asia. Women believe that the whiter your skin, the more beautiful you are. In the Philippines, Malaysia, Hong Kong, Taiwan, and South Korea, 4 in every 10 women use a whitening cream daily. One cream is called "White Perfect." An ad for another asks, "White or Wrong?"

And the whitening does not stop at the face. Also crowding the shelves of pharmacies and supermarkets are creams that whiten darker patches of skin in the armpits and "pink nipple" lotions that bleach away brown pigment. Some of the most effective bleaching agents may be risky to one's health.

Small groups of women in Asia are bucking the trend. In Japan, for example, some young women have been regulars at tanning salons for a decade.

Why would Asians, who are divided by language, ethnicity, and religion, share a cultural preference for ever-whiter skin? Social class may play a role. Lighter complexion may be associated with wealth and higher education levels because those from lower classes—laborers, farmers—are tanned from exposure to the sun. Another hypothesis is that waves of lighter-skinned conquerors and colonizers reset the standard for beauty. More recently, films and advertising have clearly played a role (Fuller, 2006).

FIGURE 16.1 **The Battle of the Bulge**



Source: "Overweight and Obese Adults" from "The Battle of the Bulge" by Kelly D. Brownell and Derek Yach, *Foreign Policy,* December 2005. Reprinted by permission.

that this has to do with nutrition and general health of the population. (Researchers are careful to screen so that only native-born citizens who speak English at home are included, thus preventing bias from immigrant groups that are somewhat shorter than average, like Chinese or Mexicans.) In addition, the Dutch have the best pre- and post-natal health care in the world—and it's free for all citizens.

These differences are more important than predicting basketball games. Tall people have significant advantages: They get married sooner, get promoted more quickly, and receive higher wages. Taller boys are the first ones to get dates. One recent study found that a 6' worker earns $166,000 more over a 30 year period than a 5' 5" co-worker—that's $800 per inch per year (Bilger, 2004). The tall get richer, and the rich get taller.

About weight, too, there is a significant irony. Wealthy countries worry about obesity; poor countries worry about malnutrition and starvation. Developing countries, particularly those that are realizing economic gains due to globalization, are in between, seeing waistlines expand with economic development that includes urbanization, less exercise, and high-fat foods that are cheap and readily available (Figure 16.1).

But within the developed countries, the rich are significantly thinner than the poor. The wealthier you are, the more likely you are to eat well and exercise regularly; poorer people eat more convenience foods with high fats and suffer more weight-related illnesses, like diabetes.

In the United States, we're both fatter and thinner. In 1990, 11.3 percent of Americans were obese; by 2000 it was nearly 20 percent; in 2006, it was 32 percent. (Obesity is measured as having a body mass index [BMI] of over 30; [Centers for Disease Control, 2007]). About one out of three Americans under age 19, and about two-thirds of all adults, qualify as overweight or obese (Hellmich, 2006). And about 5 percent of Americans are "morbidly obese," which is so obese that they qualify for radical surgery (Crister, 2003).

Within the Americas, the United States is by far the fattest country (International Obesity Task Force, 2007), but that weight gain was unevenly distributed throughout our society. The average American is a

Did *you* know?

Body mass index, or BMI, is a new term to most people. However, it is the measurement of choice for many physicians and researchers studying obesity. BMI uses a mathematical formula that takes into account both a person's height and weight. BMI equals a person's weight in kilograms divided by height in meters squared (BMI = kg/m^2).

bit chubbier, but overweight Americans are *much* heavier now than ever. According to the National Health and Nutrition Examination survey, America's BMI has moved towards the extremes; that is, the thin are getting thinner, and the fat are getting fatter. We're either exercising obsessively or sedentary couch potatoes, eating tofu and organic raw vegetables or Big Macs and supersized fried foods.

The five states with the highest levels of obesity are Mississippi, where nearly 30 percent of the population is obese, followed by Alabama, West Virginia, Tennessee, and Louisiana. The five states with the lowest levels are Colorado, at 16.7 percent, Massachusetts, Vermont, Rhode Island, and Connecticut (Centers for Disease Control, 2007).

TABLE 16.1

U.S. Obesity: Percent by Race and Class

	ANNUAL INCOME		
	$10,000 OR LESS	20–25,000	50,000 OR MORE
White	19	20	16
Black	33	27	23
Hispanic	26	18	22

Source: Adapted from Crister, 2003.

Inequalities of class, race, and gender fuel these trends. Among Mexican American women, for example, those below the poverty line have a 13 percent higher obesity rate than those above it. About 16 to 26 percent of Hispanic and Black Americans have diabetes, one of the possible medical consequences of obesity, compared with 12 percent of Whites (Crister, 2003, pp. 4–5) (Table 16.1).

Once a modest girth was a sign of prosperity; today it is the poor who are more likely to be heavy. Diets of cheap fast food coupled with significantly less exercise lead to unhealthier lives. Many poor people don't know that exercise is good for their health. In 2000, 37 percent of people whose income was less than $25,000 agreed with the statement "There are so many conflicting reports, I don't know if exercise is good or bad for me," compared with 14 percent of those making between $50,000 and $75,000 and 12 percent of those making more than $75,000. Two-thirds of those making more than $50,000 said they "would definitely exercise more if I had the time," while less than half (46 percent) of those under $25,000 said they would (cited in Crister, 2003, p. 71). Among young people, the best predictors of being overweight are how much exercise one gets and what types of food one eats (Crister, 2003).

Globally, obesity is a growing health problem, the mirror image of hunger and starvation. The World Health Organization claims that there are now as many overnourished people as undernourished around the world; they call obesity "the dominant unmet global health issue" (Crister, 2003, p. 1; see also Newman, 2004). The World Health Organization gathered information about obesity from 36 different countries between 2000 and 2004 and found that 29 of them—including New Zealand, Mexico, Finland, Israel, Canada, Australia, Ireland, Peru, Sweden, Belgium, and Brazil—have fewer obesity-related public health problems than does the United States (World Health Organization, 2007).

Obesity is coupled with starvation and malnourishment in many developing societies as well. Recent surveys in India find consistently high levels of malnourishment among children and dramatically increasing obesity, despite record levels of economic development. Over half of all Indian children between 10 and 16 years old are either obese or malnourished (Sengupta, 2006).

Despite their connection, we think of starvation and obesity very differently. We have pity for the hungry and donate significantly to charities that minister to hunger. We have contempt for the obese and believe it is their fault that they are fat. Both hunger and obesity are

Obesity has become a global problem, not restricted to industrialized consumer societies. And imported images of the beautiful body, as in the poster looking over this Chinese teenager's shoulder, also become the standard against which everyone is measured. ▼

▲ **Most girls are preoccupied with body image and their weight—at least most middle-class White girls are (body image varies by class and race). At one end of the continuum are fad diets and efforts to stay fit and in shape. At the other end lie dangerous, and potentially lethal, eating disorders, such as anorexia.**

physical responses to a changed environment. The hungry can no longer consume their own food because of the transformation of subsistence agriculture and overfarming of arid land; the obese are also responding to a new dietary environment of supersized fast foods, the use of cheaper saturated fats in fast foods, and the partnering of fast food companies with school lunch programs.

Feeding and Starving the Female Body. Current standards of beauty for women combine two images—dramatically thin and also muscular and buxom—that are virtually impossible to accomplish. Research on adolescents suggests that a large majority consciously trade off health concerns in their efforts to lose weight. As a result, increasing numbers of young women are diagnosed with either anorexia nervosa or bulimia every year. **Anorexia nervosa** involves chronic and dangerous starvation dieting and obsessive exercise; **bulimia** typically involves "binging and purging" (eating large quantities and then either vomiting or taking enemas to excrete them). These are serious problems, often requiring hospitalization, which can, if untreated, threaten a girl's life. To a sociologist they represent only the farthest reaches of a continuum of preoccupation with the body that begins with such "normal" behaviors as compulsive exercise or dieting.

It is important to remember that rates of anorexia and bulimia are higher in the United States than in any other country—by far. Estimates in the United States calculate that 3.7 percent of American women suffer from anorexia at some point in their lifetime; up to 4.2 percent struggle with bulimia at some point in life (U.S. Department of Health and Human Services, 2006). In Europe, about 0.3 percent of women suffer from anorexia and around 1 percent from bulimia—more than ten times less than the United States (Hoek and van Hoeken, 2003). By contrast, many non-Western societies value plumpness, and throughout Europe and the United States, non-White girls are far less likely to exhibit eating disorders than are White and middle-class girls. Recent increases have been observed among young middle- and upper- class Japanese women (Efron, 2005).

While some stereotypic understandings would have it that such a dramatic emphasis on thinness afflicts only middle- and upper-class White girls and women, the evidence suggests that these standards also define working-class and Black ideals of the feminine body. Largeness "was one accepted—even revered—among Black folks," lamented an article in *Essence* magazine in 1994, but it "now carries the same unmistakable stigma as it does among Whites" (Gregory, 1994). And a study the following year found that Black adolescent girls demonstrated significantly higher drive for thinness than did White adolescent girls. The media coverage of Oprah's dramatic weight loss and the depiction of ultra-thin African American models and actresses may have increased Black women's anxieties about their weight; indeed, it may be a perverse signal of assimilation and acceptance by the dominant culture that "their" ideal body type is now embraced by the formerly marginalized (Fitzgibbon and Stolley, 2000; Schreiber et al., 1995).

Pumping up the Male Body. Men have become increasingly concerned with their bodies, especially fitness and weight. While men have long been concerned about appearing strong, the emphasis on big muscles seems to increase as an obsession during periods when men are least likely to actually have to use their muscles in their

Try It Body Image and Eating Disorders

MyLab

Developed by Katherine R. Rowell, *Sinclair Community College.*

OBJECTIVE: Examine the research on body image and eating disorders.

STEP 1: Research
Take some time to read some of the reviews of body image research available on the Internet. Websites like the Social Issues Research Centre and the Media Awareness Network are good places to start.

STEP 2: Develop
Participate in an online body image survey by going to the Monash University website and searching for "open learning psyII." Click on the top result. (Please note that some instructors may also ask you to look at the collated data for this project and answer some questions about the data; directions for this option will be given in class.)

Answer the following questions on a separate sheet of paper:

1. What does body image research suggest about gender and body image?
2. What did you think about this survey? How accurate do you think it might be? What are some of the potential problems with an online survey?
3. What differences would you expect to find between men and women on this survey? Explain.
4. How might you study the topic of body image?
5. What if anything does this have to do with eating disorders? Cite some sources for this question.
6. How does all of this relate to sociology?

STEP 3: Discuss
Bring your responses to class and be prepared to share and discuss your thoughts on this assignment.

work (Gagnon, 1971; Glassner, 1988). Today, successful new men's magazines like *Men's Health* encourage men to see their bodies as women have been taught to see theirs—as ongoing works-in-progress. In part, this coincides with general concerns about health and fitness, and in part it is about looking young in a society that does not value aging. But more than that, it also seems to be about gender.

Men's bodily anxieties mirror those of women (see Bordo, 2000). While women are concerned with breast size and weight, men are concerned with muscularity—that is, both are preoccupied with those aspects of the male and female body that suggest and exaggerate innate biological differences between the sexes. It would appear that the more equal women and men become in the public sphere, the more standards of beauty would emphasize those aspects that are biologically different.

Many men experience what some researchers have labeled **muscle dysmorphia,** a belief that one is too small, insufficiently muscular. Harvard psychiatrist Harrison Pope and his colleagues call it the **Adonis complex**—the belief that men must look like Greek gods, with perfect chins, thick hair, rippling muscles, and washboard abdominals (Pope, Phillips, and Olivardia, 2000).

