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Issue Theme: The Body

Dear Reader,

Spring 1992 of DSQ represents somewhat of a departure in format and content. I have chosen as a theme 'the body' but have gone outside (one of my colleagues said 'way, way outside') the field of disability studies for our major source of contributors. I am convinced that this new wave of theorizing has much to teach us and we them. In this endeavor I called on someone who is just such a bridge between the two groups - Arthur W. Frank. Without his involvement, this effort could never have come together.

Both the previous issue and this one have been quite full and frankly the costs of all the additional pages has been quite daunting. For this issue, we had to cut down or out some standard features. A Focus column isolated from the essays on 'the body' seemed redundant so we put it (Arthur W. Frank's intro) together with the essays and created a special Midsection.

As a result of the above and other matters with which we will not bore you please note the new schedule of 1992 issues and deadlines. Summer 1992 (deadline June 1) will be called "The Politics of Disability". Fall 1992 (deadline September 1) will deal with Technology with Deborah Kaplan (World Institute on Disability, 510 16th St., Oakland, CA 94612. Tel. 510-763-4100) as coeditor. Winter 1993 (December 1, 1992 deadline) will as usual be a generic one. In 1993 there will also be a thematic issue on Genetics with Adrienne Asch as coeditor and one on the Rethinking Mental Illness From the Inside Out with Jean Campbell coeditor.

As always, we welcome your thoughts, suggestions, and criticisms.

The Editors

FOCUS

Gore Road, R.R. #6. Rome, NY 13440 or call:
(315) 339-6750, ext. 322.

May 21, A National Teleconference on Retirement and Developmental Disabilities (various locations throughout the United States). Contact: Kathleen Bishop, Rome DDSO, 8163

May 21-22, "Creating Family-Professional Partnerships: Educating Physicians and Other Health Professionals to Care for Children with Chronic and Disabling Conditions," a conference for parents and professionals who have developed models to educate pediatricians and other

health professionals about children with special health needs and their families. at the Sheraton Station Square Hotel in Pittsburgh. Contact: Beginnings at 406 Main Street, Suite 201, Johnstown, PA 15901 (814) 539-1919.

May 26-30, American Association on Mental Retardation. New Orleans Hilton Riverside and Towers, New Orleans, LA. Contact: Stephen H. Stidinger, AAMR, 1719 Kalorama Road, NW, Washington, DC 20009 or call (800) 424-3688 or (202) 387-1968.

May 27-29, Annual Meeting and Exhibition of the President's Committee on Employment of People with Disabilities. Theme: "ADA: Working Together...For a Change." Washington Hilton Hotel. Contact: Debra Mayer, Exhibition Manager, (800) 318-0300/318-8833 (Fax).

June 3-5, Second National Conference on American Indians With Disabilities. Crescent Hotel, Phoenix, AZ. Contact: Libby Reeg, Conference Manager, American Indian Rehabilitation Research and Training Center, P.O. Box 5630, Northern Arizona University, Flagstaff, AZ 86011-5630. (602) 523-4791/523-9127 (Fax)/523-1695 (TDD).

June 17-20, Society for Disability Studies, 5th Annual Convention, Rockville, MD. Themes: Policy, History, Sexuality, Law Culture, Methods, Politics Media, Literature, Pedagogy, Gender, Self-Image, Cross-Cultural, Family, Advocacy and Activism. Contact: Barbara Altman, 14608 Melinda Lane, Rockville, MD 10853. Tel: (301) 227-8400 and see "Society Pages" in this issue of DSQ.

July, 1992, VII International Conference on AIDS, Amsterdam, The Netherlands. Contact: World Health Organization, Office of Information, 1211 Geneva 27, Switzerland, Tel: 791 21 11, Fax: 791 07 46.

July 7-9, 3rd International Conference on Computers for Handicapped Persons, Vienna, Austria. The Austrian Computer Society and the Technical Institute of Vienna., Harry J. Murphy, Office of Disabled Student Services, CSUN, (818) 885-2578.

July 22-25, The Association on Handicapped Students Services Programs in Postsecondary Education provides opportunities for the professional development who work with disabled students in higher education settings. Annual conference Long Beach, California. Sam Goodin, Co-Chair Program, CSLA, 5151 State University Drive, Los Angeles, CA 90032, (213) 343-3140 (V), (213) 343-3139 (TDD). Richard Harris, Co-Chair Program, Ball State University, Student Center 307, Muncie, IN 47306. (317) 285-5293 (V) (317) 285-5297 (TDD).

August 5-9, Mental Deficiency: 9th World Conference of the International Association for the Scientific Study of Mental Deficiency, Gold Coast, Australia. Contact (program info): Dr. Terrance Dolan, Waisman Center, University of Wisconsin-Madison, Madison, WI 53705-2280, USA, Fax: 1-608-263-0529. Contact (registration info): 1992 IASSMD Congress Organizers, GPO Box 2069, Brisbane, Q. 4001. Australia. Fax: 61-7-371-5107.

Courses on the Developing World

International Disability Exchange and Awareness (IDEA) is offering five-day international courses on disability. The course offers ideas and information with a focus on the issues surrounding disability services in regions affected by poverty and war. The courses promote positive changes in service delivery and employment for people with disabilities.

The courses emphasize causes of poverty and disability, the politics of aid and disability, alternative models of service and training in health, employment and social welfare; design of appropriate equipment and aids; project planning and management. Courses are scheduled for July and December in the UK. Details: IDEA, William House, 101 Eden Vale Road, Westbury, Wilshire BA13 3QF ENGLAND, Tel: 373 827635.

CALL FOR PAPERS

Deadline: November 1, 1992.

DISABILITY, HANDICAP & SOCIETY
SPECIAL ISSUE. 'Citizens of the State? The Experience of Disabled People'. In the late twentieth century, in many different societies, citizenship has become a key concept in talking about the relationship between the individual and society. Further, citizenship has been central to discussions about how successfully populations are socially integrated into their societies and how successfully individuals are personally integrated in to their communities. Finally, the state, however conceptualized, has been seen as the mediating mechanism between individuals and society and as the enabler of social and personal integration.

In recent years all this has been rendered problematic by the assertions of many groups that the systematic deprivation and discrimination they experience is a denial of their basic human rights and thus, the entitlements of citizenship. Coupled with this, social movements have developed from oppressed groups who have begun to show that, if they continue to be denied the entitlements of citizenship, they may no longer be prepared to accept the responsibilities and obligations. The state, in confronting this discrepancy between rights and responsibilities has responded in many different ways; with welfare programs, legislation and social developments on one hand; with repression, control or simply ignorance on the other. In this special issue of the journal we intend to explore these issues specifically in relation to disabled people. We would welcome contributions from people in different countries. The papers will go through the normal refereeing procedures. We need 4 copies of the paper sent to Professor Len Barton Division of Education, University of Sheffield, Sheffield, S10 2UJ.

GARY KIGER and DAVID PFEIFFER will edit a special issue of the **JOURNAL OF HEALTH AND HEALTH SERVICES ADMINISTRATION (JHSA)** on "disability studies." We encourage you to submit manuscripts (perhaps a version of your SDS presentation). Send four (4) copies of your manuscript to:

Gary Kiger
Department of Sociology
Utah State University
Logan, UT 84322-0730

DEADLINE is September 1, 1992. Please refer to recent issues of the JHSA for format and style requirements. Papers will be refereed. If you decide not to submit a manuscript and would like to serve as a manuscript reviewer, please contact:

David Pfeiffer (617) 573-8316
D.PFEIFFER@ACAD.SUFFOLK.EDU
e-mail (INTERNET):

OR

Gary Kiger (801) 750-1235
FAX (801) 750-1240
e-mail (BITNET): KIGER@USU
e-mail (INTERNET): KIGER@CC.USU.EDU

Note. Please do not FAX or e-mail manuscripts!!

OPPORTUNITIES/FUNDING

New York University/Rehabilitation Counseling Program announces a new grant awarded by the Rehabilitation Services Administration for Rehabilitation Counselors who wish to complete doctoral study leading to the Ph.D. The traineeship provides full tuition plus a stipend for three years of study and prepares students for teaching and administrative positions in college and university rehabilitation counseling programs. Applications must have completed the Master's degree in Rehabilitation Counseling and be available to begin the program Summer, 1992. The New York University/Rehabilitation Counseling Program is the oldest in the country and its doctoral program is one of the few in this geographic area. Students have the advantage of using New York's extensive selection of rehabilitation agencies and research facilities to design and execute their doctoral studies. Contact: Hannah Kates, Recruitment Coordinator, New York University/Rehabilitation Counseling Program, School of Education, Health, Nursing and Arts Professions, 50 West 4th Street, Shimkin Hall - Room 432, New York, NY 10012. Tel: (212) 998-5298.

SOLICITATIONS

Art Images of Disabled Persons wanted.

A computer data base of art works which depict disabled persons is nearing completion. Over 1600 works of art are listed, along with location, a description, and the type(s) of disability(ies) shown. We are looking for anyone who has compiled a similar list to help us add to the collection. In exchange, contributors will receive a pre-publication copy of the museum guide to this art. Articles or references on art and disability would also be welcomed. Send material to: Liz Bredberg, Department of Instruction and Special Education, OISE, 252 Bloor Street, Toronto, Ontario M5S 1V6 or FCTY731@RYERSON.CA.

Quality of Life Research at the University of Toronto. A team of researchers at the Centre for Health Promotion at the University of Toronto are developing indicators of the quality of life of developmentally disabled persons. We are looking for any "fugitive" literature on this topic such as assessment scales, reports, conference papers, etc. Please send to: Dr. Ivan Brown, Centre for Health Promotion, University of Toronto, 100 College, Suite 207, Toronto, Ont. Canada M5G 1L5. On BITNET contact Ivan Brown at FCYT731@RYERSON.CA.

The Division of Gastroenterology (Sinn Anuras, MD, Director) and the Department of Neurology (Amitabh Shukla, MD) at Texas Tech University, are conducting a survey about gastrointestinal problems (abdominal bloating, constipation, swallowing difficulties) of polio survivors. If you would like to receive the questionnaire and participate in the survey, contact: Terri Bozeman, RN, Research Coordinator, Texas Tech University, Health Sciences Center, Division of Gastroenterology, 3601 4th Street, Lubbock, TX 79430, (806) 743-3136, 743-3168.

Help needed on History of Disability Movement in Jamaica. If you have literature or information on this topic please write to: Karen

Blackford, Graduate Sociology, 4th Floor Ross Building South, York University, 4700 Keele Street, North York, Ontario, Canada M3J 1P3 or telephone (416) 677-0979.

The Medical Sociology Section of the American Sociological Association announces its competition for the award for the best doctoral dissertation in medical sociology as summarized in article form. To be eligible for the competition, candidates must be currently paid members of the Medical Sociology Section and have been awarded the PhD degree (not necessarily from a department of sociology) in the two years ending June 1, 1992. Travel support is available to the 1992 ASA meetings in Pittsburgh, and the winner will present her or his work at the Section business meeting. The submitted paper may have been published, but reprints cannot be submitted for consideration. Papers must be sole-authored, no more than 30 Doubled spaced, typed pages, with the author's name appearing only on the title page. Three copies of the paper based on the dissertation should be sent to Nancy G. Kutner, Emory University School of Medicine, 1441 Clifton Road, NE, Atlanta, GA 30322. Other members of this year's Awards Committee are Michael Hughes, VPI and State University, and Fred Hafferty, University of Minnesota, Duluth, Deadline: June 1, 1992.

The University of Missouri - Kansas City Institute for Human Development has recently received a grant from the National Institute of Disability Rehabilitation and Research (NIDRR) to develop a curriculum on work and retirement programming for older persons with developmental disabilities. As part of the planning process for the development of the curriculum, we are conducting a survey of individuals who have had experience with programs that serve older persons with developmental disabilities. The survey is divided into four sections: (1) Topics that could be included in a curriculum on work and retirement for older persons with a developmental disability; (2) Work options and how aging has affected these options; (3) Planning for work enhancement and/or retirement; and (4) Retirement programming. The survey is four pages. Contact: Christine Rinck, Director of Research, UMKC Institute for

Human Development, 2220 Holmes, Kansas City,
MO 64108-2676 (816) 235-1770, Fax: (816) 235-
1762.

Arthur W. Frank
Department of Sociology
The University of Calgary
Calgary, Alberta, Canada

Volunteers Needed for Study Of The Disabled And Their Families. I am a person with a developmental disability who is conducting a nation-wide study of the positive and negative effects of a developmental disability upon the individual and the extended family. My colleague on this project is Dr. John DeFrain, a professor of human development and family studies at the University of Nebraska, Lincoln. We are looking for persons with every kind of developmental disability and members of their families who would be interested in filling out a questionnaire, sharing their strengths and stresses. Questionnaires are available for all ages of people, and all roles in the family. If you are willing to volunteer for the study, please send us your name, address, and tell us which type of questionnaires you need (disabled adult, disabled child, mother, father, adult sibling, child or adolescent sibling, grandparent, etc.). We will send results of the research to those who are interested in obtaining results. Complete confidentiality is assured to the families; no one's name will ever be divulged or used in print.

Dr. DeFrain is the co-author of six books on various aspects of family life, and our ultimate goal is this project is a book for family members which discusses the strengths of these families, and the challenges they face.

Thanks so much!

Susie Dahl, M.S.
Child Guidance Center
215 Centennial Mall So.
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Lincoln, NE 68508
(402) 475-7666

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104H Leverton Hall,
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MIDSECTION

Guest Editor's Introduction

The rationale for this special issue is simple: disability begins with a body that is not what someone feels it should be; to study disability is to study the body. The papers collected in this issue cover a range of theories, research interests, and personal experiences. Each attempts to understand the body as a force in the social world and as a grounding of personal experience, including the writer's own experience.

I began studying the body in response to academic interests: Freud's body of drives and energies, phenomenology's body as the possibility of shared experience and communication, Foucault's body as the object of power relations, postmodernism's consuming and commodified bodies, and feminism's body as difference. But as a sociologist I found the body in sociological theory strangely silenced. As I taught courses on Durkheim, Mead, and Parsons, I realized how much the body grounds the ideas of each, but then how little voice the body is allowed in the processes it sets in place. I began to wonder what it might mean to hear the body speak.

These theoretical musings were swept aside in 1985-86 when I had a heart attack, followed by cancer. My own body's speech drowned out academic talk. Recovering from those experiences, I wanted to write for and about people whose bodies were in pain and at risk: the ill, the disabled, and the suffering. But I remain a social scientist, and recognize that bodily suffering is not simple to understand or to respond to. I still need those same theories, but with a new edge of relevance.

The body is what we each are; thus to "study" the body confounds us, even as it attracts us. The first layer of body study is straightforward in principle. Most scholars as well as non-scholars agree that the body is subject to a variety of social conventions and practices, including both expectations and taboos. What glorifies the body and what pollutes it are culturally determined. Anthropologists from Marcel Mauss to Mary Douglas, ethnographic sociologists like Erving Goffman, and historical sociologists like Norbert Elias have instructed us in the variations of body use and understanding.

The scars that mark a body as powerful and privileged in one culture are stigmatizing in another. "Impairment" is a cultural standard reflecting what a society values and devalues about bodies, what society needs from those bodies and what it cannot make use of, and what historical traditions pervade those cultural understandings.

The next layer of body study is far more controversial. Probably the most provocative claim in any of these papers is Caroline Walker Bynum's research hypothesis that the body not only has a cultural and social history, it has a natural history as well. When I read Bynum's research on the violences involved in medieval ascetic practices, particularly fasting when it becomes self-starvation, I had to question whether the reports we have of what women in particular did to their bodies in past centuries were exaggerated, or whether bodies in those centuries shared our physiological limits. But until Bynum's recent writing the latter possibility has been unaskable; our culturally predisposed belief is that the body is constant, at least over the last several thousand years.

But the historical documents are not so easily dismissed: reports come from too many writers with different interests, in different countries, over too long a time period. Bynum brings us back to her unlikely possibility: the body has a natural history; its limits and possibilities may not be the constants that our medicalized view leads us to believe. To paraphrase Pascal, the body may have a physiology that Physiology knows not of.

The third layer of body study is the reflexive relation of "research" to the body of the researcher. Papers by Achenbaum, Bynum, Denzin, Stam, Turner, and Young each reflect on this relation in what have to be very different ways, given the different embodiments of each writer. Each paper marks a recognition that is just as controversial to the ideal of social science as the "natural history of the body" hypothesis is to biological science. For all we talk of the "objectivity" of research, all research is mediated by -- filtered through -- the body of the researcher. That mediation includes a personal history of body usage (Young), relations to others' bodies (Bynum, Denzin), and professional enculturation (Stam). The Weberian scientific dilemma of the relation of facts to values in

research yields to the more inescapable relation of embodiment to thought.

The radical idea is this: we never write simply of the body without also writing out of a body that is uniquely ours. But as Bryan Turner suggests in his paper, if there were not equally a commonality to bodily experience, we be unable to share experiences and the basis of our mutual, interpersonal intelligibility would be lost.

What does this mean to those whose immediate concerns are illness and disability? The sufferer simply knows she or he suffers. But to speak seriously of how to respond to suffering, whether in relation to our own suffering, the suffering of individual others, or aggregate groups with their needs and demands, we must ask the questions posed in these papers. We must ask about the social and cultural variation in body uses and expectations, about the physiology of the body and its potential for variation, about how mutual our "common" human embodiment really is, and about how we can question the body when that questioning is itself an embodied act.

The papers in this issue have all the excitement and perplexity of "cutting edge" material. They are original, provocative, condensed, and experimental. If issues become too specialized, I invite the reader to move on. The mood of these papers changes as quickly as bodies can change; could it be otherwise?

Acknowledgement: I thank Lynda Costello for her invaluable assistance in gathering these papers together. I also thank these eminent scholars for taking time to join in this reflection on the body.

Editor's note. Irving Kenneth Zola. I have taken the liberty of including the essay of Linda Andrist and Harlan Hahn in this Midsection.

THE POETRY OF AGING'S BODY LANGUAGE

by W. Andrew Achenbaum
University of Michigan, Ann Arbor, U.S.A.

What printed texts best embody the images, meanings, connotations we associate with aging bodies? I wrestled strenuously with that question before writing this essay. Words in text

matter because of their power to establish idioms and fix identities. They convey as much body language as a caress or a kick.

In my mind's eye, I espied an opportunity to comb the Bible for body language. Scripture seemed a reasonable place to look: many of our current images of the faces of age can be traced back to the Psalms and the Wisdom literature. The Hebrew Bible uses the word "body" rarely (Gen. 47:18; Isaiah 31:3). Writers were more inclined to allude to matters of the flesh by referring to specific parts (such as the "heart" in 1 Sam. 25:37 or "loins" in 1 Kings 21:10) of the human anatomy, not necessarily implying any physiological unity to the organism as the whole. Contributors to the New Testament, in contrast, invoke somatic language to distinguish body from soul. New ambiguities, however, were introduced into Scripture. For instance, one of the phrases Gospel writers and Paul most frequently employ is "the body of Christ," an expression fraught with literal and metaphorical allusions. In the passion narratives and post-Resurrection passages (such as Heb. 10:20), physical details are to be revealing. Yet the phrase also refers to the structure and dynamics of the early Jesus movement, especially its eucharistic liturgy. Amidst such diverse frames of reference tracing notions of senescence in the Bible would be difficult.

Lacking the nerve to engage biblical exegesis, I listen to my gut: I plunged into a personal account of how I was, at age 44, perceiving and responding to my aging self. Some themes were easy to express. Too myopic and uncoordinated to be a decent athlete in my youth, I related to how happy I am now to spend time each day swimming. (Truth be told, I am getting fast enough to beat some of my students!) Like other men my age, my rapidly graying beard compensates for a receding hairline. But for my story to be honest, I would have to tell how I came to take lithium twice a day. This revelation, in turn, would require some candor about how it feels to be in my "prime" -- only to realize that "brokenness" (not just vulnerability or a sense of finitude) will be a major force shaping my sense of myself as a human being for the rest of my life. That evolving, sometimes contradictory, nearly always contingent, concatenation of potential and limits are deeply ingrained in my perception of what

aging means. I admire people like Arthur Frank, who can inspire others how to dare to mature, "in recognizing with them the frailty of the human body," by sharing reflections of his own life-threatening illnesses. I am becoming comfortable sharing such intimacies with my circle of friends. Sometimes I will reveal my warts and wounds to relative strangers; I take risks with people who, having exposed the pain in their stories, might take some solace in hearing me tell them I have been (or am) where they are struggling. But I am not yet so strong as to be so open here.