Take, for example, those two icons of ideal femininity and masculinity, GI Joe and Barbie. Their proportions are so unrealistic that if they existed in real life, they couldn't function. But they've also changed over time. Barbie's measurements have changed dramatically, in part because of pressure by feminists. In the 1990s, she went from measuring 38-18-34, to the "Happy to Be Me" Barbie in 1998 who measured 36-27-38. In 2003, Mattel launched the "It's a New Barbie World" for a younger "tween" audience; she measured 30-19-32—somewhat more supermodelish, but also less curvy. "Barbie may only be a doll," wrote one irate mom to the company, " but when some little girl's best friend and role model is a doll, we have to consider what will become of young girls when they grow up" (Hand, 2003).

The standards for men are increasingly impossible. In 1974, GI Joe was 5' 10" tall and had a 31-inch waist, a 44-inch chest, and 12-inch biceps. Strong and muscular, but

▲ **Barbie has changed since she first appeared in 1959. At first she got both thinner and more buxom—with a 38-inch chest and 18-inch waist (to scale), until pressure from women's groups led Mattel to make her look more "realistic," with a 36-inch bust and 28-inch waist. Here are "Barbie Chic" (2006), left, and "Barbie No. 1" (1959), right, during the exhibition "World of Barbie" exhibition in Germany.**

at least within the realm of the possible. GI Joe in 2002 is still 5' 10" tall, but his waist has shrunk to 28 inches, his chest has expanded to 50 inches, and his biceps are now 22 inches—nearly the size of his waist. Such proportions would make one a circus freak, not a role model (Pope et al., 2000).

Images such as Barbie and GI Joe make many men and women feel inadequate. Nearly half of all men in one survey reported significant body image disturbance. A 1997 study reported in *Psychology Today* found 43 percent of the men were dissatisfied with their appearance, compared with only 15 percent 25 years earlier (Garner, 1997). As one college student told a journalist:

> When I look in the mirror, I see two things: what I want to be and what I'm not. I hate my abs. My chest will never be huge. My legs are too thin. My nose is an odd shape. I want what *Men's Health* pushes. I want to be the guy in the Gillette commercials. (Morgan, 2002)

Increasing numbers of men are also exhibiting eating disorders. Nearly 10 percent of those seeking treatment for eating disorders are male. A 1997 survey of 1,425 active-duty Naval men found that nearly 7 percent fit the criteria for bulimia, another 2.5 percent were anorexic, over 40 percent fit the criteria for having an eating disorder, and nearly 40 percent reported current binge eating (Pope et al., 2000). And the use of steroids to get large and enhance competitiveness has mushroomed, especially among college-aged men. Legal prescriptions for steroids have doubled since 1997, to more than 1.5 million, and countless more illegal sources provide less-regulated doses. Steroids enable men to increase muscle mass quickly and dramatically, so that one looks incredibly big. Prolonged use also leads to dramatic mood changes, increased uncontrolled rage, and a significant shrinkage in the testicles (Kolata, 2002).

Eating disorders among women and muscular dysmorphia among men are parallel processes, extreme points on a continuum that begins with almost everyone. One hears this in the voices of anorexics and obsessive bodybuilders themselves. The young women, literally starving to death, talk about how fat they are, and lament that if only they could lose weight they'd feel better about themselves. Their male counterparts, so muscle bound that they can barely bend over to tie their shoes, talk about how "small" they are, how much they have to eat and work out to get larger. Maybe we ought to think about anorexics or compulsive bodybuilders not as deviants, but as "overconformists" to gendered norms of embodiment.

Embodying Identity

Virtually all of us spend some time and energy in some forms of bodily transformation: We wear clothing we think makes us look good, or jewelry, or other adornments. But until recently, only a few marginalized groups like motorcycle gangs, criminals, or transvestites practiced permanent bodily transformation—running the gamut from piercing to tattoos, cosmetic surgery, and even the rare case of sex-change operations.

Today, body piercing involves far more than the earlobes and can include the tongue, eyebrows, navel, nose, lips, nipples, and even the genitals. Increasing numbers of young people are also getting tattoos. Given their vaguely "naughty" character in American society, tattoos and piercing denote a slight sexualized undertone—if

only because they indicate that the bearer is aware of his or her body as an instrument of pleasure and object of desire.

Tattoos: Inking Identity. Tattoos have long been a way to decorate the body among people in North and South America, Mesoamerica, Europe, Japan, China, Africa, and elsewhere. Their decline in Europe occurred with the spread of Christianity. This may account in part for the association of tattoos with deviance and transgression (Sanders, 1989). Today, however, tattoos have become quite common—and not just among celebrities and athletes. In North America, Japan, and many countries of Europe, tattooing has increased broadly in the population. About 24 percent of all Americans between 18 and 50 have at least one tattoo, up from about 15 percent in 2003 and more than double the prevalence in 1985—making tattoos slightly more common than DVD players (Brooks, 2006). In the United States, tattooing is most popular among those under 40, people living in the West, and gays and lesbians. Men and women are equally likely to have tattoos (Harris Interactive, 2003).

Did *you* know?

People who have had tattoos include World War II–era Prime Minister of Great Britain Winston Churchill, U.S. President Franklin Delano Roosevelt, Soviet dictator Josef Stalin, actor Sir Ian McKellen, Watergate-breaking *Washington Post* editor Ben Bradlee, singers Cher and Janis Joplin, and Oscar-winning child star Tatum O'Neal.

Tattoos are seen as a way people can design and project a desired self-image (Atkinson, 2003). In cultures becoming increasingly image oriented, tattooing is conscious identity work. Tattoo design and placement are often sexually charged; about a third of all tattoo wearers say it makes them sexier. (On the other hand, a third of nontattoo wearers think it makes other people less sexy.) While the mystique of transgression may attract people to tattoos, the motivation for middle-class people to "get inked" today has a lot to do with social groups. Tattoos are increasingly seen to symbolize traits valued by peers, including environmental awareness, athletic ability, artistic talent, and academic achievement (Irwin, 2001). Of course, gangs and other marginalized groups continue to use tattoos as specific markers of identity.

Cosmetic Surgery. One of the fastest-growing methods of bodily transformation is cosmetic surgery. According to the American Society of Plastic Surgeons, the total number of cosmetic procedures increased from 413,208 in 1992 to 11.5 million in 2006. The most common types of surgeries included breast augmentation and reduction, rhinoplasty (nose jobs), liposuction, eyelid surgery, Botox injections, and facelifts (American Society of Plastic Surgeons, 2006). Reality television shows like *Extreme Makeover* make cosmetic surgery increasingly normal; one recent survey found these shows influenced about 80 percent of cosmetic surgery patients (Singer, 2007).

Though women continue to be the primary consumers of such cosmetic surgery, male patients now comprise 20 percent of all procedures. "More men are viewing cosmetic surgery as a viable way of looking and feeling younger," observed ASPS president Dennis Lynch, "especially, to compete in the workplace." Teenagers are also having more plastic surgery, especially rhinoplasty, now the second most common cosmetic surgery in the United States after breast augmentation (American Society of Plastic Surgeons, 2006).

Once the preserve of wealthy Whites, cosmetic surgery has become increasingly common among non-Whites and the middle class. The number of people of color seeking cosmetic surgery quadrupled between 1997 and 2002, to over 1 million a year (American Society of Plastic Surgeons, 2006). In an age of declining fortunes and downward mobility, the body may be the last arena left that we can make perfect and over which we can exercise control (see Blum, 2003).

And it is not just the United States that is witnessing accelerated growth in cosmetic procedures. Europe accounted for more than one-third of all cosmetic procedures

performed worldwide in 2004, second only to the Americas. Asians, South Americans, and Arabs are also undergoing cosmetic procedures in increasing numbers. As in the United States, these procedures are becoming increasingly affordable to the middle class and are being sought by men as well as women. The popularity of different procedures, however, does vary by country.

- In Japan, South Korea, Singapore, Colombia, Russia, and Romania, eyelid surgery is the top operation.
- In Brazil, Argentina and Germany, liposuction is the most popular.
- In Spain, Italy, Great Britain, Sweden, Norway, and Slovenia, breast augmentation is the procedure performed most frequently.
- In Jordon, Lebanon, Cyprus, Turkey, Taiwan, and France, nose reshaping tops the list.

Why eyelid surgery across Asia? Why nose work in the Middle East? Perhaps we are seeing an emerging global standard of beauty due to globalization. Not only are people living and working in more multinational settings, but also Western images long exported worldwide by magazines, movies, and television have been accelerated in recent years by the addition of satellite TV and the Internet. Like globalization in other arenas, some influence goes both ways, but the dominant tendency is for beauty standards to trend from West to East (Guteri and Hastings, 2003; Lewis, 2005).

Changing Identity by Changing the Gendered Body: Transgenderism. **Transgenderism** is an umbrella term that describes a variety of people, behaviors, and groups whose identities depart from normative gender ideals of masculinity or femininity. Transgendered individuals develop a gender identity that is different from the biological sex of their birth; they array themselves along a continuum from those who act in public as members of the sex other than the sex they were born, to those who chemically (through hormone therapy) or surgically transform their bodies into the body of the other gender. Transgenderism implies no sexual orientation—transgendered individuals identify as heterosexual, homosexual, bisexual, or asexual.

Think of gender identity and behavior along a continuum from "our culture's definition of masculine" to "our culture's definition of feminine." Some people feel constrained by gender role expectations and seek to expand these by changing their behavior. Though there are significant penalties for boys who are effeminate ("sissies") and some, but fewer, penalties for girls who are "tomboys," many adult men and women continue to bend, if not break, gender norms in their bodily presentation. Some may go as far as to use the props of the opposite sex to challenge gender stereotypes; some people find erotic enjoyment in this, while others do it to "pass" into a forbidden world. Again, this runs along a continuum: At one end are women who wear man-tailored clothing and power suits to work; at the other end are those men and women who wear full cross-gender regalia as a means of mockery and the pleasure of transgression. Transvestites regularly dress in the clothing of the opposite sex, for play or in everyday life.

Transgendered individuals may have one biological sex and present as the other gender, or they may seek to surgically make their biological sex and socially presented gender the same. Either way, they make clear that gender is an embodied performance. Here, Italian actor and transgender political candidate Wladimiro Guadagno poses on a movie set. ▼

Some people, though, feel that their biological sex doesn't match their internal sense of gender identity. Transgendered people may feel a "persistent discomfort and sense of inappropriateness about one's assigned sex (feeling trapped in the wrong body)" as the diagnosis for transsexualism in the American Psychiatric Association's *Diagnostic and Statistical Manual*

(DSM III-R) puts it. And rather than change their gender, they want to change their biological sex to match their felt gender identity. After two years of therapy and radical hormone therapies to mute or reverse secondary sex characteristics (like body hair, voice, breasts), some of these people undergo sex reassignment surgery (SRS), by which the original genitalia are surgically removed and new realistic medical constructions of vaginas and penises are created. What more evidence of "social construction of gender" could one ask for?

Historically, transgenderism was quite rare; in 1980, only about 4,000 people in the world had undergone these surgical interventions, almost all of them males seeking to become females. New medical and surgical procedures facilitated both male-to-female and female-to-male transsexual operations, and the inclusion of sex-change operations as procedures to be covered by Medicare (1978) and the listing of transsexualism in the DSM-III in 1980 allowed for insurance coverage for SRS. The increased visibility of transgendered people within the gay and lesbian movement has also increased the viability of SRS as an option.

Typically, transgenderism is experienced as a general discomfort that becomes increasingly intense during puberty; that is, with the emergence of secondary sex characteristics. As one female-to-male transgendered person told an interviewer:

> I hated the changes in my body . . . I couldn't stand it . . . It affected my identity. I became very upset and depressed. As a matter of fact, by this time in my life, I spent most of my time in my room . . . I thought about suicide . . . . (Devor, 1997)

While transgenderism remains relatively uncommon, the implications of such procedures are enormous. Once, a discrepancy between one's biological sex and what one experienced internally as one's gender would privilege the body, as if it contained some essential truth about the person. If such conflicts were to be resolved by therapeutic interventions, they would "help" transsexuals accept their body's "truth" and try and adjust their feelings about their gender. Transgenderism enables us to dissolve what is experienced as an arbitrary privileging of the body-at-birth and give more weight to who we feel we are, bringing us close to a world in which we can choose our gender because we can change our sex.

The "Disabled" Body

According to the Americans with Disabilities Act of 1990 (ADA), a **disability** is "a physical or mental impairment that substantially limits one or more major life activities." A person is considered to have a disability if he or she:

> has difficulty performing certain functions (seeing, hearing, talking, walking, climbing stairs and lifting and carrying), or has difficulty performing activities of daily living, or has difficulty with certain social roles (doing school work for children, working at a job and around the house for adults). A person who is unable to perform one or more activities, or who uses an assistive device to get around, or who needs assistance from another person to perform basic activities is considered to have a severe disability.

Disabilities are not always visible, nor are they necessarily "disabilities," in that many disabled people could live full and "normal" lives if only the larger society would cooperate. Disabilities do not reside solely in the bodies of the person but rather emerge through a relationship with the society. For example, the standard design of streets and sidewalks makes it extremely difficult for people in wheelchairs or walkers to use the same sidewalks as other people. The standard design of buses means that people in wheelchairs cannot use them. Is that their fault? Disabilities are the result of an interaction between the person and the society.

▲ **People with disabilities are today living full and productive lives—and even incorporating their disabilities into their self-presentation. Comedian Josh Blue, who was born with cerebral palsy, won the reality TV competition on *Last Comic Standing* in 2006.**

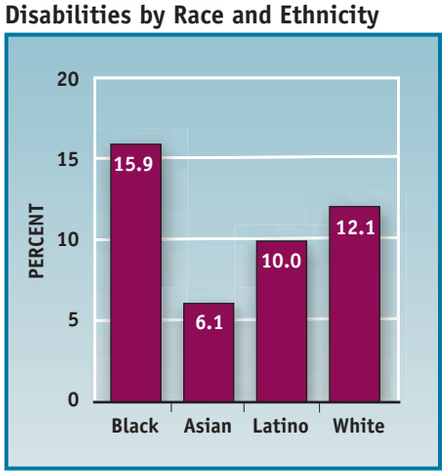
Nearly 20 percent of all Americans have one or more disabilities. Seven percent of boys and 4 percent of girls between the ages of 5 and 15 have disabilities; 43 percent of women and 40 percent of men age 65 and older have disabilities. There are 2.7 million people in wheelchairs in America, and 9.1 million who use a cane, crutches, or a walker. There are 1.8 million who are unable to see and 1 million who are unable to hear; another 7.8 million have difficulty hearing a normal conversation.

One of our family members is a good example. Diagnosed with rheumatoid arthritis at age 2, she came perilously close to death several times in early childhood. As a result of the medication she has taken for 25 years, several other systems failed, and she is now blind as well. She has had spinal fusion surgery twice to compensate for deteriorating discs and complete knee replacements in both knees. She also graduated near the top of her class in high school and majored in psychology at Princeton, where her books were read to her on tape or offered in Braille.

The number of Americans with a physical or mental disability has increased in recent years. This is due to several factors. First, advances in medical technologies mean that many people who might not have survived with their disabilities are now living longer lives. In addition, those medical breakthroughs are enabling the survival of people born with disabilities that would earlier have been fatal. Third, life expectancy continues to rise for everyone, and some disabilities, such as arthritis, are age related.

Most disabilities are not present at birth: They are the result of accidents, disease, and war. About 2.5 million veterans receive compensation for service-related disabilities. Some disabilities are the result of industry and pollution. The highest rates of disability by county in the United States are in coal mining regions; the highest rates in cities are in those cities near oil refineries. Globally, poorer countries have higher rates of disability, caused by malnutrition as well as accidents and disease. In Brazil, 14.5 percent of the population is disabled; in Ecuador, about 12 percent; in Panama, more than 11 percent (Inter-American Development Bank, 2007). Across the developing world, 10 percent of the population is disabled, according to the World Health Organization.

FIGURE 16.2 People with Disabilities by Race and Ethnicity



Source: U.S. Census Bureau.

Disabilities are unevenly distributed by race and class within the United States as well. (Figure 16.2) African Americans have significantly higher levels of disability than Whites, but Asians and Latinos have lower rates than Whites. The poor have more disabilities than the rich. Disabilities not only reflect existing social inequalities by race and class, but disabilities are, themselves, the basis for further discrimination. People with disabilities are employed at about half the rate as people without disabilities—about 37.5 percent of the disabled compared with 74.4 percent without, and they earn about $3,000 less per year (*DiversityInc*, 2006). The Americans with Disabilities Act made it illegal to discriminate against people with disabilities in public accommodations. As a result, buses were adapted to accommodate people in wheelchairs, ramps replaced high curbs at streetcorners, and landlords built ramps to accommodate disabled tenants. "Black people fought for the right to ride in the front of the bus," said one disability activist. "We're fighting for the right to get on the bus" (cited in Shapiro, 1993, p. 128.)

Many people find themselves feeling uncomfortable and even angry around people with disabilities, as if somehow the disability is contagious.

When the actor Christopher Reeve fell off his horse and was paralyzed from the neck down, he became a vocal campaigner for the disabled; the actor who played Superman showed superhuman courage as he became one of the most visible campaigners for the rights of the disabled.

People with disabilities are increasingly integrated into society. In addition to their efforts to overcome discrimination, they actively participate in sports like wheelchair basketball tournaments, marathon races, and the paralympics. In 2006, Josh Blue, who has cerebral palsy, won the television competition *Last Comic Standing*. Our family member mentioned above has sailed in regattas for the blind and won races in New Zealand and Newport, Rhode Island.

Healthy Bodies, Sick Bodies

A major concern of sociologists has been to understand health and illness, from the personal experience of being sick to the institutional arrangements that societies develop to care for the sick, and the political issues that surround health care, such as health insurance and prescription drug coverage.

The World Health Organization (WHO) defines **health** as a state of complete mental, physical, and social well-being, not simply the absence of disease. But when social scientists measure health, they typically do so using a "negative health standard"; that is, we are healthy when we are not sick. Statistically, the presence of a fever, pain, or illness that interferes with our daily lives means we are not healthy. Anyone who has ever been sick can tell you that it transforms your daily life.

Health and Inequality

Health and illness are among the most profoundly social experiences we have. For one thing, not everyone gets sick with the same illnesses in the same ways. Health and illness vary enormously by nationality, race, gender, and age.

The study of the causes and distribution of disease and disability is called **epidemiology.** This includes all the biomedical elements of disease and also social and behavioral factors that influence the spread of disease. The focus on these social and behavioral factors is called **social epidemiology.**

All health researchers begin with baseline indicators, such as the **mortality rate,** which is the death rate as a percentage of the population, and the **morbidity rate,** which indicates the rates of new infections from disease. Epidemiologists then attempt to understand the *incidence* of a disease—that is, how many new cases of a disease are reported in a given place during a specified time frame—and the *prevalence* of a disease, which usually refers to the distribution of the disease over different groups of the same population. For example, when a new disease like SARS is discovered or a new epidemic of the flu breaks out, epidemiologists tracking the spread of the disease will try to observe its effect on different groups (race, age, region) to assess the risks of different groups and even suggest policies that may inform the sorts of precautions people might take.

Measures of health care include:

- *Life expectancy:* an estimate of the average life span of people born in a specific year.

Did *you* know?

Around the world, scientists are marrying technology with biology to develop "bioartificial" organs that may transform millions of lives. In the United States, an artificial lung is in preclinical testing, an artificial pancreas and kidney have been tested in rats, and an artificial kidney is in early human trials. In Germany, a bioartificial liver is in early human trials. A computerized eye for the blind is in human testing in Belgium. Several universities around the world are testing artificial ears for the deaf (Arnst, 2003).

- *Infant mortality rate:* the number of deaths of infants under 1 year of age per 1,000 live births in a given year.
- *Maternal mortality rate:* the number of deaths of pregnant or new mothers either before, during, or immediate following childbirth, per 1,000 births in a given year.
- *Chronic diseases:* long-term or life long diseases that develop gradually or are present at birth (rates are calculated in proportion to the population—number per 1,000, 100,000, or 1 million).
- *Acute diseases:* diseases that strike suddenly and may cause severe illness, incapacitation, or even death.
- *Infectious diseases:* diseases that are caused by infectious agents such as viruses or bacteria.

Age and Health. Our health changes as we age. Not only does our general health decline, but our susceptibility to various illnesses shifts. For example, men aged 25 to 44 are twice as likely to die of HIV or unintentional injuries than they are to die of heart disease or cancer. By age 45 to 64, though, these two leading causes of death for young men barely scratch the surface, and heart disease and cancer are about 20 times more likely to be the cause of death.

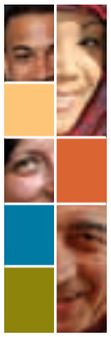
Breakthroughs in medical technologies and treatments, as well as increased attention paid to health, mean that life expectancy will continue to increase at roughly the same rate as today. As our population gradually ages, the divisions between the "young old" and the "old old" will sharpen, and people will come to expect to live into their 80s and 90s as a matter of course. The burden of health care will fall disproportionately on the younger members of society.

Race, Class, and Health. In the United States and throughout the world, the wealthier you are, the healthier you are. People in more developed countries live longer and healthier lives, and in every country, the wealthy live longer and healthier lives. Of course, wealthy people are not immune to illness simply because they are wealthy. But they have better nutrition, better access to better-quality health care, and better standards of living—and these all lead to healthier lives.

Just as being wealthy is a good predictor of being healthy, so too is being poor a good predictor of being ill. Lower-class people work in more dangerous and hazardous jobs, with fewer health insurance benefits, and often live in neighborhoods or in housing that endangers health (peeling lead-based paint, exposed and leaky pipes that attract disease-bearing rodents or insects, unsanitary water and food supplies, for example). Stated most simply, inequality kills.

In the United States, men with fewer than 12 years of education (a broad measure of class position) are more than twice as likely to die of chronic ailments such as heart disease and almost twice as likely to die of communicable diseases than those with 13 or more years of education. Women with family income under $10,000 per year are three times more likely to die of heart disease and nearly three times as likely to die of diabetes than those with incomes above $25,000. White men earning less than $10,000 a year are 1.5 times more likely to die prematurely as those earning $34,000 of more (Isaacs, 2004).

Poor urban Blacks have the worst health of any ethnic group in the United States, with the possible exception of Native Americans. One-third of all poor Black 16-year-old girls in urban areas will not reach their sixty-fifth birthdays. High rates of heart disease, cancer, and cirrhosis of the liver make African American men in Harlem less likely to reach age 65 than men in Bangladesh (Epstein, 2003). Latinos die of several leading causes of death at far higher rates than do Whites, including liver disease, diabetes, and HIV. Racism itself is harmful to health: The stress



Sociology and our World

Race and Illness: The Tuskegee Experiment

Few scientific "experiments" reveal the racial aspects of health care better than the infamous Tuskegee experiments. Begun in 1932, 399 poor African American men who had been diagnosed with late-stage syphilis by the U.S. Public Heath Service were told that they had "bad blood" and could obtain free medical care, transportation to and from the Tuskegee Institute medical center for treatment, and even hot meals on days of their examination—all for simply joining a social club called "Miss Rivers' Lodge."