So, opting for middle ground, I searched for some "data" that would enable me to be playfully serious in trying to delineate some continuities and changes in the words and themes people have used to describe aging human bodies over time. Serendipitously, I came across two relevant poems. "The Old Man Comforts," written by Robert Southey at age 25, was first published in 1799. This poem inspired Lewis Carroll (a.k.a. C. L. Dodgson) roughly 65 years later to update Southey's aging motifs in "You Are Old, Father William." Failing to find a contemporary poem in the meter and spirit of this pair, I have committed some doggerel to print. Examining what is said, not said, repeated, revised or foreshadowed by three different authors should offer some insight into how body language takes shape in poetry on aging that builds on the same form and focus.

"The Old Man's Comforts - And How He Gained Them"

by Robert Southey

"You are old, Father William," the young man cried,

"The few locks which are left you are grey;
You are hale, Father William, a hearty old man,
Now tell me the reason, I pray."

"In the days of my youth," Father William replied,

"I remember'd that youth would fly fast,
And abused not my health and my vigor at first,
That I never might need them at last."

"You are old, Father William," the young man cried,

And pleasures with youth pass away;
And yet you lament not the days that are gone,
Now let me tell the reason, I pray."

"In the days of my youth," Father William
replied,

"I remember'd that youth could not last;
I thought of the future, whatever I did,
That I never might grieve for the past."

"You are old, Father William, the young man
cried,

"And life must be hastening away;
You are cheerful and love to converse upon
death,
Now tell me the reason, I pray."

"I am cheerful, young man," Father William
replied,

"Let the cause of my attention engage;
In the days of my youth I remember'd my God!
And He hath not forgotten my age."

To a cultural historian, several ideas about Father William's aging body merit comment. To begin: the first image signifying William's elderhood is the color of his remaining hair. Writers since biblical times have honored gray hair (Prov. 16:31; Prov. 20:20). Not only is Southey faithful to literary archetypes, but he salutes the conventions of this day. Note his emphasis on how the old might take comfort in theodicy. William apparently followed the Ten Commandments in his youth; now, God rewards him as death approaches. Other lines in Southey's poem would have consoled less pious readers who were willing to follow prevailing medical wisdom. Ever since Luigi Cornaro's tract (1558), physicians have claimed that moderation promoted longevity.

I do not mean to suggest that Southey intended to represent Father William as an Everyman ideal. He was attuned to his peers' ageism. In another poem published in 1800, Southey characterized winter in anthropomorphic terms: "a wrinkled/crabbed man they picture thee." And twice he says that Father William "remember'd" sobering facts of human existence that few youth in any era would take time to heed. William recognized (earlier than most) that the mere passage of time provided moments for (re) discovery of self: he celebrated aging because

of (not despite) a keen awareness of his own fragility.

"You Are Old, Father William - After Southey"
By Lewis Carroll

"You are old, father William," the young man
said,

"And your hair has become very white;
And yet you incessantly stand on your head --
Do you think, at your age, that is right?"

"In my youth," father William replied to his son,
I feared it might injure the brain;
But now that I'm perfectly sure I have none
Why, I do it again and again."

"You are old," said the youth, "as I mentioned
before,

And have grown most uncommonly fat;
Yet you turned a back-somersault in at the door
Pray, what is the reason for that?"

"In my youth," said the sage, as he shook his grey
locks,

"I kept all my limbs very supple
By the use of this ointment - one shilling the box

Allow me to sell you a couple?"

"You are old," said the youth, "and your jaws are
too weak

For anything stronger than suet;
Yet you finished the goose, with the bones and
the beak

Pray, how did you manage to do it?"

"In my youth," said the father, "I took to the law,
And argued each case with my wife;
And the muscular strength which it gave to my
jaw,

Has lasted the rest of my life."

"You are old," said the youth, "one would hardly
suppose

That your eye was as steady as ever;
Yet you balanced an eel on the end of your
nose --

What made you so awfully clever?"

"I've answered three questions, and that is
enough."

said his father; don't you yourself airs!
Do you think I can listen all day to such stuff?
Be off, or I'll kick you downstairs."

"You Are Old" was dashed off by a man bursting with energy. Lewis Carroll had finished studying for Holy Order (1861); he was putting finishing touches on Alice in Wonderland and Dynamics of Particle (both 1865). The sequel begins with a nonsensical rendition of Southey's opening stanza. Thereafter, the Rev, Dr. Dodgson departs from Southey's moralistic tone, anticipating a more "modern" voice.

To a greater degree than Southey, Carroll emphasizes the negative features of growing old - widening girth, weakening jaw, failing vision, unsteady gait, and diminished mental capacities. Such observations must have come naturally to a man who photographed nudes for a hobby. Nor is this the first time that Dodgson made allusions to late life's vicissitudes. In a poem he wrote at age 13, Carroll referred to "an aged, hoary monk" who had a "shriveled hand." And at age 67, the Oxford don would frankly acknowledge his own senescence: I am an "aged, aged man."

There are hints in this poem, moreover, that new societal forces are transforming the social construction of old age. Preventive medicine -- not just through living prudently but also by applying commercial remedies -- help to ward off the ravages of age. And the patriarchal conventions of Southey's verses are toned down here: "father" is capitalised only in the title. Indeed, Carroll's old man stands on his heads, does somersaults, and balances eels on his nose. Has he entered his "second childhood"? Is father William a pure senex? But perhaps I strain the interpretation.

Some of the humor in "You Are Old" elaborates ideas Carroll precociously penned in his Useful and Instructive Poetry (1845). A sister's threats to her brother of a "battered hide/or scratches to your face applied" anticipate William's warning that he would throw his son downstairs. And the incessant parody here of the distinction between what's "right" and what's "disorder" shapes much of Dodgson's early poetry. All of which is to say that his references to an aging physique notwithstanding, Carroll may not know much about what it means to be old. Rather, he seems content to rework literary conventions to delight readers young and old.

alike. In contrast, Clio, not Calliope, inspired the last poem.

"Shucks, You Don't Look Your Age -- After Southey, After Carroll"

BY W. Andrew Aehnbaum

"You don't look your age, old man," the scion said.

(He was fifty, dad eighty-three)

"You seem reasonably fit, not over the hill
What's your secret? -- please tell me.

"You are as old as you feel," his dad said proudly.

"Why use a calendar to mark years?
I quit smoking and started swimming every day --
Though I still like to drink a few beers.

"But didn't you work much less hard than Gramps did?"

Asked John who works 12-hour days.
"And your idea of a second childhood.
Consists of bingo and plays."

"It sure beats Shakespeare's "sans teeth, sans eyes, sans taste"

Papa Gregory Declared.

"I replace parts that break, take pills for the rest..."

Golden Agers -- stay prepared!"

"So, Dad, when the Bard declared 'ripeness is all,'"

Asked John, with tongue wedged in cheek,
"Do you take that to mean that old age is just
Middle age lived to its peak?"

"Shakespeare's old hat, son; Eliot's where it's at,"

The father said with much glee.
"As he wrote, 'Old men ought to be explorers.'
And that's how I mean to be."

"But isn't all this quite self-serving," cried the son.

"Didn't mom beat you to the grace?
My brother dies of AIDS; Sally, of cancer.
How dare you act so brave?"

"Who said that "In the end is my beginning"
Replied Dad, knowing full well.

"We may age in new ways, but limits remain.
What's next? Who cares? Who can tell?"

The two hackneyed cliches in my first stanza, I believe capture the paradox of most contemporary views of our aging bodies. On the one hand, octogenarians no longer look and act as we expect -- at least they do not appear as haggard as did crones a generation or so ago. Technology, social progress, cosmetics, positive thinking, and hard effort do make it possible to mask the physical marks of advancing years. On the other hand, most of us fear going "over the hill." It connotes obsolescence, dependency. It presages death. In a society in which age consciousness is shaped by the cult of youth, old age -- even if no longer cursed as a disease sui generis -- remains problematic.

Papa Gregory seems at first a caricature of the card-carrying AARP member who has good health and enough insurance to enjoy easy access to decent medical care. After growing up in the Depression and fighting in World War II, he earned a nestegg beyond expectation. No wonder he exults in his good fortune. Son John doubts that he will be so lucky. Oh well - Bingo does not sound so appealing anyway. But what about the generational succession at stake? Honor must be preserved.

So John raises several points not suggested by Southey or Carroll. He recognizes the importance of gender. In revising the second stanza, I substituted "drinking beers" for "pinching rears" because the latter was sexist. But my protagonist should be Mother Deborah. Women, pace Eliot, are the true pioneers. This amateur's slavish copying of literary prototypes distorts an objective rendering of the diversity in the elderly population. Many people suffer from multiple, chronic ailments. Others are recovering or in remission from acute illnesses. Some cannot benefit from (or afford) operations or drugs that have restored functionality to other people. Furthermore, John's last stanza challenges conventional wisdom. For the first time in history, dramatic increases in life expectancy at birth and gains in adult longevity seem to have postponed the day of reckoning with Death. Yet Sudden Infant Death Syndrome, Agent Orange, AIDS, victims of alcohol-related accidents, and other scourges forcibly remind us that death does not strike just the old.

How apt, then, that Gregory, quoting Eliot, should have the last word. With mixed success he reaches some conclusions about aging bodies. He agrees with his son that old age is not just an extension of middle age. It requires the elderly to be brave and mutually supportive of one another, for never have so many in a given cohort lived so long. There, at a novel frontier, the new old are poised to experience and recount the pleasures and risks of an expanded late life. The aging voices will be shaky. Thus "who cares?" rings false. But "Who can tell" has the virtue of honesty even as it affirms the ignorance we prefer to deny.

WOMEN'S VOICES - A REVIEW ESSAY

by Linda Andrist
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In the past few decades, a revolution has occurred regarding the biology and treatment of breast cancer. We now understand that it is a systemic disease and that breast cancer itself does not kill women, but rather metastasizes to other parts of the body, threatens women's lives. We also know that because most breast cancers are slow growing, women can have a recurrence 10 to 20 years after the initial treatment, although the longer women go without recurrence, the less likely they are to have one. Therefore, most breast cancers are currently considered a chronic disease.

Breast cancer is receiving more public attention than ever before as the incidence continues to climb. Whether the increased incidence is due in part to early detection, or an absolute increase is unknown. Nevertheless, the volume of lay literature on breast cancer has dramatically increased during the past few years.

This book, by Amy Gross, and Dee Ito. Women Talk About Breast Surgery: From Diagnosis to Recovery. (New York: Clarkson Potter Publishers, 1990, 333 pp., \$22.95 hardcover) is a collection of stories about women's lived experience of their journeys through breast cancer diagnosis and treatment.

Written for the lay public, it includes definitions of medical terminology, a bibliography, sample consent forms for various procedures, a section on hospitals and patients' rights, and information on health insurance. A list of resources on breast cancer would have been an additional benefit for readers.

The authors, who are journalists, interviewed 25 women and 7 health care experts in order to help women negotiate the complexities of breast cancer treatment. The book is divided into 3 sections. The first discusses surgical procedures, and the decisions that need to be made. The only missing piece here is the biology of cancer, which can be found in other resources, but would help women understand the systemic nature of breast cancer. The second part is devoted to the women's voices as they answer the interview questions. They are varied in their decisions, and in the reasons why they chose different treatment regimens. The third section includes interviews with prominent providers, including physicians, clinical nurse specialists, and other experts in breast cancer treatment. Noteworthy in this section is the bias of medical specialists which should be scrutinized by the reader. Plastic surgeons are invested in breast reconstruction, and radiation oncologists are invested in breast conservation. This shows the importance of obtaining many different opinions prior to decision making.

The women are articulate, assertive, and highly opinionated about the manner in which women must become involved in their health care, reiterating what the women's health movement has been calling for - more symmetry in patient- physician relationships, access to information, and participation in decision making. In their own voices, they encourage women to seek as many opinions as they can - several surgeons, radiation oncologists, medical oncologists, as well as plastic surgeons, before they settle on the treatment plan (and the provider) that is best for them individually. Because all of the women are well educated and probably upper class, they have the resources to enable them to do this; my concern is that disadvantaged women do not have these resources, and are unable to shop for quality

health care that comes with class advantage.

Breast cancer treatment is undergoing major transformation, and current therapies are quickly outmoded. Gross and Ito attempted to control for this by interviewing women who had gone through treatment within the past 5 - 6 years; however, the book was published in 1990, which means that the "data" are already 7 - 8 years old (perhaps older since they do not tell us when the interviews took place). Women reading this book must take this into consideration.

The book is structured so that women describe their experiences, but also share the medical information that they have learned; in this respect the authors promote the concept of self help and education. However, I found a few instances of information that is misleading; for example, the American Cancer Society recommends that women have their first mammogram between the ages of 35 - 40, not at age 40 as the authors state. Another woman says that chemotherapy generally lasts one year (in 1992 it is more like six months or less, depending on the protocol), although the authors do state that in another part of the book, the reader may be confused. I would encourage women to concentrate on the women's experiences and how they negotiated quality care, rather than relying on the medical information as being the standard of care in a rapidly changing environment.

In reviewing this book, I reflected on the focus of this volume of DSQ - "the body." I looked for ways in which women conceptualize their bodies in choosing therapies that are right for them. I also looked for language and attitudes that physicians used in discussing treatments which reflect how they conceptualize women and their bodies. I decided to apply some of the concepts that Frank raises in his review, "Bringing bodies back in: A decade review" (Theory, Culture and Society, Vol 7, 1990) to the women's stories, particularly in the area of the medicalized body. The women's health movement has been very vocal about the ways in which women's bodies have been medicalized. Breast cancer is a critical example of how the feminist agenda of the "self/body/politics/violence nexus" (Frank, 1990) is

played out in medical encounters.

The two major surgical procedures involved are modified radical mastectomy followed by immediate or later reconstruction, or no reconstruction at all, and lumpectomy followed by radiation. Lumpectomy is considered "breast sparing" and many studies show that it has the same survival rate as mastectomy. The stories clearly pointed out that without careful explanation, women who chose mastectomy were convinced the decision was around living or keeping a breast. Furthermore, the decision whether or not to have reconstructive surgery was central to how they felt about their bodies.

"Did you consider reconstructive surgery?"
No, a breast is a breast. Once it wasn't a breast, what was I going to do with this other thing? I just didn't feel like it would ever be a breast (p. 115).

You know, I mourn losing my breast because it was a sensitive part of my body, and the loss of it alters your responses, your sexual response--when you lose a part of your body, I don't care what it is, you have to readjust. I didn't like that. But I wouldn't want to live with a breast, thinking cancer could come back (p. 198).

I know a woman down in Florida who had a total mastectomy of her left breast. She didn't want to have reconstructive surgery, so she was considering having the scar tattooed and making an adornment out of the scar, like a patch. She was going to do something with a flower. I thought that was very brave of her (p. 40).
(Woman who had a lumpectomy)

The implicit tone throughout the book is that reconstruction has become mainstream, and that it provides a way for women to become "whole" again. This is one way in which medicine attempts to "recreate" the body (Frank, 1990), and reinforces the importance of being two breasted. The invisibility of women who have had mastectomies is profound, and I believe the social stigma attached to having one breast has silenced women. One woman stated that what helped her the most was a friend who said, "The first thing you have to remember is that there are

thousands of us walking around" (p. 110). Finding each other is difficult at best; however several women are challenging the status quo, as the following examples illustrate.

In the beginning, for about three months, I wore a prosthesis, too. Then I went to Cape Cod. I had this three-pound, silicone, ugly breast, and I thought, I can't wear this in the heat. Everybody I know knows I don't have a breast. What is the secret? Who am I hiding this from? That polyester fill hangs down to your stomach when it gets wet and you have to pull it up and squeeze it out. I certainly wasn't going to lie on the beach with it on, so I have it up there. God, it felt so good not having it on! But these women [Reach to Recovery] do push you to wear it. I think it's about keeping the secret--women are supposed to have breasts (p. 153).

There are lots of different stages of adjusting to who your are, and one is just adjusting to yourself physically. I went to a gym about a year and a half ago where everyone runs around naked, and when I was getting into a shower, I had a kind of moment of truth. I thought, I am not going to hide the fact that I am a perfectly good human being with a body that's a little different from somebody else's. I will not walk around hiding behind a towel when everyone else isn't. I will not do it. And I didn't (p. 116-117).

The women's health movement has long decried the "medical patriarchy" that Frank discusses in his review of Illness and Self in Society (Herzlich and Pierret, 1987) and In the Patient's Best Interest (Fisher, 1986). This is one of strongest themes in Gross and Ito's book. The women wanted to be active participants in their health care; many elaborated on the patriarchal ways in which they were treated.

... He quickly did a needle aspiration in the office. And when he couldn't remove any fluid he said ---very brutally, I thought --- 'it's a tumor, and you're going to have to have a radical mastectomy. You have to get yourself a medical specialist (p. 24).

I mean, they never talk to you in the office! It's always in the examining room. You're wearing your paper dress, you're supposed to bring a

little pad and pencil, but you don't have a pocket for your pencil --- you're always in this very vulnerable, really inferior position (p. 59).

So I went and had the biopsy, which was an office procedure, and the lump was removed. The surgeon said, again, "Don't worry about it -- it looks terrific." He sent it off to the lab, and it was malignant. Everyone was surprised (p. 141)

Women's experiences with paternalistic physicians encouraged them to look for other physicians who would listen to them and treat them with more respect. Many saw at least 2, if not more surgeons.

Another way in which women felt medicalized was around how they were treated during surgical procedures, particularly in the operating room.

Anyway, they put a kind of blanket over me with a hole cut out over my right breast, pulling up one end in front of my face so I couldn't see anything. But I could hear everything. It was very strange because it was as if I weren't there so far as anyone in the room was concerned (p. 75).

I was wheeled into the same operating room I had been in for the biopsy. The same pleasant nurse bustled around, strapping me down, while other nurses set up IV bottles and prepared me for surgery. They were all very professional but impersonal. I would have loved for someone to acknowledge that I was the reason for all this activity (p. 83).

Another theme that is heard throughout the interviews is that women believe, or have been told that stress or loss cause cancer, or at least predisposes people to cancer. Frequently physicians fed into this ideology of victim blaming.

My oncologist said to me, "Well, the latest findings are that not a little stress, not anything light, but some deep sadnesses seem to coincide with a higher percentage of breast cancer. There seems to be some correlation" (p. 32)

...when I asked the oncologist, "Could this have

come from stress?" he said, "Well, we think maybe yes." I was afraid (p.39).

The Chinese call breast cancer "the childless woman's disease," because it's so connected to women who had no children or who lost children--it's connected to loss. Cancer in general is connected to loss (p. 47).

... a well meaning friend sent me [the] book, and I think it was supposed to be a comfort. It virtually says that if you get cancer, it's your fault because you didn't think positively, you didn't eat the right foods--a lot of people swear by this (p. 214).

This "victim blaming" is what Frank suggests is the dilemma of the ill in this century: "they are constructed as responsible for their health and thus feel guilty, and simultaneously understand themselves as having less and less control over their bodies." (emphasis added) Women who are diagnosed with breast cancer are not sick, unlike most other cancer patients, yet throughout the process of diagnosis and treatment, they do sense less and less control over what is happening to their bodies, as well as what is being done to their seemingly "normal" looking bodies. No matter what type of surgery they have, it is mutilating and disfiguring. The taken for granted body, as Frank puts it, has failed women with breast cancer. The theme of wanting to be in control was also prevalent in many women's voices.

The next day, I'm in this goddamn operating room trying to be a hero. It's an uncomfortable procedure. If you're awake, you don't feel the pain, but you feel them cutting and pulling. You know that they're invading your body, and it's not nice and you don't like it (p. 33).

I really could have lived through a mastectomy perfectly fine. This is where my husband was really helpful. He said to me, "You have just had several major losses in your body. You have no body confidence right now--your body has failed you on so many levels. If you have the option of hanging on to your breast, I think you should do it. Go for the thing that's going to be the least intrusive to you" (p. 52).