In fact, they were not treated at all but were deliberately left untreated so that the doctors could observe the ravages of the disease when left unchecked. "As I see it," one of the doctors explained, "we have no further interest in these patients until they die." The nature of the experiment was concealed from the men, because health officials feared they would refuse to participate if they knew. They were required to have painful spinal taps and were denied penicillin after it had become the best treatment option. After 25 years, all the patients who were still alive received a letter from the United States Surgeon General thanking them for their continued participation.

The Tuskegee Experiment lasted for 40 years. By its end, 28 of the men had died directly from the disease, 100 were dead of related complications, 40 of their wives had been infected, and 19 of their children had been born with congenital syphilis. The shocking indifference to human life, the callous contempt for these African American men's health and well-being, exposed a level of racism in America's public health system that was reminiscent of the experiments carried out on concentration camp inmates by the Nazi doctors. To this day, many Black Americans do not trust the health care system. In 1997, President Bill Clinton apologized to the eight surviving members of the study by saying, "The United States government did something that was wrong—deeply, profoundly, morally wrong. It was an outrage to our commitment to integrity and equality for all our citizens . . . clearly racist" (Jones, 1993).

brought about by discrimination and inequality may contribute to the higher rates of stress-related diseases, hypertension, and mental illness (Brown, 2003; Jackson and Stewart, 2003).

While new scientific research suggests some medicines may be more or less effective depending on the patient's race, poverty explains far greater health disparities. As health care costs and the number of Americans living in poverty or in the ranks of the working poor all increase, health and health care disparity depends on inability to pay—for screening and preventive care, treatment and follow-up, as well as safe and healthy living conditions. Thus, those who need health care the most actually have the least access and the poorest care. In addition, those at the bottom end of the socioeconomic ladder are also less likely to have health insurance, and, if they do, their insurance is more likely to place strict constraints on spending. Most have no insurance at all. America is paying a huge price in terms of health inequalities for its growing class inequalities. (See Asch, et al., 2006; Kawschi, et al., 2005).

Gender and Health. Not only do class, race, and age affect health and illness, but so, too, does gender. Before the twentieth century, women's life expectancy was slightly lower than men's, largely due to higher mortality rates during pregnancy and childbirth. Through the twentieth century, though, women have been increasingly outliving men, so that today American women's life expectancy is 80 years and men's is 78 years. In the highly developed countries, women outlive men by about five to eight years, but they outlive men by less than three years in the developing world. (Japanese women have a life expectancy of over 85 years, the highest in the world.) In general life expectancy for both women and men has been increasing at a rate of 2.5 years per decade—with no end in sight.

TABLE 16.2

Ratio of Male to Female Death Rates for the 15 Leading Causes of Death in the United States

ALL RACES, MALES	PERCENT*
1. Heart disease	27.2
2. Cancer	24.3
3. Unintentional injuries	6.1
4. Stroke	5.0
5. Chronic lower respiratory diseases	5.0
6. Diabetes	3.0
7. Influenza and pneumonia	2.3
8. Suicide	2.2
9. Kidney disease	1.7
10. Alzheimer's disease	1.6

Source: Centers for Disease Control, 2005. (www.cdc.gov/men/lcod.htm)

ALL RACES, FEMALES	PERCENT*
1. Heart disease	27.2
2. Cancer	22.0
3. Stroke	7.5
4. Chronic lower respiratory diseases	5.2
5. Alzheimer's disease	3.9
6. Unintentional injuries	3.3
7. Diabetes	3.1
8. Influenza and pneumonia	2.7
9. Kidney disease	1.8
10. Septicemia	1.5

Source: Centers for Disease Control, 2005. (www.cdc.gov/women/lcod.htm)

But why do women in the advanced countries outlive men now? For one thing, improvements in prenatal and maternal health care during pregnancy and childbirth save many lives. But another reason may be the gender of health. Norms of masculinity often encourage men to take more health risks and then discourage them from seeking health care services until after an illness has progressed. As health researcher Will Courtenay put it:

> A man who does gender correctly would be relatively unconcerned about his health and well-being in general. He would see himself as stronger, both physically and emotionally than most women. He would think of himself as independent, not needing to be nurtured by others. He would be unlikely to ask others for help. . . . He would face danger fearlessly, take risks frequently, and have little concern for his own safety. (Courtenay, 1998, p. 21)

Or, as one Zimbabwean man put it, "real men don't get sick" (cited in Courtenay, 1998, p. 21).

In Table 16.2, you can see the ratio of male to female age-adjusted death rates for the 15 leading causes of death for the total population in the United States in the year 2000. Note that the two causes of death that have the highest male-to-female ratio, the highest differential by sex, are those most closely associated with gendered behavior, not biological sex: unintentional injuries and suicide.

Another reason for the disparities between women's and men's health has been the success of the women's health movement. Beginning in the 1970s with a critique of a male-dominated health care industry that seemed relatively uninterested in women's health issues, the women's health movement has brought increasing awareness to certain illnesses such as breast cancer that overwhelmingly affect women (a tiny number of men get breast cancer per year). In addition, the movement has also spurred new interest in women wresting control over pregnancy, labor, and childbirth from the medical establishment, sparking increased interest in natural childbirth, a wider variety of reproductive and neonatal health care options, and the breast-feeding of newborn babies.

The Global Distribution of Health and Illness

Globally, the problem of health and inequality is enormous. The wealthier the country, the healthier its population. In the poorest countries, high rates of poverty also mean there are high rates of infectious diseases, malnutrition, and starvation. In Haiti, for example, a newborn baby has only a 50–50 change of surviving to age 5.

The cause of death for most people in the developed world is chronic diseases, such as heart attacks, cancers, and others; over one-half of all deaths in the developing world are the result of infectious diseases or complications during pregnancy and childbirth to either the mother or the baby (Figure 16.3).

But even some wealthy countries do not manage to safeguard health for their citizens or take care of the ill or fragile in their populations. Despite the fact that the U.S. health care system is among the world's most advanced, the United States does not rank particularly high on many of the most basic health indicators. We

rank seventeenth in life expectancy, and twenty-first in infant mortality (United Nations, 2005).

In fact, when comparing wealthy countries, there is considerable variation in the levels of health achieved. To look at the amount of money spent on health care, one would think the United States is the healthiest country in the industrialized world. Today, U.S. health expenditures equal $6,102 per person per year, while Japan spends just $2,249 (in U.S. dollars). Australia spends $3,120. Yet life expectancy in Japan is the highest in the ten most industrialized countries of the world, and life expectancy in the United States is lowest of all these countries. Australia, eighth in spending, enjoys the third highest life expectancy of the top ten countries. Canada spends $3,165 per capita, yet the average Canadian's life expectancy is also more than two years longer than the average American's. Moreover, on many measures of health care quality, the United States ranks at the bottom when compared with other developed countries, including Canada, Britain, and Australia (Table 16.3).

▲ **Globally, health varies with wealth: the poorer the country, the poorer its citizens' health. This girl in Mauritania holds a bowl of water from the village well, its only source of drinking water. In the developing world, the major cause of death is infectious disease, many of which are transmitted by unclean water.**

Sickness and Stigma

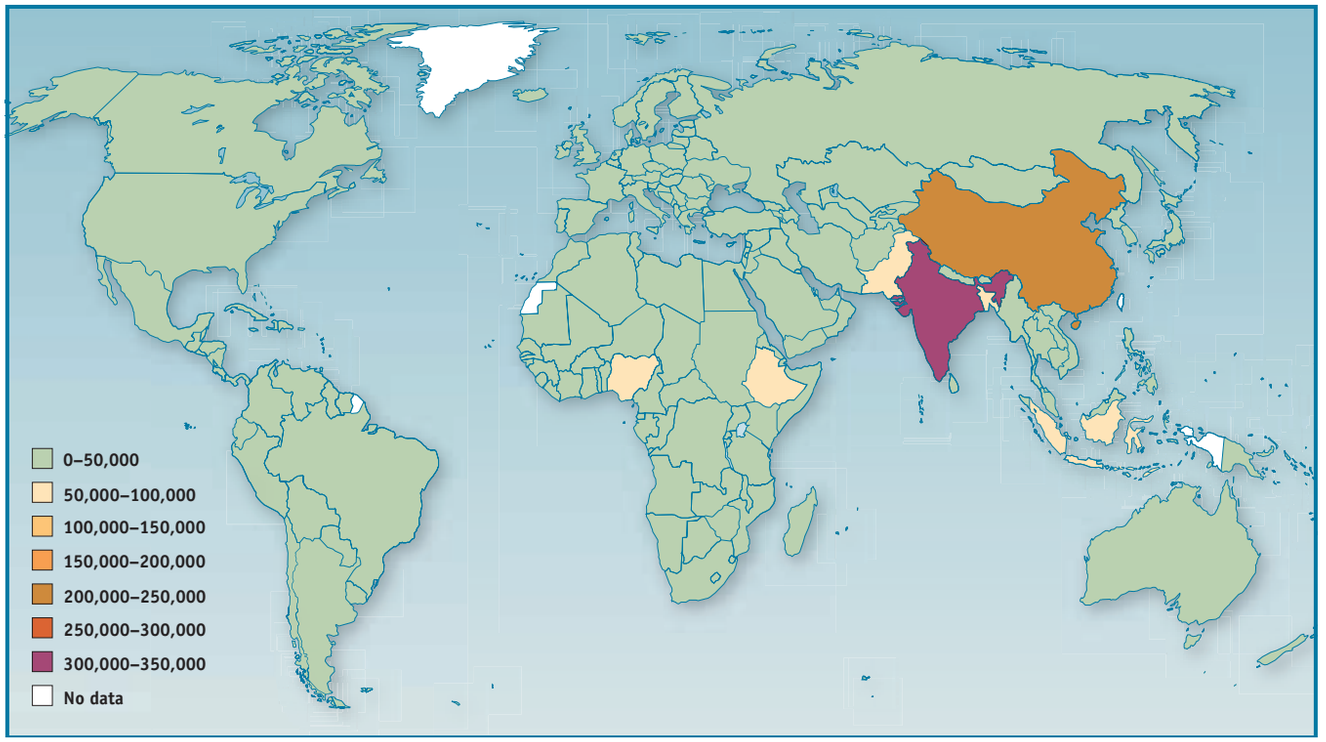
Our experience of illness may be individual, but the way we understand our illness and the way we act are deeply socially patterned. In a still relevant formulation, sociologist Talcott Parsons (1951) described what he called the **sick role** to describe not how we "get" sick, but how we learn to "be" sick.

The Sick Role. According to Parsons, the individual is not responsible for being sick. Getting sick is not a moral failure; the origins of illness are seen as coming from outside the individual's control. As a result, the sick individual is entitled to certain privileges, including a withdrawal from normal responsibilities, and to expect others to exhibit compassion and sympathy, often in the form of caretaking behaviors. However, such rights and privileges of the ill are not indefinite; they are temporary. The sick person must actively make an effort to get better, by seeing a doctor, taking medication, and doing whatever therapies a medical expert prescribes (Parsons, 1951).

Other sociologists refined the idea of the sick role. Elliot Freidson specified three different types of sick roles (Freidson, 1970):

- The most typical is the *conditional* sick role. This concerns individuals who are suffering from an illness from which they will recover. As long as the sick person plays his or her part (tries to get better), then other aspects of the role (relief from work or family obligations, expectation of compassion) will be forthcoming.
- The *unconditionally legitimate* sick role concerns those people who have either long-term or incurable illnesses, such as certain forms of cancer, and who are unable to get better by their own behavior. They are therefore entitled to occupy the sick role for as long as they are ill with no moral disapproval.
- Finally, there is the *illegitimate* sick role. This may concern those people who do nothing to improve their situation or people who are believed to be ill because of something they themselves did. Those who suffer from sexually transmitted diseases (STDs) may be seen by some as bringing the disease on themselves and therefore are not entitled to play the sick role. Initially, those suffering from

FIGURE 16.3 **Tuberculosis Deaths in 2004**



Source: "Tuberculosis Deaths in 2005" from The Henry J. Kaiser Family Foundation, www.globalhealthfacts.org., 2007. Reprinted with permission.

HIV/AIDS were seen by many as occupying an illegitimate sick role. But after two decades and serious political campaigning, most people now see those with HIV as occupying an unconditionally legitimate sick role.

The example of HIV illustrates some limitations of this theory. What happens when the sick person believes he or she is legitimately ill, but others do not? What happens when those who don't think you are sick include your family, your boss, or your medical insurer? What happens when doctors and patients disagree? How do the general cultural values informing health care figure in? Can the sick role actually empower some patients to take on their doctors and treatment options? The sick role assumes that all members of a society agree, and obviously this is not always the case (Shilling, 2002; Stiggelbout and Kiebert, 1997; Von Ornsteiner, 2000).

TABLE 16.3

International Ranking of Health Care Quality: Selected Dimensions

	AUSTRALIA	CANADA	GERMANY	NEWZEALAND	UNITED KINGDOM	UNITED STATES
Overall	4	5	1	2	3	6
Patient safety	4	5	2	3	1	6
Patient-centeredness	3	5	1	2	4	6
Timeliness	4	6	1	2	5	3
Equity	2	4	5	3	1	6

Note: 1 = highest ranking, 6 = lowest ranking.
Source: Adapted from Frogner Anderson, 2006.

Other sociologists use these possible conflicts among different people to examine the ways that illness operates within social life. For example, in modern society, people are living longer, and they are also living with chronic illnesses that would have killed people just a few years ago. How do people negotiate their social lives—work, family life, friendships, sexuality—in the face of such chronic illnesses? What effect does illness have on people's identity?

Sociologists Juliet Corbin and Anselm Strauss (1985) identified three types of "work" that individuals do to manage their illnesses within an overall context of identity management. *Illness work* consists of the things we do to manage the actual illness—the timing of medicine, treating pain, cycles of doctors and hospital appointments, and the like. *Everyday work* consists of what we do in the rest of our life—family life, friendship networks, routine household responsibilities, as well as our actual jobs. Finally, individuals also perform *biographical work* to interpret for themselves and others the impact the illness has had on their life. We revise and rewrite our autobiographies constantly, especially in the light of new information such as a chronic illness.

Some illnesses leave a person doubly affected. Not only do people who have these illnesses suffer from the illness itself, but they also suffer from discrimination because they have it. Those who suffer from mental illness, alcohol or drug addiction, physical or mental disabilities, or HIV also suffer from a **stigmatized identity**—a perception that they are somehow responsible for their illness and that it is their fault. People who have these types of illnesses struggle against social expectations and prejudices. Ironically, people who suffer from these illnesses constitute the majority of Americans.

The dominant trends in dealing with these stigmatized illnesses are deinstitutionalization and medicalization. **Deinstitutionalization** means the reintegration of the sick back into society, instead of isolating them in separate places like mental institutions. Isolation is understood as further contributing to the illness; integration, it is believed, will facilitate recovery. Thus, for example, the number of children with learning disabilities who are "mainstreamed" in regular classes has expanded rapidly, and special education classes are now reserved for those with severe handicaps. **Medicalization** refers to the way that medical treatments have supplanted other options for both the healthy and the ill (Conrad and Schneider, 1992). For example, childbirth, a perfectly natural, healthy process, has become medicalized; once managed by midwives or other lay personnel, pregnancy and childbirth are now managed by doctors, mainly in hospitals, and often involve equipment and drugs (and often maternity leave is characterized as a "disability"). Similarly, death is now seen as a medical moment, rather than the natural destiny of all living things.

Natural experiences, such as childbirth, have become increasingly medicalized procedures. Caesarian section births have increased 46 percent in the United States since 1996—far more than in any other industrialized country. This baby appears to have been born without a mother. ▼

Mental Illness. We once thought people who acted strange were deviant, weird, or perhaps evil and "possessed" by demons. Now we're more likely to think they have a treatable medical condition, a "mental illness." A **mental illness** is "any of various psychiatric disorders or diseases, usually characterized by impairment of thought, mood, or behavior," according to the *American Heritage Science*

Dictionary (2002). Mental illness is one of the least understood illnesses, precisely because the body seems to be "normal," and yet behavior and expression are often not at all normal. The causes of mental illness are as varied as the causes of bodily illnesses. In some cases, genetic factors before birth affect brain or neurological development; in other cases, mental illness can be caused by trauma (head injuries), side effects of other diseases (AIDS-related dementia), chemical imbalances in the brain (schizophrenia), or even aging.

The definition of any illness is strongly affected by social construction. Since the 1960s, studies have found the way odd or mentally ill people are perceived by the medical profession as well as the public depends a great deal on the label that is attached to their behavior (Jones et al., 1986; Scheff, 1984; Scott, 1969; Szasz, 1974). In fact, in one landmark study, Rosenhan (1973) found if we are told a person is a mental patient or mentally ill, we may perceive all his or her behavior as strange, no matter what he or she does.

Those defined as mentally ill or even merely strange or neurotic are strongly stigmatized in our society. Studies of public attitudes have arrived at the persistent conclusion that the public fears people with mental health problems (Martin, Pescosolido, and Tuch, 2000) and desires to be socially distant from them (Pescosolido, et al., 2000).

Since the 1960s, sociologists have encouraged mental health practitioners to reconsider the nature of mental illness. Many argued that the label "mental patient" or "mentally ill" had become too powerful and that people were being kept in asylums who might be able to live in society if properly supervised. At the same time, new drugs were developed that were proving effective against a number of disorders. These factors resulted in the deinstitutionalization movement of the 1970s: Patients were relocated to halfway houses and community-based organizations to help reintegrate them into society. By the 1990s, the number of patients in mental hospitals had decreased by 80 percent from what the number had been 40 years earlier (Mechanic and Rochefort, 1990). Yet care alternatives were plagued by disorganization and underfinancing, and many severely and persistently mentally ill people were left without essential services (Mechanic and Rochefort, 1990). One effect has been increasing numbers of mentally ill people on the streets or in prisons, because lack of treatment and supervision have abetted their committing a crime or because there is no place else for them to go (Kupers, 2003).

At the same time that deinstitutionalization reintegrated the mentally ill into "normal" life, mental illness began to be redefined more biologically and treated more medically, especially with drugs. Mental illness was medicalized. Instead of people who have "problems," the mentally ill are increasingly seen as patients with symptoms. Insurance companies and managed care require that most psychological problems be treated not with therapy or counseling but with prescription medication, which is significantly cheaper. Remarkable medical breakthroughs in managing psychiatric disorders such as depression have been accompanied by even more dramatic increases in the writing of prescriptions for antidepressants. Fewer people are institutionalized, but far more are diagnosed with medically treatable conditions.

The mentally ill continue to suffer prejudice. Large numbers of Americans say they would ostracize people with mental health problems. Martin and colleagues (2000) found, on average, that nearly seven out of ten Americans are unwilling to have someone suffering from depression, schizophrenia, or drug or alcohol dependency marry a family member. A majority of Americans express an unwillingness to have people suffering from these problems as co-workers, largely because they fear the "disturbing behavior" more often directly observed by the public. Wealthier people have long been more likely to say they would avoid the mentally ill. But urban

residents recently emerged as significantly more likely to do so than in the past. What's more, the label of "mental illness" only increases desires for social distance.

Understanding mental illness is increasingly important, not only because so many mentally ill people have been deinstitutionalized but because more than half of Americans will develop a mental illness at some point in their lives, according to a recent survey. In part, this is the result of ever-expanding definitions of mental illness, but it also indicates an increased awareness of the prevalence of mental illness.

Drugs, Alcohol, and Tobacco. The treatment of addictions, such as tobacco and alcohol, is also increasingly medicalized and deinstitutionalized. Alcohol and tobacco addictions are considered treatable medical conditions, but the treatments for them are typically not performed in institutionalized settings. On the other hand, drug addiction is understood to be a treatable medical condition, but it receives so much social disapproval that its treatment is often ignored in favor of being dealt with in another institution: prison. The "war on drugs" ushered in a massive campaign to criminalize the use and sale of drugs. While this has not measurably reduced the number of addicts, it has more than quintupled the prison population since the "war" began and created the impetus for cheaper and more powerful new classes of drugs.

Drinking alcohol, taking nonprescription drugs (or taking prescription drugs recreationally), and smoking tobacco are lifestyle choices—choices that individuals may make

What do you think?

16.1

MyLab

Emotional Problems

Current estimates are that at least one in five American adults has some diagnosable emotional or mental disorder. Some theories hold that emotional problems are caused by biological factors. Others explain them as social, a by-product of living in a confusing and overwhelming world. Experts agree that seeking some kind of treatment is important. So, what do you think?

Say you went to treatment for an emotional health problem, such as feeling depressed or anxious, that affects your work and other daily activities so that you accomplish less than you would like . . .

1. Would you definitely expect, probably expect, probably not expect, or definitely not expect to feel better about yourself as a person?
   - ❍ Definitely expect
   - ❍ Probably expect
   - ❍ Probably not expect
   - ❍ Definitely not expect
2. Would you definitely expect, probably expect, probably not expect, or definitely not expect your overall quality of life to improve?
   - ❍ Definitely expect
   - ❍ Probably expect
   - ❍ Probably not expect
   - ❍ Definitely not expect
3. Would you definitely expect, probably expect, probably not expect, or definitely not expect to be cured?
   - ❍ Definitely expect
   - ❍ Probably expect
   - ❍ Probably not expect
   - ❍ Definitely not expect

See the back of the chapter to compare your answers to national survey data.

for a variety of reasons to enhance or express something about themselves. Because we believe that each individual is free to choose what to put into his or her body, we often believe that these addictions are not social problems but individual problems.

A **drug** is any substance that, when ingested into the body, changes the body's functioning in some way. Drugs may be used therapeutically, the way you might take an aspirin for a headache, a prescription antibiotic for an infection, or a painkiller after a surgical procedure. Drugs are used to treat a variety of medical and psychological conditions, such as erectile dysfunction, cancer, depression, and other mental illnesses. Drugs may also be used recreationally to experience some physical or psychological alteration of the body or mind.

The line between therapeutic and recreational drugs is not so clear cut. Sometimes, therapeutic drugs can be used recreationally, as is done by people who use prescription painkillers to dull their physical sensations or amphetamines to stay up late and study for a test. Some recreational drugs were developed initially for therapeutic uses, and their side effects were deemed so pleasurable that the drugs fell into more widespread use for recreational purposes. Cocaine, for example, was initially derived as a local anesthetic (Sigmund Freud used it in eye operations).

The most extensively used illegal drug in the United States is marijuana. Humans have been using marijuana since prehistory, but in recent decades, its use for spiritual, recreational, and medicinal purposes has increased dramatically. About one in three Americans over age 12 has smoked marijuana at least once. Most users are between 18 and 25—that is, college age—but use among teenagers has more than doubled since 1990. It is estimated that about 4 percent of the world's population uses marijuana regularly.