In many respects, hearing these women's voices "puts the reader in the wheelchair" (Frank, 1990) in that their personal experience becomes a powerful tool for understanding the other. As I mentioned earlier, their stories may indeed help women with decision making, but should be read as a companion piece to other resources. I think the medical community should read this as well in order to understand the complexities that patients experience, and how patients perceive interactions with providers.

WRITING BODY HISTORY SOME AUTOBIOGRAPHICAL AND HISTORIOGRAPHICAL REFLECTIONS

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Some of my early work, such as the essay "Jesus as Mother", dealt with bodily and gendered images of the divine (Bynum, 1982). My recent writings -- especially the article on "The Female Body and Religious Practices", anthologized in Fragmentation and Redemption, and my current extended project to examine the doctrine of the resurrection of the body from the early church to Dante's Divine Comedy -- is explicitly about ways in which ideas of the body have developed over the past nineteen centuries (Bynum, 1987, 1991a, 1991b, 1991c). I have gone so far as to suggest that certain bodily behaviors, such as the somatizing of religious experience in stigmata, trances and visions, themselves change over time -- to suggest, that is, that the body itself (and not merely the conception of it) has a history (Bynum, 1991a). I am grateful to the Disability Studies Quarterly for this opportunity to speculate -- theoretically and autobiographically -- about where my research stands in relation to other historical and literary work in the 1990s.

The body has been a "hot topic" recently in historical circles, especially, especially among what we might call the Berkeley-Princeton school representing figures such as Peter Brown, Natalie Davis, John Gager, Catherine Gallagher, Stephen Greenblatt, Lynn Hunt, Thomas Laqueur and Elaine Pagels. Even among this group, so influenced by each other, there are several rather

different methods and sets of assumptions about "body". Certain of these historians, preeminently perhaps Brown, David and Pagels, have been deeply influenced by cultural anthropology, especially by Mary Douglas and Clifford Geertz. They therefore tend to be interested in the human body as model "of" and "for" (Geertz's terms) the body social (Geertz, 1966). The concerns in a given period for drawing or breaching bodily boundaries is, for example, seen as a metaphor for attitudes toward outcasts and scapegoats, on the one hand, heroes and exemplars on the other. Others among the Berkeley-Princeton group, preeminently Laqueur, Hunt and Greenblatt (sometimes called "new historicists"), have been more influenced by Michel Foucault. They tend therefore to focus on the human -- especially the sexual and gendered -- body as a social construction. Whereas David and Brown see the individual body as an instrument of withdrawal, rebellion, or even liberation, Laqueur, Greenblatt and Hunt are more concerned with the ways in which the scientists, social scientists and political leaders construed physiological "fact" to limit and oppress. For the both these groups, issues of class and gender (especially of gender) have been at the forefront, as much so that the new field of body history they have inspired could really also be called the history of sexuality and sexual difference.

In many ways, my own work belongs to the new field of body history. And I have myself been deeply influenced by the cultural anthropology that has shaped Brown and Davis. I am sure I have also, although less consciously, been influenced by Michel Foucault; no academic who reads widely could assert otherwise. Nonetheless, as I work on the variety of religious practices and belief in the Middle Ages, I am struck repeatedly at how little my observations and explanations fall into the pattern popular with the Berkeley-Princeton group. Unlike them, I tend to see body as a locus of experience and expression rather than an object of repression. I tend to assume that discussion of body is about body (i.e. about physicality) rather than about society or sexuality or power.

In the book I wrote on the religious significance of food to medieval women, I found myself compelled by my sources to consider the highly somatic quality of women's experiences --

not only to register the prevalence on women's writing of organic and bodily images but also to argue that the female body in the high Middle Ages actually behaved in new ways (Bynum, 1987; 1991a, pp. 194-95). In the book I am presently writing on the doctrine of bodily resurrection in its social context, I find that an abstruse point of Christian belief can be understood only by considering physiological theory, gender roles and burial practices (Bynum, 1991c). So I am in a sense analyzing body as a social construction; I do, of course, notice that corporate metaphors for self and society mirror each other. But again and again I find myself less interested in how body was construed to draw boundaries and make distinctions than in the fundamental fact that body is what we human beings have in common. I find pain and death the basic evil, ecstasy experienced by a psychosomatic unit of self the basic liberation. Shaped (as were my contemporaries in the Berkeley-Princeton school) by the 1960s, I am nonetheless concerned less to name oppression than to understand difference. For all my awareness of deconstruction and social construction, I still believe empathy for the position and voice of "the other" is possible (although very, very hard) and that there are common human experiences.

For these emphases and convictions, I could adduce many sources. The most recent intellectual influences are phenomenology, psychology, and philosophy of mind. To ask, however, why I have been reading William James, Oliver Sacks, Thomas Nagel and Bernard Williams while my fellow historians and feminists have been reading Michel Foucault, Julia Kristeva and Jacques Derrida, is only to push the question of intellectual influence back toward autobiography. I see a few clues in my past.

Growing up in the American South gave me an abiding interest in historical context. As I discovered when I went North to college at age seventeen (my first time across the Mason-Dixon line), the South is the only American region with a deep awareness of being shaped by history -- a vestige perhaps of the sense my grandparents, among others, still had of being a "conquered" people. The racism of those grandparents, and the stubborn if not very courageous efforts of my parents to oppose it, lodged in my memory as incentives sometimes to self-loathing, sometimes

to rebellion, but always to self-reflection. Moreover, my upbringing was religious; and the hymns and rituals of my adolescence were surely the place where both my discomfort with body and my budding sensuality found fullest -- and safest -- expression. Arguing throughout my teenage years with a philosopher-mother, who had a Ph.D. from Harvard but was a full-time 1950's housewife, gave me not only a lasting interest in epistemology and philosophy of mind but also a strong conviction that -- as a woman -- I could neither fully exploit nor fully abandon the high achievements of western civilization. Surely these ways in which I was marginal, but incompletely so, led me to a sense that I was the white, female body I inhabited -- a body constructed (and constrained) by my culture -- but that I also profited from, and bore the burden of, a common human experience. More recently, being the adoptive mother of a minority child who suffered extreme emotional and physical damage before she came to me, well beyond babyhood, has made me chary both of ignoring "oppression" and "marginality" and of using these terms lightly. But -- above all else -- it has been the responsibility for a parent who has suffered more than two decades with severe Alzheimer's disease that has shaped my sense of body history.

My father has not known me for fifteen years. He can neither stand nor sit. He is incontinent and unable to feed himself. He makes no eye contact, appears to hear nothing; he mumbles, but the sounds form no words. And yet the body in the geriatric chair is my father. The shape of the face, the movement of the eyebrows, the introduction of the rising and falling syllables of nonsense -- those are a person. And that person is living death. Most immediately, then, I was led to read John Perry's Dialogue on Personal Identity and Immortality and Bernard Williams's Problems of the Self by my increasing conviction that my father was not in his mind or in his memories, for those had departed. And I came to feel that the producers and viewers of a good deal of current TV science fiction (Star Trek, Quantum Leap, and Max Headroom are only the most obvious examples) share with me the same disturbing conviction that a self is essentially embodied: a mind, psyche, a stream of memories, cannot body-hop; transmigration of a personal soul is inconceivable (Bynum, 1991a, pp. 239-287; Spicker, 1970). My

present work on the resurrection of the body is really an effort to see how we in the west came to this conviction (not shared by certain other cultures) that body is intrinsic to person.

Two assumptions are thus basic to my vision of the past: first, a sense that beyond the oppressions that divide us there is the common oppression of death; second, a sense that the person is a psychosomatic unit. Surely the books I've read and the pleasures and pains of my life as a scholar and as a woman have led me to these assumptions in ways I can only dimly understand. But I do not think I would be writing the book I am, at this moment, writing without having spent many hours of my adult life beside my father's geriatric chair holding his hand.

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AN AIDS CHRISTMAS

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The virus that causes AIDS inscribes its effects on all of the surfaces of the human body. The lungs fill with fluids. Convulsing bowels spew diarrhea. The feverish brain mirrors an emaciated, perspiring body. Ulcers grow on the insides of the mouth. The tongue swells, and irritated white spots appear on the skin. Blindness and the itches of shingles begin. Incandescent purple patches splotch the face, hands, arms, hips, thighs. For anyone, but especially the gay man, this is devastating. Once handsome bodies shrink to skeletons, and strong men become little babies, cared for, if they are lucky, by lovers and family members. Their need is palpable.

There are, however, few ethnographic accounts of how the gay male dies from this disease; although this issue has been eloquently examined in the Hollywood film, Long Time Companion (1990), the popular press (Shilts, 1988 And the Band Played On. New York: Penguin), and a handful of sociological works. In what follows I offer a case study account, part fiction and part ethnographic, of an AIDS death.

Prologue

Steve Gallagher was a 41 year-old gay activist, and candidate for the M.S.W. degree when he died of AIDS complications on January 10, 1991. He was also a recovering alcoholic with over seven years of sobriety. We were close friends. He took classes from me and shared holiday dinners with my family. Over coffee we often discussed mothers, fathers and our lives.

On a fateful (for me) mid-summer afternoon at Coslows Restaurant, in 1989 we discussed Heidegger, death and Steve's T-cell count. The count was below 20. He had experienced fever, thrush, and shingles. He has tested positive for the HIV virus.

"It happened in the San Francisco baths, that January before I came into the Program. I was a mad man. I went wild. Yep, that's where I got it. Pretty sure about, that! Norm, I'm afraid

to die. I'm afraid to take AZT. That means I really have it."

I was chain smoking Camels, and didn't want to talk about this stuff. I was mad at my wife who at the time was working 90 miles away. That was what we were supposed to be talking about. But Steve took it away from me. I won't let him have his way. I lit another Camel and started.

"You know I don't know what my T-cells are? Does anybody? Maybe yours are really all right. Did you think about that?" He'd have none of this.

"Norm, don't be silly. I have it!" He stared at me hard. "Now let's talk about death. What does Heidegger say about death? You gave me this book for my birthday."

"O.K. let's give it a try. I'm not sure I've got this right. We are born dying. We won't live forever. Knowing that takes a big burden off my shoulders. Like the Program, One Day At A Time, all I've got is the time I have until I die. You know the two concepts go together. All I have is today. I think it is something like this. Now a lot of us think we are going to live forever and we're afraid to die. You've got it over me. You have to accept your own death. I'm afraid to even talk about mine. What are you afraid of? You were born dying. So was I. Now you know. I think the big deal is acceptance."

He comes back strong. "When I was in Oakland this summer, Mother Theresa spoke to the gay activists. She said we were God's gift to humanity and it was her job to learn from us. I like that. We're special people. I can live with that."

We talk back and forth a little more.

"So are you going to take the AZT?"

"Yeah. What have I got to lose. You know now I've got Heidegger and Mother Theresa on my side."

"We didn't get into Heidegger and that Nazi stuff. Just made plans for coffee the next Thursday. The story I want to tell begins about two years later.

* * * * *

When Steve came back from Spain he had changed. not the expected suntan. Pale, withdrawn, on the run, as usual. He had no happy stories to tell. He'd stopped taking AZT.

His body couldn't take it anymore. The T-cells were again below 20. His fever was high and he had no energy. I didn't know what any of this meant. We were having coffee. He tried to explain.

"I think," he paused for a second and looked away, "I'm going crazy. I'm so angry. Norm, what's wrong with me? Dave drove me crazy. He lied to me. We didn't have a private apartment. His landlady checked on us everyday. It was a nightmare. I had to hide in the bedroom. He lied. He lied. The man doesn't know what the truth is!" He stopped.

I got up and got us more coffee. Came back and cross my legs. He went on.

"It got worse. I couldn't sleep. Those damn Spaniards don't go to bed. Three in the morning and they're drunk in the alley below our window! My Spanish did get a little better, Senor."

I guess none of this matters anymore. He died on January 10, 1991. It was quite sudden. That's how it seemed at the time. I guess it all started a lot earlier.

Kathy and I had dinner with Steve and Dave four days before Thanksgiving, 1990. Silver Creek. The new restaurant in town. Polished walnut, gleaming brass, soft greens, pastoral setting. It was the last fight I had with him. Really not a fight. He made me angry. He and Dave were bickering back and forth. Who was going to order first. Who was going to pay the bill. My God! It was his birthday. Kathy wrote it off to the first semester in graduate school. I said he was overworked and overcommitted.

He'd have none of it. "It's Dave. He lies to me."

I let it go at that. I suppose you could see it coming. That October Saturday afternoon we had Celia over to take Nate's high school graduations pictures; the doorbell rings and there's Steve on the front steps. Dave's in the car.

"Norm, I've got to talk with you. He's driving me crazy. We just had a fight in the middle of main street. I get so angry. What is it? My head hurts all the time. The doctor says I have AIDS psychosis. Now they want me to see a psychiatrist. It's new. They don't know what it means. They don't know how to treat it. Is this what makes me so mad?"

As for me, I feel like I'm in the middle

of a three-ring circus. Celia in the backyard with Nate, Kathy, and the cat taking graduation pictures. Celia's girl friend's in the living room. She's afraid to go outside. We're watching Notre Dame play Penn State. She loves football. It was supposed to be a relaxing afternoon. Steve's in the dining room screaming about Dave. Dave's out in the car holding his head against his hands. If they don't get going they are going to miss Diva at the Art Theater.

The phone rings. it's right after the bad dinner at Silver Creek. Dave's on the line. Steve's in the hospital. Seems he's lost his memory. It took two hours to get him dressed. He lost his socks. The doctor diagnosed it as a flare up of the pneumocystis carni pneumonia. But what do they know. Steve's regular doctor is skiing with his girlfriend in Michigan. He's due back on Monday. Everything's fine. Dave's doing better, going to his meetings, handling his classes.

Another phone call.

"Norm, I've relapsed! I've been taking Valium. Now I'm hooked. Should I go into treatment? Mark thinks I should. I can get an extension from school. What should I do? I've got three pills left. I started taking them for anger."

Now he's got me. I don't know what to say. "Throw them out. Get to a meeting. You need a break. What's wrong with treatment? Let's have coffee and talk about it. Why don't you guys get away for a long weekend?" We make plans to meet.

I've got my own stuff to deal with. End of the semester. Term papers. Grades. Christmas trees, lights, cards, presents. Driveway full of snow. Christ, what next?

On December 10 it gets more complicated. Another phone call. Steve's back in the hospital. He's been there for four days. Now he can barely walk. He has no appetite. Dave doesn't know what to do. Can we come see him? He's at Carle. He's in the Hospice. We don't get it.

We make a trip over. Bryan comes with us. Christmas candies in hand. Double park besides the emergency room entrance. Slip on the ice. Find the room. Sixth floor. We walk into a museum. Pictures of Steve everywhere. The Spain trip. The summer trip to England. Ken and Steve at Allerton. Steve and his mother. His smiling face everywhere, tanned, slim waisted,

always dressed in one of his ensembles, as he called them. His diplomas on the wall. Christmas cards from all over the country tacked on the door. A little Christmas tree in front of the window. Blinking Christmas lights strung over the bed, run next to his IV tubes, and the cord for the bell to bring the nurse.

There he is. Propped up in his bed. Three teddy bears in his arms. His gold necklace looks too big. His head against the pillow, face against the wall. Dave warns us. "He may not remember you." As usual Dave's wrong. Bryan starts.

"How ya doin?" Steve turns his head.

"Where have you guys been? Hi Kathy.

What do you want for Christmas?"

We are both stunned. He looks so small.

Kathy tries a line. "Dave says you can't talk. I told him he was wrong. Gallagher is never without words!" Steve agrees, with a tiny grin.

"What does Dave know?"

I lean against the wall, next to the Christmas tree. I stumble for words. I don't know which way to go. "How you doin'? Where's your Big Book? How's your spiritual program? Are you talkin' to the Higher Power?" Now I feel bad. I've come on too strong.

Dave nods. "Talk to him." I'm still lost.

"What's going on here?"

"Can't hurt," I mumble. "Listen we've gotta run. Be good, we'll be back. Bye. Merry Christmas.

We get our coats and head for the hall. Dave follows. Bryan stands next to Kathy. I turn on Dave. I'm mad.

"Where's his Big Book? Where's his A.A. literature? What's going on here? He needs the program! What are you people doing to him?"

Dave, ever calm,, "He's dying. That's why he's in the hospice. He's got toxoplasmosis. It's a parasitic infection of his brain. There's nothing they can do." I won't have any of it.

"You mean you're letting him die. What does he say about it?"

"He's given up."

"I don't believe it. I want to talk to him."

"It's too late. He's asleep."

Back in the car. Ice again. What to do now?

It's like there's two Steves. Two people, two bodies, one belongs to A.A. All the principles, sobriety and that stuff. Now there's an

AIDS body, and these people don't understand A.A. He belongs to them, not us. I guess Steve held all of this together, but now it's falling apart.

The doorbell again. Edward, his old roommate. "Matt's wired his brother in Los Angeles. They have a new drug for what Steve has. They're faxing an article. Maybe it will help. You know he's given up. It was his decision to relapse. If he hadn't relapsed he wouldn't be almost dead. He didn't go to his meetings. Oh, I can tell you the stories."

I can't believe it. This is Edward talking. His old roommate. He's known Steve for years. O.K., so he can't deal with his own situation. This is Mr. Perfect. The man who had to have a dentist tell him he was HIV positive. This is the man who eight months ago had shingles and said it was a flare up of childhood measles. This is the man who had purple blotches all over his face and legs and said he bruised easily! Give me a break Edward, where do you get off saying Steve relapsed! I can't listen to this. I go to the kitchen and fix a big bowl of ice cream.

Kathy won't let him off the hook. "What do you mean he relapsed? The doctor put him on the valium! He was under doctor's orders."

Edward won't back off. "You see you don't understand. This is all spiritual. When my Program is working, I'm doing fine. Steve didn't have a program. That's why he's dying. It's simple. Don't you see?"

"That had nothing to do with being HIV positive."

We look at each other. I ask with my eyes, where are you going with this? He sees the message. "I've gotta go. You guys take care."

Now I'm really confused. Everybody's got their own theory. Kathy and I think Edward is in denial. Edward thinks Steve is in denial. If he'd accepted his alcoholism he'd never have gotten AIDS. I don't think it works that way.

It gets worse. Another phone call. Another Steve. Not the one who is dying. This is the Steve who calls to ask me if I'll help write the obituary for Steve.

"He's not dead yet," I scream. "What are you doing?"

"Don't get alarmed. We're making plans. You know you're one of the executors. We're meeting on Sunday at the Courier to plan the funeral."

"But he's not dead yet," I mutter. I put the phone down and walk away. I feel trapped. "O.K. I'll be there. Gallagher would get a kick out of this. He's certainly getting a lot of attention."

Five of them are there when I arrive. Sandy, his lesbian sponsor. Mark, his old friend, the nurse. The other Steve, Mr. Organizer! Jerry, an old friend who has his head screwed on straight. Dave, Mr. Nowhere Man, Mr. Out of It. I squeeze in and order coffee. Me, his other sponsor. It gets going fast.

"He doesn't want his mother in the room. She called last night."

"His father called. Can you imagine that? I thought he was dead."

"He wants a memorial service two weeks after he dies. Mare said we can have it in her house."

"He want's Mike from Kansas City to speak."

"Dave gets his money after expenses."

"I read his journals last night. Very interesting man. I don't think I ever knew him. Um, the Gallagher Journals."

"What do you want in his obituary?"

"What should we say about A.A.?"

"You can't say anything. It's an anonymous program."

We're back in the hospital. It's Christmas day. Kathy brings a plate of turkey, mashed potatoes, gravy, cranberries, chocolates for dessert. We walk into a crowd. Five gay men surround the bed. Steve's asleep. What are we doing here? "Merry Christmas" I say to no one in particular.

Dave takes over. "Steve, Norm and Kathy are here. It's time for Christmas dinner." Then he turns to us, "How are you guy's doin'?" He had a good night. He sleeps almost all the time now. I don't think he can eat anymore."

Steve's head moves slowly. His eyes stare at the tree at the window. I think he smiles, but I can't be sure. He moves Teddy away from his neck and tries to move his body so he looks straight out into the room. His left arm is paralyzed and he can't move it. Tears come to his eyes. His head rolls back, Teddy falls down, and his eyes drop shut. The turkey and cranberries get cold.