Most use is recreational, although several Native American cultures have used marijuana in religious ceremonies (its use on some reservations is legal). In recent years, marijuana has been used medically to alleviate the suffering of cancer patients. Several states have passed laws permitting the use of medicinal marijuana, although the Supreme Court has also sustained arrests of people who have tried to administer it therapeutically.

Marijuana has been associated with some dangerous health effects. High doses during pregnancy may affect the normal development of the fetus, and some lung problems may occur from inhaling deeply. These do not affect casual users. And there is no reliable evidence that marijuana use leads to a diminution of pleasure that would lead to experimentation with more serious drugs.

Alcohol is a drug that is used recreationally by the overwhelming majority of the adult population. Americans consume an average 8.6 liters of alcohol per year, which would be relatively low compared with Europe as a whole (10.0 liters). However, it is not a case of every American drinking so much. About 10 percent of all drinkers account for about half the total alcohol consumption in the United States (Wechsler, 2002).

Alcohol is so ubiquitous in the United States, and its effects are so short-lived (the effects usually last only several hours) that we often are unaware of the cumulative effects of alcohol and its addictive properties. Alcohol has negative physical effects, including heart and liver damage and digestive problems. Drinking during pregnancy may harm the fetus and lead to birth defects. A specific form of cirrhosis, the development of scar tissue around the liver that prevents proper functioning, is linked directly to alcohol. Alcoholic cirrhosis is among the leading causes of death in the United States. Alcohol also directly interferes with sexual functioning in men.

Alcohol dependency is also psychologically damaging. While many people report that being drunk lowers inhibitions, those lowered inhibitions may range from loud and boisterous partying and increased sexual activity to increased incidents of domestic violence, child abuse, and assault. According to the National Highway Traffic

Safety Administration (NHTSA), 17,602 people died in 2006 in alcohol-related collisions, which represents 41 percent of all traffic deaths in the United States. Over 500,000 people were injured in alcohol-related accidents in the United States in 2003 (NHTSA, 2007).

On college campuses, alcohol has become the drug of choice among most students. College students spend $5.5 billion a year on alcohol—more than they spend on soft drinks, tea, milk, juice, coffee, and their schoolbooks combined. About 6 percent of college students qualify as "alcoholic," and nearly one-third would be given an "alcohol abuse" diagnosis. Nearly 1,500 college students, age 18 to 24, are killed each year as a result of drinking (Wechsler and Wuethrich, 2002).

A specific problem on campuses is binge drinking—drinking large quantities of alcohol in a short amount of time. Binge drinking is defined as consuming five or more drinks in a row for males and four or more in a row for females, at least once in the past two weeks. But binge drinking is confined largely to White students; the vast majority of Black, Hispanic, and Asian students do not binge drink (Wechsler and Wuethrich, 2002).

Alcohol dependency and addiction can be treated medically or through a variety of other therapies that enable the alcoholic to confront the source of his or her addiction and develop strategies to resist. One of the most successful of these is Alcoholics Anonymous, founded in 1935, which combines group therapy and a kind of secular spirituality to help people. The therapeutic model of AA has been so successful that it has also been adapted to other types of addictions.

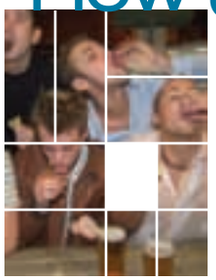
Tobacco contains a drug (nicotine) that is powerfully addictive, toxic, and psychoactive. It is more addictive than heroin. Technically, tobacco is a stimulant, because it raises blood pressure and heart rate and thus provides a temporary feeling of being alert. Tobacco is the single largest cause of preventable death in the United States. Nearly 500,000 cigarette smokers die each year from smoking-related illnesses (Doweiko, 1996).

Tobacco consumption varies by race, class, and gender. While cigars had historically been associated with the working class, recent luxury cigar makers have transformed their image so that now they are associated with Wall Street tycoons. Among adolescents, Whites smoke more than Hispanics, who smoke more than Blacks, who smoke more than Asians. Males have historically smoked more than females, though the gap has been steadily closing (Anderson and Burns, 2000).

Mounting evidence of the harmful effects of tobacco led the Surgeon General, in 1964, to require warnings on all cigarette packages that smoking is linked to cancer and other diseases. This caused modest declines in smoking. But the past two decades have witnessed dramatic declines; the Center for Disease Control's National Health Interview Survey reports that 20.9 percent of adults aged 18 years and over were current smokers in 2004, down from 24.7 percent in 1997. These declines are attributable to two factors. First, evidence on the harmful effects of **secondhand smoke**—the smoke that is inhaled by nonsmokers as a result of other people smoking—led to public health campaigns to ban smoking in movie theaters, airplanes, restaurants, bars, and all public offices and buildings. Second, the medicalization of tobacco addiction has enabled many smokers to receive medical treatments, such as the nicotine patch, for their addiction.

Alcohol dependency is often treated nonmedically, through programs such as Alcoholics Anonymous. AA combines group therapy, in which individuals tell their stories of addiction to the group, and secular spirituality of 12 Steps to keep people sober, "one day at a time." ▼

How do we know what we know?



Intervention Strategies to Combat Alcohol Abuse on Campus

On many college campuses, administrators have searched for ways to reduce alcohol abuse. While the problem is widespread, it is not uniform: Some campuses have higher rates than others. For example, large, public universities, with dominant fraternity and sorority presence, in "college towns" (not major cities) are more likely to have higher rates of alcohol abuse than schools that are smaller or private, religious or denominational, in urban settings, and without fraternities (Kimmel, 2008).

What strategies reduce the likelihood of alcohol abuse? Lecturing about morality or threatening to enforce existing legal age limits seems to have little effect. Sociologist Wesley Perkins developed a "social norms" approach. Students were surveyed about their own alcohol use and also their estimation of alcohol use among others on their campus. Perkins found that students dramatically *overestimate* the use of alcohol among other students and therefore adjust their own use upward "to keep up" with their perceptions of others' perceived use.

At his own campus, Perkins found that two-thirds of the students on campus consumed only one-quarter of all alcohol consumed. The overwhelming majority of students had between one and four drinks at a party.

Perkins then developed a public awareness campaign, using everything from posters, to Frisbees with data on them, to campuswide meetings, to reveal the actual rates of alcohol consumption. Alcohol abuse rates dropped significantly because students' *perceptions* of others shifted. It turned out that they were not lagging behind the others after all! (Perkins, 2003).

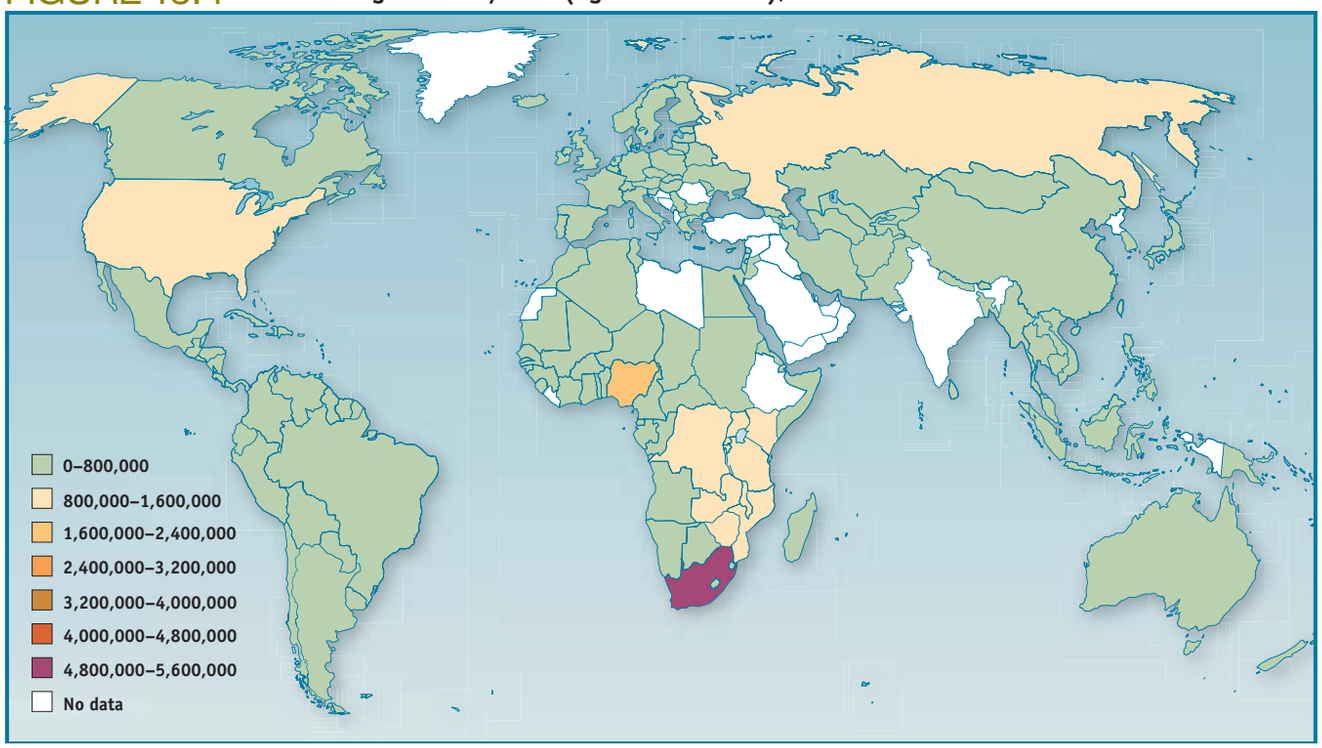
HIV/AIDS. The HIV epidemic illustrates all the themes we have raised in this chapter. AIDS (acquired immune deficiency syndrome) is a disease of the immune system caused by HIV (human immunodeficiency virus). This virus attacks the white blood cells and thus makes the body vulnerable to a number of opportunistic infections (infections that seize the "opportunity" of a compromised immune system). The disease can take up to several years to become manifest, so that many people are HIV positive (they have been infected) but remain asymptomatic and can transmit the disease to others.

HIV is both a sexually transmitted disease, like other STDs such as syphllis, gonorrhea, and HPV (human pappaloma virus), and also transmitted with exchange of other body fluids, like blood. Widespread misunderstanding of the disease, and the stigma attached to it, leads to its uneven spread across different groups.

Since it was first diagnosed in 1981, the social epidemiology of HIV/AIDS has changed dramatically. Initially, it was so localized among urban gay men in the United States that it was called GRID (gay-related immune deficiency). But gradually, it emerged among people who had received blood transfusions with infected blood supplies (especially hemophiliacs) or those sharing intravenous drug paraphernalia. Black people are especially vulnerable to HIV, either because of unprotected same-sex behavior among males (which also makes women vunerable) and higher rates of sharing IV drug paraphernalia. Blacks make up 12 percent of the U.S. population but account for half of all new reported HIV infections. Initially, AIDS was also a "gendered" disease, with men accounting for nearly 9 of every 10 cases in the industrial West. Even as late as 2003, 85 percent of all HIV cases are male, but in the developing world, HIV/AIDS affects women and men in equal numbers.