We stop going to the hospital. I can't take it anymore. Reports keep coming back. On

New Year's Eve they dressed him up in his favorite outfit and took him to dinner at Rick's: An American Cafe. The tables were finally turned. He used to be maitre-d'hotel at Rick's. Now they waited on him. They said he smiled and had a good time. I doubt it, but I wouldn't know.

It was due to come. The final call. I was watching Bird and Boston play New York. Things weren't going well for the Celtics.

Kathy yells from the kitchen. "Mark's on the phone."

"He just died. He smiled and took a deep breath and looked straight up. We knew he was leaving us. We held his hand and said the 'Serenity Prayer.' I think he understood. He just stopped breathing. We couldn't stop holding each other's hands. We stood there for ten minutes. I think, just saying that damn prayer. He's gone and I miss him!"

I don't know what to say. Why weren't we there? Nobody called us. Why? I feel guilty. I remember that Christmas dinner he couldn't eat. I don't know what to say.

"It'll be OK. Mark. This is how he would have wanted it. He's where he wants to be."

They have the memorial. Huge crowd. A handful of A.A.'s. The gay male and lesbian community is out in force. Social Work faculty mingle with the rest of us. There's a keg of beer in the dining room, non-alcoholic punch, whisky, gin and scotch on the table. It would be easy to get confused. Nobody knows for sure who belongs to which crowd. Mike's speech is eloquent. People take turns talking. It gets weepy. People cough and wipe their eyes. The air is blue from cigarettes. It gets late. We're supposed to go to a wedding reception later. I stand on one leg and then the other. It looks like it's my turn to talk. I can't think of anything to say.

TOWARDS A POLITICS OF THE BODY THEORY AND DISABILITY

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Despite the profusion of stimulating new literature on social theory and the body (Turner, 1984; O'Neil, 1985; Feher, et. al. 1989;

Featherstone, et. al., 1991), no satisfactory conceptual framework has yet been developed for assessing the political implications of corporeal differences.

In part, this situation reflects the neglect of the body in Western political theory. Scholars have tended to ignore the fact that humans are embodied creatures who frequently use their bodies as a means of organizing perceptions of the circumstances and events surrounding them. Moreover, there appears to be at least some epistemological justification for the contention that different bodily characteristics are associated with different perspectives on social and political issues. But such studies have not yet emerged. As Zola (1991, p. 5) has noted "What others have claimed for age, gender, race, and social class needs to be done for bodily experiences (references omitted). Initially these experiences need to be placed at the center of analysis." The purpose of this brief essay, therefore, is to explore the potential contributions that post-modern, phenomenological, psychoanalytic, neo-Marxist, feminist, psychological, and sociological theories might make to a conceptual framework for the investigation of the politics of bodily differences and disability.

Perhaps a major inspiration for the increasing emphasis on the body can be ascribed to post-modernists such as Foucault (1978, 1979). Shapiro (1981) has even attempted to formulate a discursive understanding of disability which is marred by the fact that most of the dialogue about this phenomenon has been dominated by so-called experts and professionals rather than by people who have everyday experiences with disability. Postmodernism does provide a valuable contribution through its critique of the Enlightenment, which may have radically redefined popular perceptions of the body, and its stress on the need to hear the voice of Other. But this school of thought is seriously flawed by the lack of a normative standard for examining prejudice and discrimination.

An increased emphasis on the importance of deriving meaning from lived experience is contributed by phenomenological perspectives. But this approach often has yielded an excessive preoccupation with ontological questions (Merleau-Ponty, 1962). Thus there is a danger that this orientation could degenerate to the trivializing syllogism asserted by the notorious

wag:

To be is to do - Jean Paul Sartre
To be is to be - John Dewey
Scoobedobedo. - Frank Sinatra

The lack of an adequate theoretical foundation for social and political action in phenomenological thought could be considered a serious omission.

Perhaps one explanation for the relative paucity of psychoanalytic insights about disability can be attributed in part to Freud's antipathy to disabled people (Hahn, 1987a), which may have been stimulated by their failure to dispense with the effects of chronic impairments after his initial success with hysterical paralysis. In any event, Freud, who had considered the possibility that the loss of other body parts such as the withdrawal of the mother's breasts during weaning and the discharge of feces might evoke castration anxiety (Fisher and Greenberg, 1985, p. 171) apparently ignored the symbolism of disability as visible evidence of bodily injury; instead, he developed a highly questionable literal interpretation of the means by which oedipal feelings are resolved which included the misogynistic concept of "penis envy." These unfortunate implications could be averted by a revisionist psychoanalytic theory based on the proposition that childhood observations of the presence of visible disabilities may evoke castration anxieties which operate simultaneously as unconscious reminders of the potential punishment that can befall girls or boys for an excessive attachment to a parent of the opposite sex and as a source of reassurance that everyone experiences such feelings. Hence intimate association with women or men with physical disabilities might offer a form of homeopathic relief from social and psychological problems that result from the failure to develop a healthy sense of sexuality due to an inappropriate resolution of oedipal issues.

From a Marxist perspective, workers with disabilities often have been viewed as a major component of the "industrial reserve army" (Gough 1979, p. 25-26). Support for this proposition is indicated by the fact that, in the absence of nondisabled males during World War II, disabled persons, along with women and minorities, were recruited into the labor force by

waiving physical examinations as a requirement for employment only to see these prerequisites restored when the soldiers returned from the war. Scarry (1985, pp. 243-256) also has noted that Marx apparently regarded the body as an integral and extended element in the creation of the use value through human labor; thus the body might also be regarded as a fundamental source of the potentially revolutionary alienation that results from surplus value. Perhaps even more relevant, however, is Marx's notion of "commodity fetishism." As a result of the inundating impact of advertising and media images in the wake of the industrial revolution, corporations may sometimes fail to persuade consumers to purchase the new car displayed by a seemingly gorgeous model on television, for example; but viewers are almost always sold on the model. Marxist criticism can be helpful in examining the pervasiveness of virtually unattainable standards of bodily perfectibility that have been a major source of discrimination against men and women with disabilities (Hahn, 1987b). While efforts to curb the influence of idealized depictions of physical appearance would raise critical free speech issues, their effects might be mitigated by policies such as increased taxes on cosmetic products (Giddon, 1983) and legal restrictions on attractiveness as a qualification for employment (Wolf, 1991, pp. 37-48).

Although feminist theory intersects with the study of the body with a disability at many critical points, perhaps the principle initial contributions of these perspectives can be derived from the concept that "the personal is political" and from the notion of sexual objectification. The former approach seems to offer the promise of eroding the traditional public-private dichotomy to promote an expanded examination of the role of issues of physical appearance and attraction in the political domain. The latter vantage point may allow increased investigation of the asexual objectification of adults with disabilities. Just as women are often viewed merely as sex objects, people with disabilities may be treated as nothing more than sexless things that lack the interest, the capabilities, or the attractiveness necessary to be regarded as sexual beings. In addition, the need to create affective coalitions with other disadvantaged groups including women might

require a re-examination of issues related to gender identity among persons with disabilities.

Even though there have been a few significant attempts to examine the body and disability in widely disparate fields, relatively little research on this subject has emerged within the dominant paradigms of the social sciences. Perhaps the primary sites of the work that has been conducted can be found in psychology and in sociological studies revolving about symbolic interactionism. Building upon the foundation of an essentially clinical paradigm, there was early enthusiasm for the study of somatopsychology (Barker, et. al., 1953), which appeared to diminish when no correlation was found between personality traits and diagnostic categories of disability (Shontz, 1975). Only modest progress has been made through experimental and other measures of attitudes toward disability, and little pertinent survey research has been conducted. Speculatively intriguing but wholly unexamined is the extent to which perceptions of persons with viable disabilities, mythical creatures, and extra-terrestrial beings are influenced by the principle of Gestalt principle.

Increasing promise seems to be reflected by work in qualitative sociology. Anspach (1979) defined the development of a new sense of social and political identity as a major dimension of activism in the disability rights movement. Utilizing concepts such as Cooley's (1983, p. 184) notion of the "looking glass self," it may be possible to explore the connection between personal identity, social prejudice, and political aspirations without blaming the members of disadvantaged groups for their realistic appraisal of the burdens that have been imposed on them by others. Yet the pregnant suggestions that perceptions of physical differences may be shaped by early childhood assessments of what is "like me" or "not like me" (Ainlay et. al., 1986) has not been linked with broader theories of socialization or personal development. Even Goffman's classic study of *Stigma* (1963, p. 144) expressed a highly pessimistic view of the possibilities of achieving political remedies for this form of discrimination. Some mechanism must also be found for separating "subject" and "object" to permit increased empirical investigation of intolerance toward persons with embodied differences that might be considered persuasive by observers who demand verifiable scientific evidence. Most importantly,

there need to be growing efforts to bridge the gap between studies of stigma and mainstream theories of relations with racial or ethnic minorities and other oppressed groups.

Remarkably, the major impetus for social and political change in the second half of the twentieth century has emerged from groups defined by embodied attributes such as race or ethnicity, gender, age, and disability seeking to transform previously devalued characteristics into positive sources of identity rather than from class conflict. It may be premature to call for a new theory of "physicalism," but the significant role of bodily traits in this process seem unmistakable. Hopefully increased theoretical explorations of disability will play a major part in achieving a new understanding of the politics of the body.

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THE BODY IN PSYCHOLOGY

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The fact of embodiment is so pervasive as to be almost unattached until it is brusquely brought to one's notice. The Cartesian mechanization of the body left almost everything of psychological interest to the mind, the substantialization of which has dominated the metaphysics of psychology until very recently indeed. Where then might the fact of embodiment be restored to a larger place in psychology? Certain of the beliefs people have about their own bodies have been studied. What are our beliefs about the size and limits of our bodies and how are these related to other beliefs and to changes in the physical environment. Philosophers have paid a great deal of attention to the role of the spatio-temporal properties of the human body and its material endurance in the genesis and maintenance of a sense of personal identity. In these contexts the human body is treated, discussed and investigated as a thing.

The things that take on importance in our lives are rarely just things. There are at least two dimensions in which bodies take on unthinglike attributes in the ways we think about them and the uses to which they are put. Human bodies are morally protected from physical dismemberment and manipulation. And they are also taken to have significance quite apart from their existence as so much protein, fat and bones. These dimensions have not been much studied for their psychological importance. Yet the

location of the bodies of a person and those who are other to him or her in networks of moral rights and duties are of enormous importance in our ways of using those bodies and of reasoning about them. What it means to have a body of this or that category, tall or short, weak or strong, fat or thin, male or female are matters of the greatest importance. Which sort of body one believes himself to have and the kind of body which others believe one to have are quite fateful. Many people find it important to find ways of so presenting their public appearances that they can actually influence the opinions that others may have on these matters. This may go so far as to demand a change in the external sexual contours of the body.

Studying the ways people classify bodies, and finding out the criteria upon which such classifications are based brings out a very important point. Most of the significant and fateful attributes are, as it is now said, socially constructed. Physical differences such as height, biological sex, skin color, right and left handedness, amount of adipose tissue and reinterpreted as moral or social attributes. The mapping of bodily attributes on to the bipolar distinction between those thought to be typical of men's bodies and those thought to be characteristics of women's bodies is a case in point. Biological sex is bipolar. Almost without exception people are either biologically male or female. But a little upset in the breast enhancement industry would hardly have merited such a furor if its revamping of the female bosom were not a matter of such profound social and psychological significance. If one were to measure the non-genital attributes of male and female bodies one would find that they overlap to a considerable extent. There are many men shorter than most women and many women taller than most men. Such distributions are bimodal. but if we are using bodies as the basis of assigning people to social and psychological categories (boys are rough and tough and girls are sweet and neat) the entire bodily appearance must be made bipolar.

The transformation of bimodal into bipolar distinctions is very widespread. The ups and downs of degrees of body fat illustrate the same point. Fat bodies were signs of worldly

success and moral worth in the last century. Only the poor were lean and fit. Now it is only the rich who can afford to cultivate body forms which were characteristic of peasants in the past.

It seems clear that one important way in which bodies are different from other material beings, things in general, is in the degree of moral protection accorded to them. Why should bodies be morally protected? The answer is again obvious but of great significance. It is because human bodies are bodies of the person. There are no disembodied persons in our moral universe, that is persons with whom we can form significant relations and with which we can normally interact without having recourse to bodily retaliations, even of the most distant kind. Many religions have referred to beings which more or less resembled disembodied persons. Interestingly with the exception of the divine order of beings, the human part of the Christian universe consists of beings who are necessarily embodied. "In my flesh I shall see God". Christians are required to reaffirm their beliefs by reciting a creed, an important and explicit cause of which is the deceleration of a belief in the resurrection of the body. There are other classes of things accorded moral protection in our culture, including animals and works of art, but analysis of what justifies the moral protection accorded to their material beings reveals the presence of a relation or connection to the good of persons somewhere in the analysis. For example works of art are morally protected in part because their destruction would deprive future generations of the advantages of contemplating them. The same argument is used to accord moral protection to the primeval rain forests. The moral protection accorded to certain animals is sometimes defended through a "thin end of a wedge" argument. Treating animals cruelly legitimizes or normalizes cruelty, to the ultimate disadvantage of human beings.

Bodies are used to establish what sort of human being we are, as well as for displaying ourselves as members of the biological species homo sapiens. But there are a great many other uses to which human bodies can be put. Wittgenstein pointed out that in many cases the significance of something is to be made clear by describing how that thing is used or to be used.

If it is through their significance that bodies have psychological importance, a corporeal psychology could be defined as an investigation of the ways people use their own and others' bodies, and a search for the conditions that make those uses possible. For example the fact of embodiment is deeply implicated in the measures by which we seek to control how people behave. Many systems of reward and punishment are built around capacities and functions of the body. The infliction of pain to train and to punish is a commonplace example. The fact of embodiment is a logical fact about people. That is, it is a condition for someone to be just this and no other person. This condition involves the principle that the person be continuously embodied in just this and no other body. Foucault realized that the history of systems of punishment could be divided into two main phases. In the earlier pain, mutilation or humiliation inflicted on the bodies of those thought to be wrong doers was the main form of punishment. In the later, it was the mere confinement of the body itself that served as the punishment. Hold the body and necessarily you hold the man or woman if it is a logical condition of personhood that a person be who they are by virtue of their embodiment in just this body. A treatment that has been reserved for debtors and traitors became the normal way in which crimes of all kinds were dealt with.

The system of punishment is just one among many systems of social control, through which social order is maintained. The fact of embodiment is essentially involved in a system which neither punishes for the act performed nor rewards for abstinence from the act which is disapproved. The threat of a disease is just such a system. If you play with the neighbor's kids, you will get ring worm, and you wouldn't like that now would you? The AIDS epidemic and the uses made of it by moral entrepreneurs is just like ring worm on a more adult scale and at a more adult scale and at a more lethal pitch. I am not suggesting that AIDS, considered within the medical framework of the pathology of the biology of the body is not a serious disease. but it is also available to bring the embodied to heel with respect to their sexual behavior. The psychology of social control is a fascinating and understudied field. The threat of contagion and

the moral panics it enables are very important facets of that emerge in the study of the social technology of mass control through the manipulation of belief.

Why don't we have a pleasure technology and a system of rewards as elaborate and institutionalized as the system of punishments? One part of what must be in the end a very complex answer comes from the fact that the concept of pleasure does not pick out a specific bodily sensation. There is the drilling and the pain of dentistry. But there is no independent sensation that is the pleasure bit of sitting relaxed in front of a log fire in the winter time. There is the warmth and other sensations, to experience which is to have the pleasure. I cannot give you pleasure, only something that you will find pleasing and which you will therefore classify amongst those things that please you. There is an asymmetry then in the bodily sensation that militates against as simple a bodily technology of rewards as there is a bodily technology of punishment. Another facet of this matter must surely be the fact that alongside the pleasures of honor and of symbolic reward the mere offer of something which pleases by the bodily sensation it creates is generally regarded as vulgar and denigratory to the recipient. (It depends of course on the implications. The gist of a dozen bottles of the finest claret is flattering since it implies that the recipient is the sort of person capable of the refined pleasures of an expensively honed palate.)

The second main cluster of uses of the body involves aesthetic judgements. The body is used explicitly as or taken tacitly to be an aesthetic object, at its most explicit as a work of art. A major distinction can be drawn between the aesthetics of good functioning and the aesthetics of good form. Exploration of the former involves an analysis of the way the concept of health is used, while analysis of the latter takes us into the sensitive fields of cosmetic surgery and the body building cults. Several authors have recently drawn attention to the fact that on everyday contexts the concept of health is polysemous. Herzlig (Health & Illness London: Academic, 1973) identifies three main senses of the term. There is the mere absence of symptoms. She calls this "health in a vacuum".

Then there is a widespread folk concept, the reservoir of health. One builds oneself up through diet or through taking cod liver oil to withstand the rigors of winter and the treats it brings to health. Then there is eudemonistic health, feeling just great, "chipper". It is an evaluation of a sense of good functioning that belongs with the aesthetics of dance and other bodily activities.

The body building cults are focussed on achieving aesthetically pleasing bodily forms. If that were all to them they would be rather routine. But even a superficial acquaintance with the cult reveals that the aesthetic principles that dominate the assessments of body shape are extraordinary. Most people find the bodies of fully developed male body builders (and some female) quite grotesque. But this is to miss the central point about the aesthetics of built bodies. It is the use of the "exaggeration principle". Big is good, but huge is better. Why is this principle at work in body building? It is because the body form is meant to display latent power, but metonymically. The same principle governs the aesthetics of the custom car cult, in which the visible aspects of power such as exhaust pipes and tires are vastly exaggerated.

The third main aspect of the uses of the body, which might properly be said to belong to a corporeal psychology, is the body and its parts as vehicles for meaning. The ways the body serves as such a vehicle is very diverse. In the seventeenth century the metaphysical poets drew systemic comparisons between the human body and the geography of the earth, the view of the body which came to be called "anthropography". It was a special version of the widespread medieval doctrine of micro and macro correspondences promulgated by such persons as St. Hildegard of Bingen. This conceit, in its decline as a metaphysics taken literally, gave rise to a great many metaphors and figures, that are still in use not only in the remnants of anthropographies but also in the use of body metaphors in political discourse.

But there is a more general point about body semantics to be made. The body with its bilateral symmetries and its opposition, such as male/female and tall/short, offers an ideal set of signs with which a semiotic system could be constructed. As Saussure has taught us it is only within demensions of contrasting signs that only

one sign can have semantic value. Furthermore the body is also in Barthesian fashion, the bearer of a rich burden of connotations. It is not surprising that Barthes (1968) Elements of Semiology, New York: Hill and Wang) takes Durer's praying hands as a main example in his analysis of the semiotic possibilities of the body.

Several books have recently appeared in which the human body is at the focus of the discussion, for instance Truner's 1984 The Body and Society (Oxford: Blackwell). In preparing for my own studies (Harre 1991 Physical Being, Oxford: Blackwell), as a prolegomenon to a corporeal psychology, I was struck both by the complexity and vast spread of the literature, by the great number of topics that hardly been addressed at all. Much remains to be investigated, more particularly the detailed ways in which the general tendencies in body use are locally implemented.

THE SIGNIFYING BODY

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In some 25 years of teaching medical students, I have always found a vaguely disingenuous quality to their espousal of a holistic approach to mind-body relationships while avidly seizing on anatomical and biochemical evidence and disease terms to assess and treat patients. However, in this confusion, they are creatures of media and consumption as much as anyone. Bodies in various states are now visible on the mass media, and whatever consensus existed about "normal appearance" is now challenged daily. At the same time, technology holds out the fantasy of perfection through bodily renewal, enhancement and extension. The idea of being full embodied while confronting the vagaries of the human condition presents a perfection paradox. The body is seen both as failed instrument and a field for the display of conservatory perfection fantasies. My students and I represent American society; in spite of the dominance of the western biomedical conception of the body (WBC), the body remains also an expressive vehicle, a culturally

problematic signifying entity. I outline here cultural analyses of the body and the postmodernist perspective of Jean Baudrillard to explore this paradox.

Conceptions of the Body

None of the following conceptions is mutually exclusive, and with the exception of the Western biomedical conception (WBC), they flow from French social theory. Each is a metaphor, or way of thinking of (and symbolizing about) something in terms of something else. The meaning of the body, it has long been recognized, is both culture-specific and universal. The body is a wonderful surface for signification. It is also a "natural machine" transacting between "inner" and "outer" environments. It serves ritual and symbolic purpose the world over. Yet, in this century, the WBC is the predominant conception.

The WBC is validated by centuries of scientific research predicated upon positivistic assumptions that the universality of the structure, function, and meaning of the body. It is institutionally supported in law and in the political economy of insurance, funerals and burial, medical care. The WBC includes: a conception of the body as a universal anatomical vessel comprised of heroically ordered systems (musculi-skeletal, event, neurological, reproductive), subject to interventions or treatments that pattern, within a range, the reactions of the body; a theory of disease, and a mechanistic notion of bodily function. The self and body are distinctive yet interacting entities that produce disease and illness. The semantics of the body (how it is cognitively divided and subdivided into "fingers," "toes," "face," "neck," etc.) are seen in western societies as standardized by medical-anatomical discourse conventions and nomenclature. Two structural matters sustain and reproduce this conception. The WBC is sustained by a massive culturally legitimated technology for intervention in and modification of the physical body. Second, legal and political legitimacy is granted to medicine to define the (varied) conceptions of "death," "life," and "competence." Diagnostically Related Groups (DRG's) shape access, cost, duration and even the equality of medical care and to what end (Freund and McGuire, Health, Illness and The

Social Body, Englewood Cliffs, NJ: Prentice-Hall 1991). In spite of contrapuntal themes such as holistic healing, and homeopathy, and religious antipathy to medical intervention, the hegemony of medical knowledge remains quite secure.

At least four other themes in bodily conceptions current in social sciences compete with WBC. These themes are that the body is a culturally constituted phenomenon (cultural context determines the meaning of the body e.g., Mauss, Levi-Strauss, M. Douglas); that the body in "encoded" by the authority of the state and law (Foucault, B.S. Turner, J. O'Neill, D. Armstrong, M. McGuire and P. Freund); that the body is a function of discourse and is a communicative field (Szasz, Goffman, G. Engel). Perhaps the most radical counter-theme in the social sciences, associated with postmodernism, is that the body is a mere simulacra or an incomplete sign. It is a signifying entity, or signifier (or partial sign) without a signified or referent (Barthes, Barthes, Baudrillard). It expresses.

This brief overview suggests that any culturally informed understanding of the body must envision it not only as a physical phenomena, but also as a screen on which cultures can "write" using techniques and symbols. The body is represented but only to and for others (selectively), but to one's self: "...man (sic.) has, at all times and in all places, been able to turn his body into a product of his techniques and his representations" (Levi-Strauss 1987:9 Introduction to The Works of Marcel Mauss London: Routledge Kegan Paul). The body, in Goffman's terms, gives signs and symbols a place and gives off or expresses signs. These themes are represented, perhaps in extreme, in the sociology of Jean Baudrillard. (1988, Selected Writings. Stanford: Stanford University Press).

The Postmodern Body

Baudrillard, whose work exemplifies postmodern analysis of the (meaning of the) body, has developed an elaborate scheme for comparing the exchange or "sign value" of commodities with their "symbolic" or expressive aspects. The exchange value of commodities create surplus value while the symbolic produce an analogous symbolic surplus. Baudrillard argues that modern society commodifies the body

and responds to the seductive capacities of the "ideology of the sign" -- the notion that consumption, the desire for what one lacks, dominates capitalism. Capitalism, as manifested in the political economy of signs, serves to transform use functions (or even bodily functions required for survival) into sign consumption for elaboration and signification. Passive consumption and display is the dominate theme in industrialized societies. Thus, Baudrillard moves attention from the Marxian concern with control of the production function to an analysis of the ramifications of the elevation of consumption over production and exchange and media shaping of consumption.

Baudrillard's analysis of the political economy of the sign serves to "deconstruct," or put in another frame, conceptions of the body and of disability, he sees the body as an object in a field created by the sign system than encodes it (See also O'Neil, 1985). Once the assumptions held in preliterate cultures about the sacra unity and similarity of bodies are shattered, a new social space is created. Consumptive individualism arises, and unity is sought in the constant quest for the new, the desirable, and the fashionable. The circulation of signs marks and differentiates bodies. Each of the senses of functions, marked anatomically in part by the body's orifices and modes of transacting with the outside world, is emblematic. The emblems are converted by post modern society into mere functions of hyperreality, or a set of simulacra (simulations of reality or signs about signs). Modern media, especially advertising, hold up mirrors so that one can see oneself as others want to be seen. Let us consider how the sense functions are consumptive foci.

Vision is believed in America to be a function of the eyes. Commodities produced for eye care may involve radical changes such as transplants of cornea, retina, or the entire eye, and prostheses (to add to or modify functions) such as eyeglasses, contact lens, glass eyes, eye patches, binoculars, are available as are routine care and machines of various kinds. Salves, drops, swabs, oils, and protections such

as face masks, goggles, sunglasses, eye shades, and hats are sold. Enhancements include colored contact lenses, designer surgery to modify the eye and its context (tucks, eye fold reductions for Asian people). Extensions of the visual functions represented by night vision scopes, microscopes and electronic microscope, telescopes and atomic telescopes. Thus, bodily modification, maintenance and health care become confuted with aspects of appearance management and mass consumption.

Audition, or hearing, is associated with the ears. Ears are subject to radical changes in function such as operations to implant plastic tubes replacing the eustachian tubes, transplants or implants of the outer ear, and prostheses such as hearing aides and sign language. Routine care involved use of swabs, salves, drops, oils, and medicine to combat infections and to hasten healing after trauma or disease. Protections such as scarves, earmuffs, hats, and ear plugs are needed. Enhancements such as ear rings, and operations to reduce the size or shape of the outer ear are available.

Olfaction, is a function of the nose. The nose is subject to alteration, although it seems a less rich field for the play of commodification processes of the postmodern society that the eyes. Radical changes are carried out to modify, reduce, or otherwise reshape the nose, to open or close nostrils, or narrow it. Transplants and prostheses are done. Medicines (e.g., allergy shots, pills, and over-the-counter remedies) are used to

reduce nasal sensitivity to noxious weeds and fumes (Little is done to enhance the nose - to make it more sensitive and receptive to odors). It's sensitivity is reduced by face masks (as found in Japan), and nose plugs (for swimming). The enhancement function seems limited to modification of physical appearance, or restoring appearance after accidents or trauma. The nose is an important locus for sexual stimulation. What others smell is related to how one smells oneself, and others' smell of you constitutes your essence.

Digestion, involves taking in nourishment (typically through the mouth), processing it and excreting waste. The mouth is one of the most decorated body parts and is emphasized by cosmetics. The anus is a primary source of interchanges of the body and the outer world and is the focus of much concern (gas, blockage, looseness) in modern societies. Its routine - through too much or too little passing of waste - can be achieved by commercial products to either sooth, or increase or decrease flow. Toilet tissue with elaborate shapes, colors, sizes, decorations and messages is now available. Salves, potions, rubs, suppositories and girdles are available. Various sprays and perfumes are available to reduce the smell of excretia in the house. Enhancements are available. Liposuction of the thighs and hips is used for cosmetic purposes. Other enhancements, such as clothing, are designed to draw attention to the shape, size and contours of the buttocks rather than of

the anus (This is true also clothing covering the penis). Radical changes are undertaken to reshape the interior of the anus, its connection with the lower bowel, intestine and the stomach. Colostomies and ileostomies provide artificial replacements for lost body parts.

Reproductive function is represented by the genitalia. Genitalia are the focus of routine care: salves, rubs, perfumes, and douches (of various flavors). The organs can be modified surgically by sex-change operations, or altered via circumcision and clitorrectomy. Functional changes can be induced by hysterectomies, or vasectomies, and castration, or can be modified by use of condoms, french ticklers, et. Protheses are available such as the inflatable (water driven) penis and dildo. Exterior enhancements for genitals such as coppices have been used historically.

The touch function, although general, is usually located in the fingers and to lesser extent in the toes and surface of the skin. Protheses are available such as canes, crutches, and wheelchairs, and sophisticated radar devices for sensing the environment. Enhancements are the general categories of oils, salves, balms, etc. These, of course, overlap with the general function of makeup. Medical changes can be used to modify finger prints to avoid detection. Surgical grafts and operations are used to replace lost fingers and toes. Any area of the body can be enhanced or reduced in sensitivity by drugs.

The mental function deserves special comment. It is diffuse and yet said to be located in the brain. All bodily functions are influenced and shaped profoundly by modes of mentation and symbolization. The brain is marked as the anatomical locus for "thoughts" and "feelings," and as a source of transducing bodily functions with the outer world. Brains are surgically modified radically (not including full transplants), but including tumor removal, lobotomies, closing off sections of the brain or opening them up after strokes. Protheses are available, while the primary extensions are robotics, electric machine and the electronic computer with associated programs. Enhancements include the vast category of "drugs," prescription or otherwise, and including natural substances that modify consciousness. A wide variety of drugs is available for the mind. Care and maintenance of the mind include adequate sleep, and sleeping is subject to vast number of commercially available items for modification, reduction, and inducement. Some drugs work directly pharmacologically, while others work indirectly on the brain, "mind," or one's moods. These might be mind-specific remedies, aspirins for headaches, or muscle relaxer, or be glossed with specific terms like mood altering drugs e.g., tranquilizers and antidepressants. Self-help, or "mind-work" is the central concern of most modern publications (books, magazines, and newspapers).

In summary, the postmodern body is the signifying body of mere representation. If this

view of the body as a function of the production and consumptions system is extended to include the analysis of the sign of such desire and consumption, the edges of a postmodern theory of the body and its disabilities are glimpsed. Bodies are shown as vessels of reflected, created, lustrous, joy (e.g., "I love what you do for me, Toyota, or "It just feels good" - Nissan); the desired and desirable bodies of the figures who cavort, jump and scream, in ecstasy for money in TV advertisements. The objectivated and idealized representations of the body of the media and one's own body are reproductions of copies of each other, or one is one's perfume, or jeans, or car. Individual smells, shaped, sizes are treated as instantiations of the universal body as shown or imagined. Differentiation for the purpose of selling more jeans, running shows, or perfumes is then in contrast or over against such arbitrary figure-created realities.

COMMENT

If these ideas about the body have relevance for the study of disability, several points ought to be underscored in closing. New frontiers of disability and temporarily able-bodiedness are crazily entangled with consummatory competence. Although these are Western trends, they may have cross-cultural relevance. The metaphorical associations used to discuss the postmodern body above e.g., "medical," "enhancement" retain connotative traces of the terms used in medical and legal institutions. These, also with consumer categories, blind one to the similarities as well as to other differences that might be found by examining any of these expressive functions cross culturally. Conversely, the symbolizing and expressive function of signs can dominate and repress instrumental or medical indications.

The embodied displayed self is differentiated within the codes created and reproduced by advertising and mass media. The body is first encoded within a system of signs and then is represented to the person of terms of this powerful code. Products are merely rationalized in terms of the "utility" or use value. Objects are differentiated as are bodily enhancements, extensions, and care, in terms of the code in which they are cast. The individual is subject to bodily whims, needs and vague desires to

consumer and display (seeking perfection) in the postmodern world. One is not satisfied by consuming objects, or by possessing what once was absent, because each object, once possessed, remains as the signifier of some new, other good. Tension arises between the system of signs (an analog to parole) and the performance of consumption (an analog to la langue). Thus, the quest for consummatory perfection drives the desire for technological modification and enhancement as well as instrumental enablement.

The commodified body is a field for the inscriptions of signs; the body is objectified, itself only "real" in the sense that commodities including medicine, operations, care and therapy are brought for it. It can be reproduced (not only naturally, but artificially via surrogates and frozen and fertilized embryos), and is therefore a "simulation" or hyperreal. Even a child is but a "product" of natural birth, something part from the bearer's self, and easily objectivated and thus bought, sold and borne for a fee.

The ideal consumer in the postmodern society displays a reduced capacity to critically evaluate the several ideologies that foster and reward consumption. The ideology of consumption integrates the system of differentiation, the body, while any given sign stands in part-whole relationships (as a synecdoche) to the body, partial signs constitute whole bodies. And we are embodied as we see ourselves. Joining the instrumental failures, lacks and malfunctions of the WAC are forms of Disabilities, failures of consumption ("Anorexia," "Bulimia," "substance abuse," "Failures of self-esteem") and display (breaking the "residual rules" ordering interaction). The quest for perfection, technologically augmented, grows while the paradox remains.

TROUBLESOME BODIES

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"If something about the human body disgusts you, complain to the manufacturer." Lenny Bruce

Like any murder, psychology has had no end of troubles ridding itself of its bodies. By conveniently adopting a model of research based in nineteenth-century physiology the fledgling discipline committed itself to a positivist and functionalist understanding of persons. And such persons have no place in breathing, living, and dying bodies. Instead, they are to be understood as complex amalgamation of functioning parts, mechanically, physicalistically strung together on some behavioral, or more recently, cognitive account. That by mid-century psychology was entirely body-less is plain from the following account from the introductions to Munn's (1950) Handbook of Psychological Research on the Rat.

Here was the almost mundane claim that:

the rat as a living organism is central...because it is through the study of the behavior of this mammal that modern psychology has made some of its most notable and substantial advance. Hundreds of investigators have studied special aspects of behavior by use of rats as subjects. The results of these studies...have had a most important place in determining the present status of the whole modern scientific psychology of behavior. (Carmichael, 1950)

The rat was the source of raw material for psychological theory and research until well into the latter half of this century. And whereas cognitivism has returned to the "mental", its preoccupation with computer metaphors is equally disembodied. At least the rat was a mammal.

The hypnotized body. In this body-less discipline I was trained well in the norms of research. Embodied persons simply disappear in the act of gathering data. The aggregation of "scores" into "groups" makes the entire enterprise completely irrelevant to any single body which took part in the research. In retrospect, this is all the more peculiar to me since I began my graduate research career investigating hypnosis. Although hypnosis research has one of the longest research traditions in psychology its current manifestations are deeply representative of all that is misguided about the positivist orientation in the discipline. Yet its origins as a research tradition go back to the French medical investigators of the nineteenth century whose

preoccupation with bodies and things psychosomatic were anything but abstract.

The tradition in which I was trained is one where individual bodies are relevant only to the extent that they contribute to some group average. In fact, there is no intention to apply such averages back to any one person. The history of modern psychology, as Gigerenzer has so clearly argued, is driven more by statistical metaphors than theory. Ironically, this is the same discipline that is also consistently critiqued for its individualism. But that individualism is abstract; the functional properties proposed by psychology apply to no one in particular - they are truly disembodied.

As a graduate student I along with some of my colleagues came to experience a consistent undercurrent of dismay which was suddenly brought home when I read Sarason's Psychology Misguided. I had quite seriously conducted research where I asked undergraduates to recite a list of words, to forget those words following a hypnotic induction, and then to try and tell me what she could remember. My only interest, as a researcher, was in which words from the standardized list "subjects" could remember. Or, in other research, how long "subjects" could hold their arms in inflated blood-pressure cuffs as the pain slowly built, or what number a "subject" could give to her pain after immersing her arm in ice-water for 60 seconds. We quite consistently and non-ironically referred to these undergraduate volunteers as "subjects" even when speaking amongst ourselves as researchers.

That there was an element of bizarreness to these practices became clear to me rather dramatically in my first exposure to chronic pain problems. I had designed a treatment program for Temporo-Mandibular Joint Pain and Dysfunction Syndrome at the dental school of a Canadian University. The exact nature of this disorder remains a source of controversy among dental researchers. Its symptoms are pain in the tempomandibular joint and the muscles of mastication with, in most cases, a clicking sound in the joint itself and limitation in chewing. It would both be incorrect to say that the disorder is at the very least strongly associated with stress and stressful conditions. Of course, the term "stress" is itself obfuscatory but I will not take that up here. But the bodies who appeared at my door for treatment were anything but

standardized "subjects." They were bodies traumatized by accidents, by grief, by loneliness, and by isolation, by dismal working conditions and so on. At the time I tried very hard to follow a "standard" regimen but I saw later how foolish this entire enterprise was. It created in me a further conflict about research and my profession - the "treatment" was incidental to all the various conversations that took place around the treatment. But it was the success of the program I had designed that would enhance my professional status and thus the program is what counted.

The Cancerous Body In July 1983 I began working as a psychologist in a cancer treatment facility, first as an intern and then as a staff member. This lasted for four years but the life I lived there is one I still "see through a glass darkly." Let me try to explicate this life with the simple observation that bodies smell. This is clear to anyone who spends time in a hospital. What such institutions try to do, of course, is rid themselves of that smell. But they are unsuccessful and instead what remains is a peculiar mixture of the bodily with the antiseptic that gives medical institutions their distinct odor. In his history of Montreal during the smallpox epidemic of 1885, historian Michael Bliss graphically detailed the relationship between stench and disease. Until the late nineteenth century it was still common to encounter the belief that most infectious diseases were caused by miasma, or poisonous gasses, which emanated from decaying animal and vegetable matter. Our current olfactory sensitivity is scarcely a century old.

The repression of smells remains a salient feature of my employment in the hospital - it represents one of the features that most people readily acknowledge as an aversion associated with hospitals. In it we find the repression of the body in its treatment. Bad smells are still signs of the plague, even if that plague now goes by the name of cancer. The smell of diseased bodies is the smell of mortality.

But bodies are not just repressed - they are handed over by patients for what is often life-saving treatment. The body becomes an object of medical practice; its individuality as the embodiment of a person is denied in that practice. This disassembling of the body from the

characteristics of identity is a process so well described by medical sociologists and anthropologists. So it is not just that the body is repressed but the connection between our identities as persons which are designed to treat those bodies. And a great deal of work must be done to maintain the separation.

This makes the psychologist in a medical facility a conflicted person at the best of times - a condition magnified in a cancer treatment setting. Trained to think of the problems of living as problems of cognition and behavior, the psychologists come ill prepared to deal with stinking, healing or decaying bodies. Further psychological or psychosocial services are not viewed as an integral component of the treatment of the disease so they do not have the priority that treatment takes over all aspects of the patient's life. In the hospital, this means that bodies are moved, fed, cleaned, radiated and infused on doctor's orders. It is only when those bodies are troublesome (they cry, they don't show up for appointments, they attract disagreeable relatives) that the "psychosocial" services are requested to provide "care." But such care is implicitly meant to regulate (discipline) those bodies and make them amenable to treatment.

Dying bodies. Sometimes such bodies are "beyond" any treatment, they are palliative. Then they become administrative problems - they require housing, specialized feeding, various forms of medication meant primarily to reduce pain, and, finally, disposal. In the absence of hospices and specialized and separate units for palliative care, (which was the case in institutions where I worked) such bodies must be regulated on active treatment units. Physicians generally withdraw from such cases except for routine visits. But the involvement of the psychosocial worker (and other auxiliary workers) increase. As the body begins to die, that body's family becomes more involved in the process of dying - in the care and comfort work required for the dying body.

What I have just written is unusual or has a peculiar ring to it only because we are accustomed to speaking of the death of persons, not bodies. Or, if the body enters such talk it is only as a property of persons, something we have. Thus we understand such talk as "he was lucid to the end but his body simply gave out" as

a common way to express this duality. It is precisely the body however that is the focus of the activity that surrounds death from a chronic illness such as cancer. The negotiations of that death by the ill, their family and friends, the medical authorities and the services they may provide serve to hide or otherwise confuse the fact of the case: this body is dying. Only the appropriation of that fact and the placement of it in a central frame of the entire negotiations is, ironically, the only way in which the person that is (also) dying can retain the dignity we assume the dying should and sometimes do have. And I think sometimes even so-called palliative care experts thwart this process by re-mystifying and professionalizing death itself.