In terms of worldwide health, AIDS is "the greatest health crisis in human history" (United Nations, 2006). In 2006, 40 million people were infected with HIV worldwide (Figure 16.4). There were 4.3 million new infections and three million deaths in 2006 alone (UNAIDS, 2006). Initially, HIV/AIDS was a disease of the industrial countries, but it has gradually spread to the developing world. Today, the epicenter

FIGURE 16.4 **Adults Living with HIV/AIDS (Aged 15 and over), 2006**



Source: Global Data, 2006; Country Data 2005 from The Henry J. Kaiser Family Foundation, www.globalhealthfacts.org., 2007. Reprinted with permission.

of the disease is sub-Saharan Africa. There, a 15-year-old boy or girl faces a 50–50 chance that he or she will contract HIV/AIDS.

One reason for the dramatic shift from the developed to the developing world has to do with global poverty. Medical breakthroughs since the 1990s transformed the disease from an almost universal likelihood of death to a chronic disease that can be managed with a combination of drug therapies. These drug therapies were enormously costly to develop and are enormously costly to purchase. Only those who are wealthy enough or who have excellent health care coverage can afford the "AIDS drug cocktail"—which can cost more than $2,000 a month. In poorer countries, virtually no one can afford these drugs, and the governments do not have enough money to pay for them.

In addition, campaigns to raise public awareness of HIV risks in the developed world have led to dramatic changes in behavior among gay men and IV drug users. Young people today are urged to practice "safe sex"—which means that during sexual activity, one should not exchange any bodily fluids (a condom prevents the exchange of fluids)—and IV drug users are cautioned to avoid sharing needles and to clean their needles with bleach solution to kill any potential infectants. The gay community's active mobilization around the AIDS epidemic led to a dramatic transformation of gay male sexuality and the development of institutions that promoted safe sex.

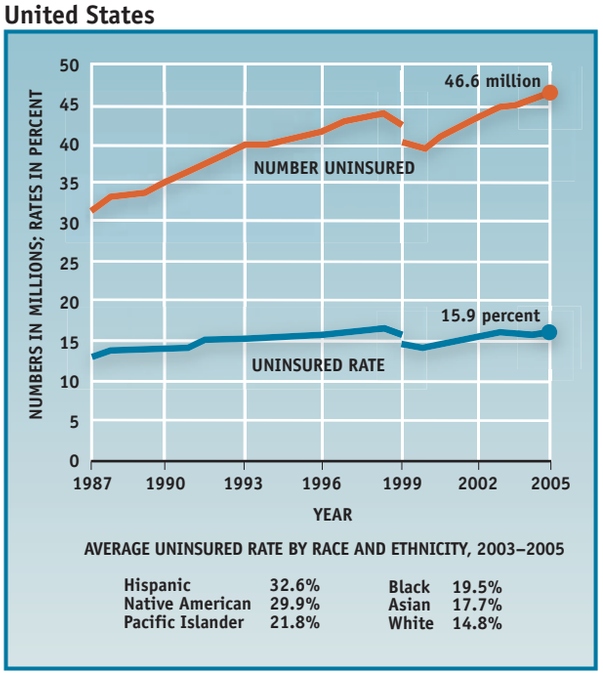
In the developing world, however, the transmission of the disease is different, and often cultural and religious beliefs have made campaigns to reduce risk difficult. Some people in Africa believe that HIV is a Western "import" and infects only gay men. Some men in southern African have begun to seek out young girls who are virgins as sex partners, on the assumption that they could not possibly be infected with the disease. As a result, many young girls are becoming infected because the men were HIV-positive and did not know.

Health as an Institution

A crucial sociological aspect of health and illness is the set of institutions that are concerned with health care. From medical professionals (and their respective professional organizations) to hospitals, medical insurance companies, and pharmaceutical companies—health care is big business. The combined spending on health care in the United States in 2003 was $1.4 trillion, making health care the second largest industry after the military.

As we've seen, the United States has both the most advanced health care delivery system in the world and one of the most inequitable and expensive among industrial nations. The United States is the only industrialized nation that does not guarantee coverage for essential medical services; rations care by income, race, and health; and allows for-profit insurance companies to exclude people who need care. Americans pay 17 percent of health care costs directly; private health insurance covers 38 percent, and direct public spending pays for about 45 percent of all health care costs. Increasing costs of drugs, medical technology, and the profit-oriented insurance industry guarantee that these percentages will continue to shift against individual health care consumers. No wonder that a 2003 survey found that 71 percent of Americans would rather have a job with lower salary and health coverage, while only 24 percent would prefer a job with higher salary and no health coverage (Health Pulse of America, 2003). In the United States, the number of Americans without health coverage is increasing. In fact, 46.6 million (15.9 percent) Americans lack any health coverage at all. The uninsured include 32.6 percent of all Hispanics, nearly 20 percent of Blacks, and 17.7 percent of Asian Americans (Figure 16.5). More than 3,000 Americans lose their health insurance every day. As the great television journalist Walter Cronkite said, "America's healthcare system is neither healthy, caring, nor a system" (cited at National Health Care for the Homeless Council, 2007).

FIGURE 16.5 The Uninsured in the United States



Source: Income, Poverty, and Health Insurance Coverage in the United States, U.S. Census Bureau, 2006.

Many of the problems in the American health care system derive from its scale and size. Health care is a massive enterprise, involving every American, every single government—state, local, federal—and a host of corporations and professions—doctors, hospitals, medical technology, drugs, insurance. With no coherent national health care policy, the American system is a patchwork of competing interests and conflicting views.

This system is also the product of competing values. As we saw earlier, in Chapter 2, Americans hold two different types of values, and these often collide. On the one hand, we believe that "all men are created equal" and that "human life is sacred." These values would push us toward supporting policies that would make basic health care a basic human right, not a privilege of the rich or the employed. On the other hand, we believe hard work should be rewarded, individual initiative and entrepreneurship should be unimpeded, and government should neither control profits nor tax Americans to pay for the welfare of those most needy. These values would lead us to "rationing" health care to those who can best afford it.

We hold both sets of values but tend to weigh them differently. In the abstract, we probably prefer to keep spend-

ing and taxation low, but our values change if we or a loved one is suddenly in urgent need of medical care. Then, we want "the best" treatment options available, regardless of the cost.

Institutionally, the health care industry reflects inequalities of race, ethnicity, and gender. Women and minorities are clustered in the more "service-oriented" areas, while White men are concentrated in the more technically demanding and prestigious occupations. The gender and racial distribution of health care professionals thus resembles all other professions, in which the closer you are to actually interacting with and touching the body of another person, the lower your status tends to be. On the other hand, the more technically proficient you are, and the more distant you are from actually being forced to interact with people, the higher your status (Abbott, 1981). (Within medicine, not only do doctors have higher prestige than nurses, but neurosurgeons have much higher status than internists.)

▲ **The current debate over health care reveals America's contradictory values. On the one hand, we believe that human life is sacred, but, on the other hand, we believe that all goods should be distributed through competition. These Floridians line up for flu shots at the county health department in 2004.**

Part of racial or gender inequality in the health professions may seem like personal preferences, as different groups of people might make different career choices. But it turns out that personal preferences are themselves shaped by institutional processes. For example, surgery is one of the most gender-skewed subfields of medicine, with far higher percentages of males than females. Personal choice about working hours, stressful conditions, and dedication to career? When sociologists asked medical students about possible careers in surgery, they found that women and men were very similar. Before they undertook their surgical rotation, neither expressed much concern about the long workhours or about the possible conflicts with family time; indeed, the female students were *less* likely to cite those problems than were the male students. But after their rotation, the women were turned off by the "old boys' club" mentality, the sex discrimination by male surgeons, and the idea that a "surgical personality" had to be male (Nagourney, 2006).

Such inequalities may actually be bad for your health. Patients are more likely to trust doctors who share their race or ethnicity—and trusting patients are more likely to follow medical advice and seek regular care. This may be especially true for minorities, who may distrust other doctors due to past discrimination and substandard care. Yet 86 percent of Whites have white doctors, while only 60 percent of Blacks and Hispanics do (La Veist and Nuru-Jeter, 2002). There aren't enough minority doctors to go around.

Conventional and Alternative Health Care

Although medicine rapidly became an institutional monopoly, and it alone controlled legitimate credentials, a thriving alternative health care system has also developed, in part running parallel to established medicine. The success of the women's health movement in raising awareness of women's specific health issues and in generating alternative health care options is a good illustration of this parallel development.

Alternative medicine involves the diagnoses and treatment of health problems using unconventional treatment strategies, drawn instead from other cultural practices or different theoretical traditions. In many ways, these alternative models may embrace elements of traditional medicine

Did *you* know?

A survey by the National Center for Complementary and Alternative Medicine, part of the National Institutes of Health, found that 36 percent of Americans used some form of alternative therapy—including yoga, meditation, herbal treatments—in the past 12 months, 50 percent in a lifetime. (Barnes, 2004).

TABLE 16.4

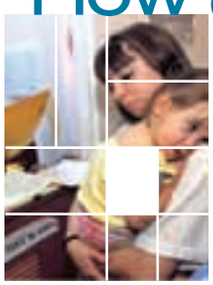
Race and Gender Distribution in Medicine

OCCUPATION	2006				
	TOTAL EMPLOYED (IN THOUSANDS)	PERCENT OF TOTAL			
		WOMEN	BLACK OR AFRICAN AMERICAN	ASIAN	HISPANIC OR LATINO
Dentists	196	22.6	3.1	11.4	4.3
Physicians and surgeons	863	32.2	5.2	17.0	5.7
Physician assistants	85	71.7	10.9	6.2	6.7
Registered nurses	2,529	91.3	10.9	7.5	4.2
Occupational therapists	78	90.3	3.1	4.7	2.0
Speech-language pathologists	114	95.3	8.1	1.4	3.6
Dental hygienists	144	98.6	1.4	4.2	4.6
Nursing, psychiatric, and home health aides	1,906	88.9	34.8	4.0	13.1
Dental assistants	274	95.4	5.4	4.2	14.9

Source: Bureau of Labor Statistics, 2007.

drawn from nonindustrial and non-Western societies. In the industrial countries, a *biomedical* model of health and illness prevails: Industrial societies tend to see illnesses as being manifest through physical symptoms and are to be treated through medical interventions. In this model, the only time for treatment is when you get sick, and the treatment is intended to cure the illness. In other cultures, however, other models of health care may prevail. Some cultures prefer a *holistic* model that focuses on the health of the whole person and the prevention of disease. People do not only go to doctors but also perform a wide variety of health-conscious activities, emphasizing diet, exercise, and spiritual health as well.

How do we know what we know?



Measuring Health Care

That health care is unequal by race, class, and ethnicity is well documented in all surveys of health care. For example, a survey of 6,722 Americans, a nationally representative sample of adults age 18 and older, found that on a wide range of health care quality measures—including communication with physicians, access to care, insurance coverage—minorities do not fare as well as Whites. This led to the assumption that wealthy White Americans are receiving very good quality of care, while the rest of the population is not.

But such findings may obscure an equally important trend: *No one* is getting the quality health care that he or she should. Using data from medical records and telephone interviews of a random sample from 12 diverse communities in the United States, a team of researchers found that only 54.9 percent of *all* respondents received the recommended care. There was only moderate variation among different groups: Women's rates were slightly higher than men's; wealthier respondents had slightly higher rates than poorer respondents; and younger people had slightly higher averages than older people. But in general, the authors concluded, the biggest gap was not among these groups, but between *all* groups and the recommended health care for specific problems. In a system of health care inequality, it seems, everyone suffers—perhaps not equally, but none but the superrich is getting anything close to adequate care (Asch et al., 2006).