But the language still strains; persons do not die in addition to bodies, they are embodied. How then does a focus on bodies return us to an understanding of persons? Persons are both emergent and incarnate, a point made by Joseph Margolis some time ago about mental events. Bodies are the foundations of development, the source of action, and the necessary seat of personhood throughout life. Or rather, personhood includes within it the understanding of embodiment. The current outpouring of books and papers on the body has made this point clearer - we have neglected the body at our intellectual and personal peril. In my view, and in my experience, it is here that the psychologist as a trained professional is poorly equipped. My training so fully inculcated psychology's dualist and functionalist narratives that it is only in resistance to the profession, that is, in reflecting on my own experience as a "fellow body" that care was at all possible. I am not saying that there should be no psychological workers involved with the chronically ill and dying. Quite the contrary - modern medicine can make such professionals important allies for the ill and their families. There are deep contradictions, however, in the practical education and training of such professionals. In my case, these contradictions only became clear as I became involved in the lives of the ill.

Professional Bodies Involvement has its price. It is a privilege to enter rapidly the private worlds of people at times of great crisis. People speak freely, give up details of their lives long held only for themselves or close intimates and often express feelings they would normally

withhold from any but their most intimate relations. It is also a dangerous moment wherein one's most intellectual and professional baggage can wreak havoc with vulnerable people. I have seen much of the latter, some of it caused by my own insensitivities and professional blinders. I have also seen profound changes in the lives of the ill which I have at times attributed to interventions by psychosocial workers.

What I said above, reflecting on one's own experience as a fellow body, is a gloss of course for an entire range of possibilities. It is also a stance that is perhaps yet possible in today's medical institutions. But it is one that is taken only at a cost. Repudiating one's profession does not come easy (nor is it always necessary). But in cases where one's moral and human judgements simply require that one side with a patient on a particular issue, the constraints are powerful and the rewards for maintaining one's professional distance are many.

Hospital administrations and university affiliations combine to keep the professional just that. One is encouraged to take part in conferences, do research and apply for grants which maintain the language and the ideology of the professional. And the model is all pervasive in medical institutions - I recall the shock upon hearing the director of volunteer services at a major cancer treatment center state matter-of-factly that her aim was to take well meaning individuals who volunteered out of altruistic motives and turn them into "unpaid staff." This required structured screening interviews and an elaborate training program with the net result that, indeed, volunteers could be relied upon not just to provide tea or coffee to patients in waiting rooms but also to engage in duties otherwise requiring paid professionals. Naturally, the administration of the institution held the director in high regard.

The dependence of my position in a professional model created more than passing discomfort. To speak with the ill, I required a professional demeanor which I had to (minimally) maintain in the presence of co-workers, health care staff and patients themselves. Frequently patients pushed me back to a professional model in their search for rapid answers to existential questions. I was forced to acknowledge the niche provided for me by my professional credentials. I did, after all, complete

a course of studies to obtain those credentials.

But the discomfort came precisely in my interactions with patients when I recognized either a resistance or a struggle with the social and personal requirements of being ill with the recognition that there were in fact such requirements which were deeply embedded in their daily interactions. Such requirements came in various guises and subtly communicated expectations. They could come from anyone; family, friends, medical staff, work settings, and so on. Here patients were frequently annoyed or confused, their frustrations often directed at the medical institution. This required of me that I be a discursive acrobat, confirming patients' interpretations, fears and hopes while all the while maintaining a professional stance or a certain distance. More often than not it required intervening with medical personnel on behalf of the patient.

Of course such discomfort was not always present nor always a concern. And we frequently live in multiple contradictory worlds. But my comfort here is to show how this contradictory stance required a form of practice that reinforced the body as a strictly biological, medical entity and belittled the patients' own reflections on their bodies and illness. To take seriously one's own experience and to ask that it be respected by those charged with the treatment of one's illness led to internal conflict for the patient and, in the very least, to disagreements with the medical staff. These might be manifest in no more than passing comments or occasional questions which the staff could readily ignore. But staff members had subtle ways of codifying these conflicts in conversations, case reports and chart notes. For example, two frequently used adjectives appeared in charts, "pleasant" and "inappropriate," as in, "this pleasant 45 year old lady..." or "Inappropriate questions by the patient..." One young man traveled to Nicaragua during the height of the contra war and actually found himself in the midst of a contra attack while there. After his return his physician penned the following note on his chart, "we will continue to treat him if he doesn't insist on getting his head shot off in Central America." (In Canada, patients rarely see their medical charts and hence such notes can be used more liberally than they might if access to files was available).

But I do not want to paint an entirely

negative picture of the medical staff who are themselves deeply enmeshed in the models they espouse. When we received referrals from physicians or nurses it was common to follow-up the referral with a brief conversation. In such cases, professional discourse drew the psychosocial worker into the "inner circle." Vaguely understood or defined terms such as "depression anxiety" or "adjustment disorder" could be used without questions and the patients' problems were cast in such pseudopsychiatric terms as a matter of course. Naturally, if the terms were simply bald assertions of professional dominance one could readily ignore them. But no such obvious power games go on in professional discourse. Instead, the language drew on all the resources that legitimized the institution and the professions and thus legitimized itself. And when spoken between two "fellow professionals" with casual references to our common plight in dealing with such cases, the discussions took on an air of reality that made it seem difficult to think of any other formulation of the patient's life. And that formulation required the most stringent adherence to the medical understanding of the patients illness and body. Any experience outside of that definition was seen as deviant, irrelevant or problematic, but not part of the medical understanding and treatment of that body.

Body Stories. Two examples illustrate the point: One of my first referrals was a woman in her 30s who had major surgery to remove a gynecological tumor that had spread throughout her pelvic region. A month after surgery she could still not walk and experienced severe pain which the physician, in my view (and according to standard medical practice for treating cancer pain) was undermedicating. I finally went to the physician in his office at a time when we would not be disturbed and delicately introduced the topic of increasing the patients dosage of morphine. His casual response was that he would be "happy to re-assess her and increase the medication. I was trained in Detroit and there we treated everyone as an addict until proven otherwise." He did increase her dosage but the event was, for him, no more than a casual conversation. In the meantime, however, the patient suffered unnecessarily for over a month. Although I could not confirm this, my suspicion was that because she was a Native woman her

pain complaints were not taken seriously.

The second case was that of a man in his early 40s who had been informed that he would die following the second recurrence of his colonic cancer. He had quit his job and he and his wife had moved to a quiet location in the mountains following his initial diagnosis, "to enjoy whatever time there might be." Following surgery, chemotherapy and radiation it was finally determined that his case was terminal. He was then seen by a surgeon who said he might be able to save the patient's life if the latter was willing to submit to the removal of large portions of the abdominal cavity followed by surgical reconstruction. The man agreed. Six months later he was still in the hospital recovering very slowly from the massive surgery. His wife, who was his main support, began to experience episodes of depression after the prolonged stress. She no longer knew whether she could envision a life with or without her husband. The surgeon was singularly unhelpful in alleviating her anxiety and, when the colostomy nurse and I called a case conference, he simply said the wife suffered from a "personality disorder." When I later confronted the surgeon alone about the problems the couple were experiencing, his dismissive response was "that's what happens when you bring them back from the grave." After a long and painful recovery the man died of yet another recurrence of his cancer.

It is only in recent years that I have come to see the sense in which one's identity is experienced as embodied. The repression of the body is also the confinement and limitation of one's identity as a person, and the restriction of one's moral world. Ron Harre notes that the pronoun "I" is doubly indexical. It refers not only to our bodily location in time and space but as well to our rights and obligations (our moral groundedness) as the speaker of that pronoun. But surely our moral groundedness is restricted if when we say "I" our location in time and space is itself doubtful, unknown, and classified by institutional prescriptions. On the other hand, when the "I" that is spoken is doubtful because the existence of that body is doubtful, but we can tell the story of that existence and its doubtfulness, we have regained a measure of what it is to be human.

A psychology of the body seems a long way off. My own embodiment as a psychologist in

a cancer treatment facility has convinced me of the futility of a psychology without bodies.

REFLECTIONS ON SOMATIC SOCIOLOGY

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On the assumption that autobiographical details may in the long run play some part in helping us to understand the origins of intellectual trend, in different periods, I want to reflect in a personal way upon my own involvement in the recent development of the sociology of the body. My "own" ideas about the importance of a sociology of the body was, in retrospect, very clearly shared at the time by the sociologists around the English journal Theory, Culture and Society, by John O'Neill (1985), by David Levin (1985) and many others. It was also the case that many of these trends in intellectual life had been deeply influenced by French social theory, and in particular by Michel Foucault. The academic community which has produced an appreciation of the importance of the body in contemporary societies is clearly world-wide, and, as I have suggested elsewhere (Turner, 1991), these attempts to re-appraise the body have been shaped by important social movements and changes, including feminism, ecologism, the aging of populations, medicalization and developments in what has now been called green consumerism. In a forthcoming study of Regulating Bodies (Turner 1992), I summarize these global changes under the general notion of "the somatic society", namely a society in which the limit of the body comes to determine production and consumption. With these cautionary comments in mind, I want to offer some reflections on why the body is a crucial area of contemporary analysis in the humanities and the social sciences.

Quite what a sociology of the body would entail has yet to be clearly worked out, and there are in any case strong arguments to suggest that we should attempt to thematize the social sciences and the humanities around the body and embodiment rather than seek to construct a sub-discipline, which will inevitably suffer from arid professionalization with the

creation of specialist journals, societies and academic career-paths (Frank, 1990). However, behind the professional question - a sociology of the body or somatization as a conceptual theme? - there lies a more profound, pressing and important question - what is the body? Again with some degree of hesitancy, I want to suggest some contrasted, but I believe compatible, lines of approach to this philosophical question by a retrospective overview of my own work on the body. The argument is that I can detect in my own hesitant and eclectic approach a possible solution to the tension between phenomenological, sociological and post-structural orientation to the body.

My own academic interest in the body grew out of a prior personal interest in the sociology of religion, which as a postgraduate had been profoundly influenced by Max Weber, Peter Berger, Thoman Luckmann and Alasdair MacIntyre. This group of sociologists and philosophers were primarily interested in the problem of meaning in a world characterized by evil, suffering, injustice and pain. Whereas those sociologists who have followed the work of Emile Durkheim have been principally concerned with the problematic nature of social order, the Weberians have all been driven by the classical problem of religious theodicy - if the God of Abrahamic religions is both absolutely just and good, why does evil exist in the world? It was Weber who turned this traditional theological debate into a sociological inquiry into the problem of meaning in social life and its ideological resolution through various life-orientations or soteriologies, especially mysticism and asceticism (Turner, 1981).

Reading Weber closely I was impressed by the fact that the human body appeared to play a large but unrecognized role in Weber's sociological conceptualization of the question of meaningfulness. Weber was attentive to the religious problem of the body in western cultures, especially with respect to sexuality, hedonism, the representation of the body in art, the question of violence against the body, and the struggle between agape and eros in the emergence of norms of reciprocity and altruistic love. The problem of meaning in western culture appeared to arise uniquely in respect of two issues, namely the frailty of the body in terms of sickness, pain and death, and the unreliable, uncontrollable and

unpredictable rebelliousness of the body, which defies human will and intention. On both counts the body appears to challenge or to defy what Weber regarded as the underlying principle of western civilization, that is the guiding principle of instrumental rationality. In Religion and Social Theory (Turner, 1983), I tried to explore this issue in Weberian sociology by arguing that the central task of religion was to impose rules and regulations on the body. One could see the spiritual disciplines of the Church as one endless vigil against the waywardness of the body as flesh. In short, my original interest in the body was motivated by ethics-religious debates in sociology about the problem of meaningfulness of human embodiment.

In much of my later reading of sociological theory, I came to see that this underlying tension between spirit and flesh, mind and body, culture and nature was a fundamental dichotomy in western thought, which has been based on an image of human beings as homo duplex. It was through a close study of the philosophy of Nietzsche that I came to believe that western social philosophy was grounded in a (male) preoccupation with the tensions and dilemmas of sexuality (the principle of Dionysus) and the civilized requirements of a stable social order (the world of Apollo). One can see this debate as fundamental to the development of the thought of Freud, Weber, Mannheim, Elias, Durkheim and many others. I attempted to develop this interpretation of the influence of Nietzsche on western thought with my colleague George Stauth in our Nietzsche's Dance, (Stauth and Turner, 1988). The argument was that Nietzsche, having declared that God was dead, attempted to ground his revaluation of values in the importance of the comfort of the body in everyday life. A healthy moral life required people, not to deny or suppress their embodiment, but to express their embodiment through creative activity, especially through art. Thus, for Nietzsche aesthetics was not a neutral, disinterested and rational appreciation of truth and beauty, but an embodied, sensual practice.

Some of these arguments were an extension of my The Body and Society, Explorations in Social Theory (Turner 1984) where I had criticized the cartesian assumptions of classical sociological theory, which failed to recognize the presence of an embodied social

actor in the theory of social action. To some extent, the aims of that book were relatively limited. In part, it merely sought to review the absence of the body in various types of social theory from Marxism to functionalism. However, I was already heavily under the spell (I use the word deliberately) of the work of Michel Foucault, and I used his persistent interest in the history of the body as a means of developing a topology of the body and societal problems of reproduction, regulation, restraint and representation. From this study, I tried to develop the theme that the social regulation of the body was in fact closely related to the problem of patriarchal authority, the accumulation of private property, the regulation of female sexuality and the establishment of hierarchal authority. In a system of primogeniture in medieval Europe, there was a clear need for heads of households to regulate female sexuality in order to secure the continuity of their property. The interpretation of the relationship between the body and property was the basis upon which I came to argue that religion and medicine were two interrelated systems of social control through which patriarchal authority has been established in human societies.

This idea was the starting point for my more general study of medical sociology which was heavily influenced by Michel Foucault, namely Medical Power and Social Knowledge (Turner, 1987). There were two guiding themes in that study. The first was that with the secularization of western culture there has been a gradual and uneven transfer of moral authority from religion to medicine, and that consequently the moral authority of society is exhibited in the everyday routine of medical encounters between sick patients and their doctors. With the medicalization of society, regulative practices of the religious order (such as the confessional) are transferred and reconstituted and in medical practices (such as the clinic). The second argument was essentially epistemological, namely that the body can be conceptualized through various frameworks, but we do not have to adopt an exclusionary view of these competing paradigms. By contrast, I suggest that medical sociology can operate at various levels - by reference to the phenomenology of illness and illness experiences, in terms of the complex web

of social roles which are organized around 'the sick role' (Parsons 1951), in terms of the social organization of health care, and with reference to the political economy of health.

This epistemological argument was an attempt to reconcile two conflicting views of the body. In conventional sociology, ideas (such as "the body") are held to have some foundation in reality. The relationship between ideas and reality can assume various forms - indirect, mediated, reflection, or whatever -, but foundationalism assumes that there is a solid reality against which we can in principle examine our beliefs. By contrast, anti-foundationalists argue that "nature" is in some sense constructed. The "natural world" is the product of, for example, scientific discourses. It has, as a result, become fashionable to argue that the body is a symbolic order which is constructed by and represented through social discourses. There are many good examples of this type of argument in a number of important studies of the body - Making Sex (Laqueur, 1990), Simians, Cyborgs and Women (Haraway, 1990), and The Woman in the Body (Martin, 1987).

In my own approach, I have tried to transcend the dichotomy between a foundationalist and anti-foundationalist interpretation of the body. I cannot go into the various philosophical arguments for integrating the arguments that the body is a system of signs and the body is an organism. The basis of my response is developed at some lengths in Regulating Bodies (Turner 1992). Suffice it to say that my reservations about anti-foundationalism is that it precludes a universalistic moral debate about the nature of human embodiment, the problem from which I started in my analysis of Weber's notion of theodicy. Anti-foundationalism makes it difficult to have a sociological appreciation of the nature of pain in human existence. I want to be able to go beyond the claim that pain is constructed by the discourses which are available in societies, a sociologist with an interest in discourse might argue that pain is represented by a language of attack, defense, violence and so on. Pain is, in these terms produced by military metaphors. I do not doubt this claim, but in my view there is still a phenomenology of pain, which human beings, because of their embodiment, share to some extent in common. Without some notion that

pain is a response of the body to some organic crisis, it is difficult to see how Arthur Frank could write At the Will of the Body (Frank 1991) as a reflection on his own illness with the intention of providing a general guide to others. To believe that body pain is only a set of metaphors within a discourse of illness is to adopt a position which, when I was a child, was called idealism. To control pain, we will need more than merely a redescription.

The view which drives me to try to adopt some version of foundationalism is the (possibly old fashioned) notion that sociology is ultimately a moral science, that is sociology is in the last analysis concerned with the fundamentally ethical problems of social existence. For me, there are two basic questions: what is pain? what is justice? It is obvious that there are the traditional problems of social theodicy. As I write this short note on the body, I am suffering from a severe bout of sinusitis. It is winter and through most of the autumn I have had an endless invasion of colds, leaving me with a painful inflammation. It is no comfort to me to know that this "pain" is an effect of medical discourses about "mucous membranes", "deformity of the cartilage" or "swollen passages", or that my colds are articulated through a series of hidden metaphors - suffering, bouts, invasions. My troublesome pain is for me a small but effective reminder of the essential frailty of the body. In my current work, which covers both the sociology of the body in the field of health studies and citizenship in the area of political sociology (Turner, 1986), I now realize that I am intellectually converging on what we might call the sociology of frailty. On the one hand, it is the frailty of the body, as indicated by pain, morbidity, and death, which has been my (largely and previously unrecognized) concern. On the other hand, it is our social frailty as indicated by scarcity of social resources, which has been my guiding concern in my pursuit of a sociology of citizenship.

In my future research I want to integrate these two concerns (with personal-organic and social-institutional frailty) into a more coherent project, which would, amongst other things, consider our citizenship rights in relationship to our phenomenologically sovereign embodiment. I have begun to devise a number of projects which would examine these interconnections with

reference to key life-events and life-processes, such as birthing experiences, aging, disability and death. In a previous "analytical review" of research on the body, Arthur Frank (1991b:36) half-seriously asked what might have happened to sociology had G.H. Mead's classical text (Mind, Self and Society) has been given the title Body, Self and Society? The suggestion is in fact a stimulating idea, since Mead's study did have the subtitle from the standpoint of a social behaviorist and Mead was concerned to understand the interaction between embodiment, symbolism and speech. For example, in my Regulating Bodies, I consider how the hand has been seen by Mead and many other social philosophers as fundamental to the emergence of language. The dexterity of the hand has been an essential feature of the emergence of complex symbolism. From the point of view of a sociology of the body, I think it would be beneficial to go back to the classics to see how we can reconceptualize the relationship between body image, gesture and social status. One starting point might be Paul Schilder's The Image and Appearance of the Human Body (Schilder, 1964). In more specific terms, this repossession of the classics might provide a more solid foundation for a sociology of disability in order to analyze the relationship between body functions, body image, self esteem and social relations. I am as a result currently re-examining the literature on hand injury and hand strain from this standpoint of phenomenological sociology. I hope such an approach might enable me to improve on a previous commentary on repetitious strain injury (RSI) (Turner, 1987:14-6).

These current interests in certain aspects of human embodiment are part of a scientific project which is based on a critique of existing theories of social action, but it is equally clear that objective scientific interests, if they are worth having are driven by values and these values are typically grounded in traumatic autobiographical events. RSI is important for me because, some months after buying a new electrical type-writer in the early 1980's, I experienced severe pain in the region of my upper arms and shortly after my fingers began to lock into a painful claw-like posture. Holding things became painful and I quickly discovered, as an academic whose career was largely based on writing books, that I could no longer write.

The story of how I eventually "cured" this problem is too long and boring to repeat here. However, I was recently reading short passages from Martin Heidegger's account of the hand in his volume on Parmenides in Heidegger's collected works where he argues that animals do not have hands; they have claws and paws. On reading this contentious piece of philosophical anthropology, I felt that chronic RSI must in Heideggerian terms reduce the victim to the animal kingdom by converting the beautifully subtle dexterity of the hand into a thing-like claw. While Heidegger's account may be bizarre, it does remind us of a useful distinction in the German language between Korper and Leib as two inseparable but distinct dimensions of embodiment. Korper refers to our objective-instrumental body, which we might render as the body-as-environment, as an "it". By contrast, the body as Leib is the subjective "lived body" for me, my body. The diseases and disorders of Korper are my tribulation and illnesses as an embodied person (Leib).

This distinction can be useful for sociologists. First we are familiar with the sociological critique of the medical mode which argues correctly that medical sciences tend to treat the human person as only Korper. The medical model treats diseases of the organism, neglects the social reality of the patient and has no scientific discourse to understand me as also Leib. However, in my view, sociology often commits a mirror-image mistake. The constraints and opportunities imposed on me by my body as Korper are often ignored because sociology defines "the agent" as an actor with values and norms who selects goals in a means-end scheme of rationality. A more adequate sociology will have to incorporate the complex interactions between Korper and Leib into its analysis of the self and society. Hence, Arthur Frank's humorously re-titled Meadian classic Body, Self and Society may well be an excellent starting point for a somatic sociology.

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EMBODIED SPORT: PLEASURE BETRAYAL AND DISABILITY

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While much attention of late has been paid to bodily practices and experiences in the context of human health, surely no part of our lives carries more potential for exploring what Arthur Frank (1991) recently referred to as the "self, body, politics, violence nexus" than sport? At first glance, one might be forgiven for assuming that sport infers things done by and to healthy bodies alone. But what of the injured body, the changing body, or the body perceived as a source of defiance and betrayal? Ironically, while popular discourses on sport tend to privilege the former view, these latter experiences are at least as common and, ultimately for all athletic bodies, are inevitably more so. Sport, then, is about active and inactive bodies, and about the selves developed around them by men and women in different social and historical moments.

In this short space, I want to address some of the multi-layered meanings experienced by athletic bodies and the struggles they encounter. I will do this by introducing work that I think is interesting and important, largely from the sport sociology area, but I would additionally like to situate myself in the discourse. Moving toward a critical feminist reappraisal of the arrangement of modern sport and my place in it as a white male, I want to show how emancipated and imprisoned athletic bodies and selves are integrally tied to broader struggles in gender order.

Embodying Power and Pleasure: Emancipating Athletic Bodies

"I watch my daughter. From morning to night her body is her home. She lives in it and with it. When she runs around the kitchen she uses all of her self. She feels pleasure and expresses it without hesitation."
(Mother, cited in Our Bodies, Ourselves, 1976: 383)

We learn very quickly as children the pleasure that comes with movement and free play. Throwing a ball, chasing a puck or climbing a tree or a frame are all potentially empowering, especially as one learns that these bodily skills may be confidently repeated and refined. Learning how we come to inhabit our bodies as adults also is for many inseparable from the process of cultivating these natural talents on playing fields and sports centers. Here, much of what we know of ourselves -- esteem, confidence, sexuality, etc., -- are to be learned, confirmed, reproduced or transformed in association with others. Detached from forces of domination and exploitation, for children and adults there is an innocent but real pleasure in discovering ourselves through our bodies; in discovering what Gilroy (1989) calls an "embodiment of power."

Bob Connell's (1983) essay on male bodies describes my experiences well. Like other boys growing up in a masculinist working-class culture, the world came to me largely through sport and other forceful and physical bodily practices. In a way, connections with crickets or rugby balls were merely moments in a broader series of masculinizing bodily exercises imposed upon me by the surrounding culture. Oblivious to the profoundly privileged manner in which I encountered sport as a white boy in a racist and sexist society, I knew my sporting body as a vehicle of self-actualization and a refuge whenever things went wrong. "Full-back," "captain," "player," became master statuses of sorts I carried with me into my teens. To me growing up, the "existential high" (Messner and Sabo, 1990:14) of slipping a ball past a goalkeeper or evading a "nutmed" (i.e. slipping a ball through an opponents open legs) were pleasurable enough, but the real process of empowerment existed in recognizing mine as a

healthy and strong athletic body.

While the "very limiting, often painful downside" (Messner and Sabo, 1990:14) of athletic experience has long since tempered its more positive upside, for me the latter nevertheless remains a possibility. As Stuart Hall (1984) and more recently David Whitson point out:

...it has been an all too common mistake on the left to see the commodification of leisure (and I would add fitness) as entirely manipulative, as if the consumers of leisure goods and experiences were passive dupes. (Whitson, 1991:15)

Our culture is replete with evidence here. For many men, of course, using one's athletic body -- to wrestle, to forecheck, to play "line" -- is more a matter of confirming and reproducing an extant site of empowerment rather than of liberating a previously repressed one. But such hegemonic modes of masculine body expression are no longer exclusive. Counter-hegemonic challenges to the hyper-masculine body not only exist but are initiating discourses and meanings which carry true relevance for thousands of participants.

Across Canada, for instance, young hockey players, unimpressed by their toothless professional counterparts, are finding new non-contact versions of their favored pastime both empowering in the pursuit and emancipatory in the avoidance of injury (Grigel, 1989). Elsewhere, gay men continue to resist the compulsory heterosexuality of modern sports organizations and strategically carve out new spaces both within and outside the mainstream (Pronger, 1990), while men of color chip away at the racist social rather than racially-linked genetic foundations of sports apartheid as they swim, tend goal and coach with competence (Davis, 1990).

Of course, female athletic bodies are also being used to resist, but now against patriarchy as well as homophobia and heterosexuality. Almost to an individual, aerobicizing female students and homekeepers, rugby and hockey players, and body builders speak of being re-socialized into new more potent selves by active bodies. If naturalizing masculinity and restraining femininity have been the cornerstones of

patriarchal sport, then we find in these alternative athletic sites new forms of empowerment for women. Crucially, they precipitate bolder discourses and "ways of seeing" (Berger, 1972) which link female bodies to more assured female selves, and ultimately help reconstitute women's social, political and intellectual lives.

Imprisoned Athletic Bodies

Bourdieu's (1984) concept of *habitus*, Gramsci's (1983) concept of *hegemony*, and Elias' (1991) notion of *the hinge*, all address in their own fashions the contradictory ways in which oppression and constraints mesh simultaneously in the lives of men and women. All three approaches have been widely adopted by students of sport (cf., Bourdieu, 1978; Whitson, 1984; Young, 1991; Maguire, 1991). Each would concur that while sport can indeed embody real promise for agency, emergent and transforming identities are always created in broader struggles fought at personal and political levels. Respecting this view, one becomes alarmed by Jean Baudrillard's (1987) recent plea to Forget Foucault. As Andrews (1991) notes, students of disciplined bodies particularly will find much in Foucault (cf. 1977, 1978) to assist in the deconstruction of embodied practices and sports related texts:

...the body is also directly involved in a political field; power relations have an immediate hold on it, mark it, train it, torture it, force it to carry out tasks, to perform ceremonies, to emit signs. (Foucault, 1977:25)

Using Foucault, the focus shifts tersely from the promise of empowerment to the regulatory forces of discipline and control, to practices geared towards political, economic, and cultural profit: "the body becomes a useful force only if it is both a productive body and a subjected body" (Foucault, 1977:26). But how may we make sense of this claim in the connection of embodied sport?

Inevitably, the sketch drawn earlier of empowering childhood self-images developed through athletic bodies is incomplete and, for some, fraudulent. Like other children, my own

positive experiences detailed here were always juxtaposed against more alienating ones: routine physical pain and injury; failure, and a decreasing incentive to try again; hostility to all postures but the brutal and the hypermasculine. Disappointing after positive encounters, the effects on how we understand ourselves is just as real. Now comes acquaintance with fear and the "pain principle" (Sabo, 1986), uncertainty and caution towards embodied movements of any kind, and disenfranchisement with the insidious tune of the "patriarchal (sports) piper" (Sabo, 1991:14).

Discussing how we "become alienated from our bodies in adult life," Whitson (1991:1) talks of how the process of knowing one's self and one's body is "profoundly different" for men and women. While my own empowering experiences are no doubt shared by many women, in the gendered arrangements that are sport and leisure, girls and women tend to live physical and psychological regulation in an even more repressive and constraining manner. It may be the teenage female gymnast, bulimic and weak in a sport that requires supreme strength and confidence, who is accompanied through training camp by a foam cup; the latter is at once a receptacle for vomit and the evidence of obsessive/dangerous "femininity." The cup, incidentally, processes perceived bodily excess in the same way as the laxatives she consumes. It may be her teammate, whose delayed puberty, a result of years of hard training, is followed by amenorrhea and rapid weight gain in the de-socializing mid-teen years. It may be the middle-aged runner, whose anxieties about her changing body are fueled by an impossible but seductive image of feminine shape and sexuality. Or, finally, it could be the aerobicizing instructor or student, for whom the male-oriented goals of her activity, always designed to be more spectatorial than participatory, ultimately serves to sexually objectify and imprison as much as to liberate.

Vadya Burstyn (1986) correctly understands gender-privileging sports experiences as part of a patriarchal double-standard with terrible consequences for women's bodies particularly. Hinting at a hegemony muscular with irresponsible imagery and discourse, she speaks of the young athletic boy who welcomes his growing bulk as the girl sees hers as a betrayal, and of the boy revelling in pre-event "fueling" while the girl must constantly resist

temptation. Like Burstyn, we must understand these common sports practices and meanings in terms of the complex connections between power, discipline and gendered identities. Specifically, and as Burstyn says of women and sport, "In a very real and symbolic sense, women's power remains temporary and precarious." More compelling support for Foucault's earlier claims would be hard to find. Far from emancipatory, then, trained, tortured, mediated and even ceremonious bodies are part and parcel of what we see around us as sport.

Disabled and Victimized Athletic Bodies

The rushing river they call
violent But the riverbed
pressing in it
Nobody calls violent

The storm that bends birch trees
They say is violent
But what about the storm
That breaks the back of
roadworkers?

(On Violence, Bertolt Brecht)

While Brecht's words do not refer to it directly, professional sport may be invoked from his notion of contrived social violence. In male team sports such as football and ice hockey, violence is not only a bodily experience in the context of work, but also an organized structure imposed externally. From antiquity to the present, combative spectator sport has always been profoundly and unabashedly violent. Shattered bones, shredded ligaments and crushed vertebrae are its products and its goal.

In modern times, professional sport is simultaneously a site of medical mastery and extraordinary medical neglect. In spite of their hypertrophy and often unnaturally developed hugeness, athletes' bodies, pummeled by "nose-tackles" and the like, are x-rayed, frozen and splinted before being sent back into the fray. But we must also speak of bodily sights here, for this is a public world of celebrated disability. The roaming television lens captures and replays the writhing body in "super slow-mo," while color commentators respond using discourses of approval. Combined, visual and oral commentaries serve to marginalize pain, to re-

present the commodified sports moments as artistic and even sensual (Morse, 1983).

Recently, research into the politics of victimization in a number of occupational settings (cf. Elias, 1986) has prompted sport sociologists to look more closely at disabled and discarded athletic bodies as sites of resistance and ideological struggle (Young, 1991). While sports culture continues to understand pain and injury in terms of the English common law notion of *volenti* (voluntary assumption of risk), an ongoing contest between ownership and labor in professional sport over issues related to work hazards, occupational health and compensation is increasingly moving discourses on appropriate bodily treatment from the locker room to the court.

The objectified and victimized athletic body is in many ways different from that which pervades other occupational spheres for it is considered largely normative by those involved. In patriarchal sport, its consequences -- injury and disability -- are frequently understood in terms of positive "masculine" character. Although parallels may be drawn between violence done to bodies here and in other occupational groups (construction site workers, meatpackers, oil driller, police, fire and military personnel, etc.) most other types of workplace violence are neither normative in this sense nor seen in such a positive fashion.

Clearly, expecting/requiring that athletes play under injured conditions precipitates a host of legal ramifications. For example, Nash (1983:205) cites the case of *Robitaille vs. Vancouver Hockey Club*; a case involving "...a hockey player who won a substantial award for proving that the club doctors and managers had negligently forced him to work after they (already knew) he had an injury." A more well-known case involved Jim Otto (Young 1988). As an NFL player, Otto sustained some twenty-five broken noses, broken ribs, broken elbows and broken fingers. By 1988, his body had lived through sixteen major surgeries including four replaced knees which have left him disabled and unable to stand for long periods. Despite being declared legally crippled by a large number of top surgeons, his ex-club and the NFL continue to deny his claims for compensation arguing, remarkably, that his injuries are not football related.

What is done to the bodies of athletic workers is at once the product of employer constraints and employee consent. Undoubtedly, it makes sense to view workers in some occupational setting as victims who are blamed for their workplace misfortunes, but workers in sport and elsewhere are consenting human agents. As Raymond Williams (1980) says of Gramsci's original concept, hegemony entails something more than a static conception of dominance.

It is a whole body of practices and expectations: our assignments of energy, our ordinary understandings of the nature of man and his world (p. 38)

Thus, a range of practices in professional sport including not only embodied violence and playing under injured conditions, but also the taking of steroids and other drugs, and even the wearing of sponsor labels simultaneously provides athletes with a powerful means of making sense of their private and public selves and reproduces their own eventual exploitation. Hargreaves (1986:6) has described this complex process succinctly:

When considering subordinate groups' involvement in sports, one of our major themes will be the ways in which they manage to evade and subvert controls, the respects in which the sport-power relation enables them to resist pressure from dominant groups and to make tangible gains for themselves, as well as the ways in which it reproduces their subordination.

Bodies Apart?

Whether one adopts an Eliasan, post-modernist, feminist, cultural studies, Foucaultian, or other perspective, it is clear that students of sport must situate their research in bodies and bodies in the research. After all, "it is the body that constitutes the most striking symbol, as well as constituting the material core of sporting activity" (Hargreaves, 1987:141). And since bodies are inhabited, body-subjects must be examined also. This necessarily means locating the body in terms of constituting social stratifiers such as gender, age, race, ethnicity and class.

It disturbs me that earlier and, to a lesser degree, current research on sport attempts to dislocate its subject from society, to see it almost as a body apart (cf. Beamish, 1985; Morgan, 1985, 1986). I prefer to view sport as inevitably context-dependent, tied to aspects of material production, and something "forged in the workshop of culture" (Donnelly and Young, 1985:19). It is also a mistake to assume that the meanings attached to sports by various groups and classes are either stable or homogeneous. As Gruneau (1983) has suggested, sports may embody both reproductive and transformative capacities and meanings simultaneously. Such contradictions frequently arise because sports are contested terrain:

...the field of sporting practice is the site of struggles in which what is at stake, *inter alia*, is the monopolistic capacity to impose the legitimate definition of sporting practice and of the legitimate function of sporting activity. (Bourdieu, 1978:826).

Ultimately, such struggles include attempts to determine the form sports should take and who should play, to determine the social definition of sport and, of course, to determine legitimate ways of using and understanding the body.

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BOOKNOTES

Bellarosa, James M. A Problem of Plumbing and Other Stories. Santa Barbara: John Daniel & Company, 1989, 120 pp., \$8.95 softcover.

The publisher's blurb on the back cover of this book notes that "here are fourteen first-rate stories, fourteen variations on the handicapped [sic] condition." Not so. The number, of course, is correct, but of those fourteen, at least four don't seem to be about disability at all, save in the most tenuous sort of way, as if the writer had only half-heatedly attempted to fit a story to the Procrustean bed of an assigned theme. As for "first-rate," let us simply note that when Bellarosa is good, he is very, very good, but when he is not so good, he is, well, not so good. And, curiously, he doesn't

seem to know the difference. Still, the seven or so choice pieces in this collection--"A Problem of Plumbing," "Vengeance," "The Family," "The Question," "Thanks," "A Roll in the Hay," "The Shadows of Other Men"--make this book quite outstanding. Here is some of the best work of fiction being done in the field.

Bellarosa is at his best when he is delineating the naive but maddeningly offensive attitude of the well-meaning TAB who suddenly comes face to face with the object (victim) of his putative compassion. Such a story is "A Roll in the Hay," in which the wheelchair-using protagonist is wheeled hither and yon, pummeled and shoved, bespattered, humiliated, and, at last, ignominiously de-chaired into a stack of hay--all in the name of helpfulness. The tables are completely turned, however, in the oddly titled "The Shadows of Good Men," perhaps the best piece in the entire collection. Here, in a delightfully sustained metaphor, Bellarosa carries to the point of absurdity--and beyond--a deadpanned, comic reversal of the kind of intrusive, condescending attitudes the disabled individual habitually faces from the world at large. In this inane Bellarosan world, a mundane and rather scrofulous beard is made to stand in for a wheelchair, while Bellarosa deftly milks every drop of humor from the ludicrous substitution. It is a story not to be missed.

One of Bellarosa's most attractive qualities is his sensitive depiction of sexual roles. He is clearly charmed and delighted by women, especially handsome, intelligent women. Listen to him in the opening lines of one of his stories: "I like beautiful women with jet black hair that tosses gently, and pearl black eyes that entrance. I love them if they are witty, sensitive, educated, talk about literature, psychology, international politics, and laugh with equal hilarity over the Red Sox and Woody Allen. If they can play chess, that's the frosting." And in another story, entitled simply "The Question," he recounts with considerable charm and wit his close encounters of the intimate kind--while anxiously awaiting the inevitable question: "Can you make babies?" Having grown accustomed to the inexorable approach of the question, he grew to anticipate it, to play with it, to thwart or deflect it, depending on the circumstances. Once while lying on the beach with a particularly close woman friend, he felt the time had come. The

question was going to break in upon the beach at any moment with the crash of the surf, "but this time I was ready. I nuzzled her ear. 'But can you make babies, Monica?' I asked."

This is enough perhaps to give some sense of the book, some feel for Bellarosa's prose. With the reservations noted in the first paragraph above, I recommend it to you as a work that will well grace your library shelves. (Joseph L. Baird, Kent State University).

Brady, Judith, ed., One in Three: Women with Cancer Confront an Epidemic. Pittsburgh, PA: Cleis Press, 1991, 286 pp., \$10.95 softcover.

Butler, Sandra and Barbara Rosenblum, Cancer in Two Voices. San Francisco: Spinsters Book Company, 1991, 183 pp., \$12.95 softcover.

Two new books have recently been published about women and cancer in the United States, One in Three: Women with Cancer Confront an Epidemic, edited by Judy Brady; and Cancer in Two Voices, by Sandra Butler and Barbara Rosenblum. These books analyze the sexual politics of cancer and recount women's experiences living with the disease. They sound a call to cancer survivors to become visible to one other, and to all of us--people living with cancer and their friends, families and allies--to demand a stop to America's upward-spiraling cancer rates.

One in Three is a crucial step toward exploding cultural myths about women and cancer. This collection of 49 personal essays, poems and short stories deals the medical model a hard blow. On the whole, Americans have been taught to privatize our experiences of illness, and we have learned our lessons well. Western medicine and New Age approaches alike promote the view that our "lifestyles," attitudes and feelings can and do make us sick. We blame ourselves when we feel unwell and summon that catch-all cause, "stress," to account for our poor health. Rarely, however, are we encouraged to look beyond our personal circumstances to the structural roots of illness and mortality in our society.

How are women's cancer experiences distinctly gendered? How have the causes of cancers been obscured? Whose interests are at stake in the multimillion dollar cancer research

industry? Why is preventing cancers not at the top of our national, public health agenda--indeed, at the top of our domestic policy platform? And at what costs, these silences? (I use the plural, cancers, because the term actually refers to multiple diseases.) Collectively, the contributors to One in Three address these questions, along with a wide spectrum of concerns ranging from the right to self-determination in treatment to social class and health care access.

In the first pages of this anthology, readers will encounter the following statistics:

*One in three Americans will be diagnosed with some form of cancer during their lifetime. Cancer will prove to be fatal for two-thirds of those who are diagnosed.

*Breast cancer is the leading killer of American women between ages 35 and 45. This year it is estimated that 44,500 women will die of the disease.

*In 1900 cancer accounted for only four percent of the US mortality rate. By the late 1970s, this figure had increased to 22-23 percent.

*In 1964 the World Health Organization estimated that 80 percent of cancers are caused by human-produced carcinogens. Today, fully 90 percent of cancers are believed to be caused by environmental toxins.

Statistics rarely faze me nor move me to action, and I don't expect that you'll take to the streets after reading these numbers. Still, they may confirm your nagging sense that "we all live downwind," a phrase used by One in Three contributor and cancer survivor Sandra Steingraber to express our shared vulnerability, as humans, to environmental carcinogens.