In the United States, many individuals seek alternative health care, seeking either natural or "naturopathic" methods of either maintaining health or curing illness. Many of these people, and particularly some racial and ethnic minorities, alternate between alternative remedies and Western biomedical techniques (Barnes et al., 2004). Among Asian Americans, for example, acupuncture and herbal remedies have long and venerated traditions for both preventing and curing illnesses. Many Latinos rely on a method of holistic healing called *curanderismo,* although they probably do so infrequently and in combination with more conventional biomedical therapies. Taken together, people spend more money on unconventional therapies (including vitamin supplements, massages, spiritual healing) than they do for all hospitalizations (Weiss and Lonnquist, 2000). Some alternative health care practitioners, such as chiropractors, have sought medical legitimacy and are licensed as health care providers. Others are unregulated and unlicensed and are therefore not subject to any governmental regulation or scrutiny.

Did *you* know?

A 2005 report by the National Committee for Quality Assurance calculated that if all health plans performed at the level of the best-performing health plans, it would save between $2.8 and $4.2 billion in medical costs, avoid 83 million sick days, and increase U.S. productivity by $13.5 billion a year (cited in Davis, 2006).

Health Care Reform

In the United States, efforts to reform the health care system have been shaped by the powerful lobbying efforts by the health insurance companies, the pharmaceutical companies, and the professional associations of doctors. These efforts have expanded the

What do *you* think?

16.2

MyLab

Genetic Testing

Genetic testing is a relatively new area of study and medical practice. With this testing, doctors can determine whether a person or a fetus has the potential to develop a wide range of disorders. There is controversy surrounding genetic testing and whether it has the potential to do more harm than good. For example, with genetic testing, women can find out if they are predisposed to breast cancer and can take preventative measures. On the other hand, parents can screen fetuses for potential genetic abnormalities and use this information as a deciding factor in abortion. So, what do you think?

1. Some people say that genetic screening may cause trouble. Others think it is a wonderful medical advance. Based on what you know, do you think genetic screening will do more harm than good or more good than harm?
- ❍ Good more than harm
- ❍ Harm more than good

2. Today, tests are being developed that make it possible to detect serious genetic defects before a baby is born. But so far, it is impossible either to treat or to correct most of them. If you or your partner was pregnant, would you want her to have a test to find out if the baby had any serious genetic defects?
- ❍ Have test
- ❍ Not have test

See the back of the chapter to compare your answers to national survey data.

Source: Barbara Kruger, "Untitled" (Your body is a battleground), 1989.

▲ **Women's bodies have been particular sites of social conflict. The women's movement claims that women's bodies are their own, while others seek to regulate social life by controlling women's bodies.**

privatization of health care, shifting the costs away from the government and toward individuals. Such policies often result in slightly greater individual choices in health care options and in significantly greater disparities in health care between rich and poor. With the passage of the Health Care Reform Act of 2003, individual choices expanded slightly, but at the expense of decreased health care for America's poor.

In the absence of federal action, states have begun to take the lead on comprehensive health care reform. A large number of states have reform laws pending in their legislatures, and six have passed meaningful health reform, including California and Maine in 2003, Illinois and Maryland in 2004, and Vermont and Massachusetts in 2006 (DeGolia, 2007). Massachusetts has voted to require all residents to purchase health insurance—just as laws require auto insurance. It includes government subsidies to make private health insurance affordable to the poor and the working poor. While questions remain about the long-term financing for the law, definitions of affordability, and whether employers will respond by reducing their levels of coverage, the law has advanced debate about how to address the problem of the nation's uninsured. In 2007, California proposed a bill to expand health care coverage to all residents using a different funding formula—and is similarly confronting rising debate among stakeholders from lawmakers to citizens groups, doctors to insurers, and advocates for children, the elderly, and the disabled.

Perhaps the future of health care reform will be to better align the two sets of competing values that we bring to the discussion. Values of the sacredness of life and that we're all created equal fit poorly with market values that emphasize profits and competition. Employers, hospitals, and drug and insurance companies want to reduce costs to preserve profits. On the other hand, the less money individuals have to pay directly for health care, the more expensive are the treatments we will demand.

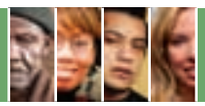
Health care policy analysts calculate that nearly one-third of all health care spending consists of profits and waste. As our population ages, the demands on the health care system are increasing at a faster rate than ever before (Hagist and Kotlikoff, 2005). As a result, health care will become one of the most urgent political, economic—and sociological—issues of the twenty-first century.

Health in the 21st Century: Living Longer—and Healthier?

The debate about reforming the health care system often comes down to a moral debate: Is health care a right that should be guaranteed by the government to every citizen, or is it a privilege, to be bought and sold like any other commodity in the marketplace? Some of the wealthier countries believe that health care is a basic human right. And just as they are wealthier, their citizens will be healthier. Other countries make access to health care the privilege of the wealthiest few. And the wealthy in those countries are among the healthiest individuals in the world.

To the sociologist, though, this debate is but one of many about the body in society. Will the rich get healthier and the poor sicker? Will we get fatter or thinner? Will social sanctions control what we can do to and with our bodies? In what ways will the body be a battleground?

The way we present our bodies is a form of social interaction, and our social institutions use and shape those embodied selves. One can see the individual body as a window into a variety of social processes: the construction of identity, the patterns of inequality, and the social organization of institutional life. Perhaps that women's health classic will need to be retitled—*Our Bodies, Ourselves—and Our Society*.



Chapter Review

1. *How is beauty defined?* The societal ideal of beauty is narrowly defined; although the "ideal" shape and weight vary, they are unrealistic for most. Problems with body image are connected to the global economy; wealthier countries are concerned more with obesity, poorer countries with hunger. In the United States, the number of obese people is rising. Obesity varies by inequalities of race, class, and gender; the poor are more likely to be overweight because of an unhealthy diet.

2. *How do bodies change?* Tattoos have historically been widespread across cultures and currently are common in the United States. Tattoos represent conscious identity work through body modification. Cosmetic surgery is increasing globally and across class, race, and gender. One emerging type of body modification occurs among transgendered individuals who feel their biological sex does not match their gender identity. Transgender surgery is historically rare but increasing because of technological innovations and increased insurance coverage. Bodies also change through accidents, disease, war, and birth defects. Twenty percent of Americans are considered disabled. This number has increased because of medical advances and increased life expectancy. The poor are more likely to be disabled than the rich, and Black individuals are more likely to be disabled than those from other groups.

3. *What is the sick role?* Talcott Parsons developed the idea of the sick role to describe how people learn what it means to be sick and what behaviors and attitudes are expected when one is sick. According to the social contract of the sick role, the patient is not held responsible for the sickness, is entitled to privileges and exemptions from other roles, and must be actively trying to get well. The sick role is a part of identity management.

4. *What is the social organization of health?* Illness is a personal and a social experience. Not everyone gets the same care; health and illness vary by race, class, gender, and age. Life expectancy is increasing; people are living longer and experiencing more chronic illnesses. Health is related to nutrition, access to health care, and standard of living. The poor are concentrated in dangerous jobs and poor housing and have less access to insurance. Poor urban Black people have the worst health in the United States. With regard to gender, women outlive men, in part because norms of masculinity discourage men from seeking health care and because of the success of the women's health movement. Global inequality is enormous; infectious diseases are rampant in developing countries but not in the wealthier ones.

5. *How is sickness stigmatized?* Some illnesses are stigmatized. This occurs often with mental illness, which is both socially constructed and poorly understood. Mentally ill individuals are feared and stigmatized, although that is decreasing as mental illness is becoming medicalized. Drug and alcohol addictions are also being medicalized, although there is strong social disapproval for these addictions and a tendency to blame the victim. HIV/ AIDS is a worldwide problem currently localized in Africa and other poor countries where medical care is not affordable. HIV/AIDS carries a particularly strong stigma.

6. *How do we view health care as an institution?* There is a set of social institutions concerned with health care. The United States has the most advanced health care system and also one of the most expensive and unequal systems. Competing values lead to conflicting roles. The sacredness of human life is pitted against the belief in profit, and the health care industry also reflects general inequality in society. The alternative health care system is thriving. It has a different conceptual framework for body and health; it takes a holistic approach.

Key Terms

Adonis complex (p. 527)
Alternative medicine (p. 547)
Anorexia nervosa (p. 526)
Bulimia (p. 526)
Deinstitutionalization (p. 539)
Disability (p. 531)
Drug (p. 542)
Epidemiology (p. 533)
Health (p. 533)
Medicalization (p. 539)
Mental illness (p. 539)
Morbidity rate (p. 533)
Mortality rate (p. 533)
Muscle dysmorphia (p. 527)
Secondhand smoke (p. 543)
Sick role (p. 537)
Social epidemiology (p. 533)
Stigmatized identity (p. 539)
Transgenderism (p. 530)

What does America think?

16.1 Emotional Problems

These are actual survey data from the General Social Survey, 2000.

1. **Say you went to treatment for an emotional health problem, such as feeling depressed or anxious, that affects your work and other daily activities so that you accomplish less than you would like. Would you definitely expect, probably expect, probably not expect, or definitely not expect to feel better about yourself as a person?** Forty percent of respondents said they would definitely expect to feel better about themselves, and another 46 percent said they would probably expect to feel better about themselves. Gender differences were not large.
2. **Would you definitely expect, probably expect, probably not expect, or definitely not expect your overall quality of life to improve?** Slightly more than 30 percent of respondents said they would definitely expect their quality of life to improve, and another 50 percent said they probably would expect their life to improve. Women were slightly more optimistic than men.
3. **Would you definitely expect, probably expect, probably not expect, or definitely not expect to be cured?** Almost 27 percent of respondents said they would definitely expect to be cured, and another 43 percent said they would probably expect to be cured.

CRITICAL THINKING | DISCUSSION QUESTIONS

1. When it comes to feeling better about oneself and improving the quality of one's life, women seem to be more optimistic than men. However, when it comes to being cured, men are slightly more optimistic than women. How might you explain that?
2. How might social class play a role in acknowledging and seeking treatment for emotional problems?

16.2 Genetic Testing

These are actual survey data from the General Social Survey, 2004.

1. **Some people say that genetic screening may cause trouble. Others think it is a wonderful medical advance. Based on what you know, do you think genetic screening will do more harm than good or more good than harm?** Slightly more than 70 percent of respondents in 2004 said genetic testing did more good than

harm. White respondents were significantly more likely to say that, as were respondents in the middle and upper classes.

2. **If you or your partner was pregnant, would you want her to have a test to find out if the baby had any serious genetic defects?** Sixty-six percent of respondents said they would have genetic testing done on their fetus. White respondents were more likely than Black respondents to say so. Social class differences were not large, but those in the lower class and the upper class were more likely to say they would have their fetus tested.

CRITICAL THINKING | DISCUSSION QUESTIONS

1. White respondents were more likely than Black respondents to say genetic testing does more good than harm, yet Black respondents were more likely to say they would have their fetus tested for genetic abnormalities. What might explain this apparent discrepancy?
2. Social class differences in responses were striking. Like the responses broken down by race, the social class differences do not seem to make sense on the surface. How do you explain them?

▶ Go to this website to look further at the data. You can run your own statistics and crosstabs here: **http://sda.berkeley.edu/cgi-bin/hsda?harcsda+gss04**

REFERENCES: Davis, James A., Tom W. Smith, and Peter V. Marsden. General Social Surveys 1972–2004: [Cumulative file] [Computer file]. 2nd ICPSR version. Chicago, IL: National Opinion Research Center [producer], 2005; Storrs, CT: Roper Center for Public Opinion Research, University of Connecticut; Ann Arbor, MI: Inter-University Consortium for Political and Social Research; Berkeley, CA: Computer-Assisted Survey Methods Program, University of California [distributors], 2005.