Downwind is both metaphor and reality. It is the direction that more than one million curies of radiation spread to communities

surrounding the Hanford Nuclear Reservation in Washington state between 1944 and 1956. Links between military, industrial and iatrogenic radiation and a host of cancers and symptoms of toxic exposure are the concern of One in Three authors Zinna Epperson, Millie Smith and Lois Camp. These women recount how they conducted their own "grassroots epidemiology," piecing together evidence released in 1986 by the Department of Energy through the Freedom of Information Act. Their stories, along with thousands of other accounts, point to the conclusion that Hanford emissions have caused an epidemic of radiation sickness whose symptoms are identical to those of Hibakusha patients--survivors of the atomic blasts in Japan.

One in Three is a reminder that you or I could be downwinders. Our susceptibility, in spite of what "lifestyle" modifications we make, cannot be overstated. In an essay entitled "Cancer as Violence Against Women," Adele Friedman explained cancer's randomness this way: "The single greatest risk factor was chance. . . . My single greatest factor for contracting one of the three largest cancer-killers [breast cancer] was having been born a woman." Friedman died last year.

"Why am I not a cancer activist?" asks Sandra Steingraber. . . . "I have been publicly and politically active on many other fronts. And yet when it comes to cancer . . . it's hard to focus. Apparently I would throw myself into any other social cause before I would take on this disease. . . . I am intellectually convinced of the importance of cancer advocacy work. But then the paralysis sets in."

Why am I not a cancer activist? Read One in Three and ask yourself this question.

* * *

Cancer in Two Voices is a map of Sandra Butler and Barbara Rosenblum's experiences living with breast cancer. The book's raw honesty offers readers a chance to open our eyes and hearts to the complex lessons cancer can teach. Its force and eloquence match Audre Lorde's Cancer Journals and Deena Metzger's Tree. And like Lorde and Metzger's work, Cancer in Two Voices will be passed among readers eager for the relief of breaking silences about "living in an unstable body," as Barbara put

it--a body with cancer.

Barbara Rosenblum lived with metastatic breast cancer for just three years. Cancer in Two Voices traces her illness through journals she and Sandy Butler, her life-partner, recorded. Several previously published pieces and Barbara's occasional letters to her friends are woven into the book, as well. (Ever self-reflexive, Barbara titled her "public" correspondence "The Rosenblum Report.") But even after Barbara's death, Sandy continued to wage battle against cancer. In 1990 she was treated for thyroid cancer, from which she has recovered with an excellent prognosis.

Barbara and Sandy's unselfconscious reflections give flesh and meaning to aggregate mortality statistics. They repeatedly remind us that cancer is about life, not death. "We chose to write this book . . . in the hopes that it would be of use to those of you now reading it," Sandy explained. "We wanted to tell you our story. Or at least some of our story. A story about struggle and courage, even more than the part about sickness and death. A story about loss and the gifts it brings. We wanted to tell our story, finally, because this writing made us visible to ourselves."

The time between Barbara's diagnosis and death was drastically shortened because for a full year, Kaiser Hospital failed to correctly diagnose a tumor in her breast. The malpractice was so gross--the negligence so obvious--that Kaiser settled her case before trial for a huge sum. "Which makes me very rich," Barbara recalled.

In ironic contrast to her childhood spent in immigrant, Brooklyn-Jewish poverty, and later, the make-do existence of a graduate student and untenured professor, Barbara lived the last 28 months of her life free of worries about having enough money to survive. (A sociologist, her expertise was the sociology of aesthetics.) "That's the way the system works," she grieved. . . . "But in my soul, my heart, it rings horribly of a Faustian pact with the devil. This money in exchange for years of my life. \$1,000 for every vomit. \$1,000 for every cut, every needle in my arm. Every gag. Every wave of nausea. . . . No sane person would make such a contract." "Blood money," she called it.

Barbara and Sandy's life together was embedded "in friendship, in connectedness."

They were blessed by the care and love of many friends, their families, the riches of their women's community, and their sturdy--if sometimes turbulent--relationship. Their devotion to each other was fierce. Like Paul Monette's AIDS memoir, Borrowed Time, Cancer in Two Voices is a story about high romance.

Cancer in Two Voices records both authors' struggles to ballast themselves as their ever-changing needs for autonomy and dependence tugged at them. Early in Barbara's illness, Sandy wrote, "Cancer is what I do now. Cancer is my work.

. . . It has become my central activity"--words that certainly could have been Barbara's own. Yet cancer is inevitably and ultimately a solitary experience. A year before her death, Barbara reflected on the ineffable changes happening inside her: "When I have sensations in my body, it's an unsharable experience; I become aware of the limitations of language in describing those sensations.

. . . I grow increasingly aware of the illusion of the intersubjective nature of the world. The world is shattered, language dissolves, and there is only body and its feeling. Even a private language, such as I have with Sandy, is a self-contradiction. There cannot be private language."

Close to death, Barbara continued her meditations on life. "I write because I'm a human being who has learned how to describe the inner landscape. . . . I am a very different person now: more open, much more righteous, much more honest, and more self-knowing. After getting cancer I saw that being a sociologist was just the smallest part of who I am." This awareness allowed her to grow and change, to open to herself and those she loved as she walked with death. (R. Ruth Linden, Sociology, Brandeis University).

Cash, Thomas F., & Pruzinsky, Thomas (Eds.). Body Images: Development, Deviance, and Change. New York: The Guilford Press, 1990, 361 pp., \$39.95 hardcover.

This book is an overview of research and theory drawn from a variety of disciplines and related to what the editors appropriately call "body experience." To a large extent, the editors do succeed in presenting an interesting amalgam--dealing with subjective and objective, and with

realistic and unrealistic, body images. In addition, the book addresses body image as both cause and effect, and in terms of both negative and positive change. For example, one chapter discusses the impact that culturally-determined attractiveness/unattractiveness can have on personality development--while another chapter addresses the effects of psychological disorders on body image.

The editors are to be commended for this ambitious and creative venture. Although the volume is somewhat over-balanced with contributions from clinical psychology and psychiatry, it does include a respectable amount of information drawn from developmental psychology and social psychology and from other domains within the social sciences. Three chapter authors--Fisher, Fallon, and Cash--deserve special credit in this regard for their attempts to expand the discussion of body image to encompass knowledge from a variety of sources.

This is not to say that the book is without flaws--the most serious of these being an unsuccessful attempt to integrate physical disability into the discussion. The editors have clearly (and correctly) tried to present disability as a legitimate body image issue. However, all reference to physical disability (with the exception of an occasional passing mention) is concentrated within only three (of the sixteen) chapters, two of which focus almost exclusively on facial disfigurement.

As a social psychologist who has done considerable research on attitudes toward people with disabilities, and as one who greatly respects an interdisciplinary approach, I anticipated the book's gradual buildup to a discussion of disability and genuinely looked forward to its occurrence. I was horrified, however, when I did encounter the first of the three chapters allocated to this subject--an extremely negative presentation by Bernstein on the impact of facial disfigurement on self-esteem. Bernstein begins his discussion on a reasonably acceptable note (although I do question his choice of language): "If people are deformed, they may be converted into things, and treated in an altered manner. The contents of an individual who is visibly marred are devalued, and the person has to struggle to avoid being discredited as an object" (p. 131). However, the ten case studies which

Bernstein chooses to present are all extremely distressing examples in which disfigurement has overwhelmed the individual and has completely destroyed his/her life. "Stacy," for example, is portrayed as "generally spending his time alone in his room, drinking beer and watching television...as he tried to hide his misery" (p. 140). "Alice" is quoted as saying, "I am no longer a woman. I am a thing" (p. 141). "Anton" is seen as "adjusting," although it is pointed out that his "adjustment occurred only after he had become forcibly retired from work and placed in a more inactive life role" (p. 143). Lest it be assumed that these negative images are reserved solely for people with facial disfigurements, Bernstein adds an interesting aside to his discussion of "Kathy," portrayed as "incomplete, unacceptable, depressed, and enraged for long periods of time" (p. 146): "She moved in with a paraplegic young man whom she supported, but who afforded her very little sex" (p. 146).

The far more positive (and realistic) chapter by Shontz which follows not only blends in nicely with the book's overall interdisciplinary approach, but also focuses on positive as well as negative reactions to disability. IN direct contrast to the devastating images presented in the preceding chapter, Shontz concludes that: "The final, and most important, principle is that, of all the factors that affect the total life situation of a person with a disability, the disability itself is only one, and often its influence is relatively minor" (p. 167).

The third chapter dealing with disability, written by Pertschuk, addresses the effects of reconstructive surgery on persons with both congenital and traumatic craniofacial abnormalities. Although Pertschuk does not present his own views as directly and as forcefully as Shontz does, it is clear that he, too, feels that subjective body image among both disabled and nondisabled persons is a function of individual differences rather than a mere reflection of society's standards.

In summary, Body Images is an interesting book for individuals from a variety of disciplines who appreciate an eclectic approach to body/mind experience/esteem links. For persons interested in disability issues, many chapters not related to disability may be thought-provoking (although the reader must extrapolate

on her/his own), and two of the chapters related to disability may be directly relevant and useful. The other disability-specific chapter, though probably offensive to many, is useful in that it presents most of the negative images which are confronted by persons with disabilities.

For those not familiar with disability issues or with individuals who have disabilities, the book, though interesting in many regards, may have a negative impact on attitudes toward people with disabilities. It may reinforce the concept of separateness of physical disability from the mainstream of "normal" body image issues (by the compartmentalization of the topic within three chapters), and it may actually exacerbate negative stereotypes of persons with disabilities. (Elaine Makas, Department of Psychology, Bates College, Lewiston, ME).

Charmaz, Kathy. Good Days, Bad Days: The Self in Chronic Illness and Time. New Brunswick: New Jersey, 1991, 311 pp., \$24.95 softcover.

Written in the grounded theory mode that emphasizes process and meaning, this study is based on 115 interviews with 55 adults (over 21) with "serious but not terminal chronic illness" that "poses uncertainty" and "effects...the persons' daily life" (p. 272).

Part I of the book presents a detailed discussion of three ways people experience illness: as an interruption, as intrusive illness, and as immersed in illness. Interruptive illness is defined by the individual as temporary, while intrusive illness is usually seen as requiring some changes in everyday life. But when people become immersed in illness, they can not longer accommodate but must restructure their lives around the illness. In Part II, Charmaz examines more specifically how people manage aspects of chronic illness. In particular, she focuses on how people control information, particularly about disclosing illness, and how they need to reorganize their time and space in order to manage their lives. While these issues have been examined already in other studies, Charmaz does an excellent job of describing how such strategies as "trading off" and managing schedules become central in living a life with chronic illness. Throughout the Parts I and II, Charmaz refers to the meaning and use of time in the lives of people with chronic illness without explicitly

focusing on the experience of time. In Part III, Charmaz shows how time--past, present and future--has an impact on chronic illness. First, an illness often requires the restructuring of time; "living one day at a time," getting tasks done, looking at the future, reevaluating the past, etc. Second, time can be a marker, in terms of creating a chronology, and defining responding to turning points. The analysis coheres best in these chapters.

In the best grounded theory tradition, this book is conceptually rich and illustrated with hundreds of quotes and examples from the interviews. As much as I admire some of Charmaz's conceptual analysis of time in chronic illness, I also have some misgivings. Throughout the first two parts of the book Charmaz repeatedly refers to the self in chronic illness or the impact of illness on the self, but never clearly indicates what she means by self. In addition, because she focuses so much on the social psychology of illness, the respondents' support structures are not clearly articulated. Finally, I found the book to emphasize the downsides and negative aspects of chronic illness. While some of Charmaz's respondents are strong and inventive in managing their illness, the resourcefulness and creativity of these people seems overwhelmed here by the descriptions of the burdens of illness. Overall, however, this book helps shift the way we see the experience of chronic illness. It decisively moves time to a place of central concern while simultaneously sharpening our understanding of the relationship between time and chronic illness. (A longer version of this review is forthcoming in *The American Journal of Sociology*) - Peter Conrad, Sociology, Brandeis University.

Eribon, Didier. Michel Foucault. Cambridge: Harvard University Press, 1991, 390 pp., \$27.95 hardcover.

Early on a morning in June of 1984, several hundred mourners gathered in a small courtyard of the Salpetriere Hospital in Paris to pay their last respects to Michel Foucault, who had died from neurological complications of AIDS there a few days before at age 57. It was a fitting place for the ceremony preceding his burial attended by many French intellectual luminaries, prominent political friends such as Simone Signoret and Yves Montand, and

numerous lesser known people who worked with him on issues such as prison reform.

Named Paul-Michel after his father Paul, a surgeon and professor of anatomy, Foucault had dropped his father's name in adolescence. While his father, whom he disliked, wanted him to follow in his footsteps and pursue a medical career, his mother, the daughter of a professor of surgery, supported her son's decision to risk his father's rage and pursue his adolescent passions of philosophy and literature. He showed an early fascination with psychiatry, working in his mid-20s as a psychologist in a mental hospital. The Salpetriere asylum figured prominently in Foucault's dissertation, his first intellectual success, published in an abridged version in the U.S. as Madness and Civilization. Salpetriere was where Pinel, the "liberator" of the mad, helped master madness in a new juridical microcosm of perpetual judgment. Residents of the asylum were condemned for their transgressions by medical reason "to be subject to an accusation whose text is never given."

Near this symbol of medical discipline and power which Foucault had struggled to illuminate, philosopher Gilles Deleuze read from the introduction to the second volume of Foucault's The Use of Pleasure: "As to what motivates me, it is quite simpleIt was curiosity--the only kind of curiosity, in any case, that is worth acting upon with a degree of obstinacy; not the curiosity that seeks to assimilate what it is proper for one to know, but that which enabled one to get free of oneself. After all, what would be the value of the passion for knowledge if it resulted only in a certain amount of knowledgeable and not, on one way or another and to the extent possible, in the knower's straying afield of himself? There are times in life when the question of knowing if one can think differently than one thinks and perceive differently than one sees is absolutely necessary if one is to go on looking and reflecting at all."

Foucault, famous in France as "the committed philosopher," developed an influential critique of western culture. Unique among the major thinkers of our time, Foucault's work was rooted in an attempt to locate the history of forms of experience of the body, including, centrally, medical practice and discourses, in the creation of the modern world. As the

intellectual figure most responsible for the recent cross-disciplinary surge of interest in the subject of the body, Foucault fits neither into medical sociology, the history of medicine, nor any other disciplinary pigeon-hole; rather, he created a distinctive perspective that reverberates ever more widely throughout an academic discourse in which, with no small thanks to him, disciplinary boundaries have become increasingly obsolete. To critically engage his work, I believe, locates the reader in a dialogue on the construction of normalizing discourses, including those impacting on disability, at a depth that no other modern writer makes possible.

Michel Foucault by French journalist Didier Eribon is the first published biographical guide to Foucault's quest. Written under the sign of an injunction by Rene Char that Foucault often quoted, "Develop your legitimate strangeness," the book admirably puts into chronological and thematic order a life dedicated to exploring the interplay of trespass and discipline in western societies, with the goal of legitimating broader zones of strangeness and freedom, if only to free oneself. It serves particularly well as an introduction to Foucault's books and the French intellectual and political milieu that helped shape them and made them famous, even notorious. Readers interested in heavy psychologizing into connections between his homosexuality and work will have to wait for works currently in progress. Meanwhile, Eribon gives us a sharp portrait of the self-cultivated mysterious figure behind simultaneously opaque and incandescent texts proclaiming the death of the subject.

For anyone who has been intrigued by this master intellect, for anyone has wondered where this new way of thinking came from, Didier's biography is a must. By showing us one exemplary attempt to "think differently" about the forms of power embedded in the medical and other disciplinary discourses of our society, Eribon's book invites reflection on what it takes to transcend the confines of tired academic and political discourse in our time and place to do something similar. It is an invitation to return to the original texts after making acquaintance with their enigmatic author; it is an invitation to revisit Foucault's project afresh, to peel away the mountains of commentary and efforts to confine it to new academic fields like the study of the

body. Didier's book invites the reader to cultivate his or her own legitimate strangeness by revisiting the moment of new possibilities opened up by the breathtaking novelty of Foucault's work. Connecting this work back to its origins in the life of its creator is one way of reaffirming that moment. (Anthony Bale, Brooklyn, NY).

Fox, Daniel M. and Lawrence, Christopher. Photographing Medicine, Images and Power in Britain and America Since 1840. New York: Greenwood Press, 1988, 360 pp., \$49.95 hardcover.

This book of and about medical photographs is still more, a history of medicine from photographs, one that compares United States and Great Britain, "a story about how images were made and used to carry messages" that in this text are "about how and where power should be exercised and by whom." Photos are selected and read like a text. Selection was a necessity since the objects of medical gaze are so numerous--bodies, patients, practitioners, operations, skills, caring acts, diagnostic machines, treatment spaces, waiting rooms, relationships, practice sites and buildings. One object alone could make a history of medicine of a kind, for example, the body and the patient--those ancient objects of medicine's art and science. Since 1839, the very beginning of photography, clinicians have snapped the shutter on bodies that are healthy (normals and somatotypes), deformed (the acromegalic), disabled (the spastic paraplegic), growing (the child), developing (under/over-nourished), wounded (the extent and site), treated (before and after), distressed (shame and grief), the mentally ill (asylum residents) and even the dead (corpse and organs). Besides these vast collections of classic medical images of the body's outside, nowadays clinicians are photographing and filming what is imaged inside the body by CT scans, MRIs, lasers, sonography and endoscopy, and, with patients, even looking and listening inside the patient-doctor encounter with videotapes while today's microbiologists are taking beautiful inside photographs of cells and their genetic stuff, DNA. Despite these old and modern views of the flesh, patients, and relationships, the authors observe that such clinical images cannot serve their historical purposes. The authors' selections are not of the

clinical body but of the institution with its staff and patients.

How does this history evolve? Selections from the 1840s to 90s consist of five of doctors in formal poses, these along with some six of patients with bizarre disorders of mouth, skin and genitalia. The first photos were to enhance the shabby public image of doctors then aspiring to be middle class professionals; the second, to illustrate clinicians' medical work in diagnosing disease.

The 1880-1918 selections are, for the most part, about institutional life--the hospital, the asylum, the TB san. They also contain a bit on professional life outside in public and school clinics; and then a few views of WWII battlefields, along with a single home visit by a Visiting Nurse. The hospital scenes appear again and again when the major site of care was the home (over 50 percent of medical visits) of which there are no shots with MDs at all. The images promote medicine's institutions as therapeutic, no longer custodial. Medicine's power to care and cure is now visually displayed. The hospital photos are read as Coser's 1960s metaphor, "a home away from home."

"Multiple images 1918-1939" demonstrate again the dominance of hospital medicine with but one exception, a unique picture of a private practice encounter, Lord Horder at his Harley Street, London office. In those decades institutions were opened to photojournalists who, in the popular press, publicized the voluntary hospital for fund raising, educated the public about the experience of the patient, began the demystification of medical work, and the popularization of medical science. Close ups of patients, medical acts and staff, the authors observe, were now common. Nurses, in particular, were doing more in the scenes of U.S. hospitals compared to those of the British, a suggestion of greater occupational mobility in America. Children were depicted far more often than adults, not alone for the reason, as the authors suggest, because they (and the family) were the object of public health efforts. In seeking help (or by avoiding the camera), kids and poor folks had less power. New photo themes of scientific research also appeared, selling the public the notion that the recipients of medical treatment depended on laboratory research (and technology).

"1939 and after" represents photojournalism's documentary style. The subject is now more often the patient and family rather than the medical staff. Why? The authors note the politics of access to care demanded such scenes. One could argue a broader ideology as did critics in that era of expanding specialization and technology. The patient focus appears as medicine loses some of its humane tradition to technology, yet tries to maintain it. Still other scenes appear, birthing babies and views of medical specialists working as a team "providing personal care." Team work around technology is a change in professional power. At least, the individual doctor loses in the group application of technique that now is a divided delegated task.

These comments aside, this is a superb book. First, because photos can be enjoyably read even without the guidance of the authors. Second, it is a rich print archive of its own for photo buffs and journalists. Third, lay and professional readers will appreciate the static-nonverbal scenes as documents about roles and functions of the profession, illustrating power, not only who is in charge of institutions but as dyadic power in the doctor-patient relationship.

Finally, sociologists, so long concerned with professional dominance may see the recent images as more bureaucratic organization of medical work. As participant observers (and reformers) of medical practice from the 40s, they might also view these old scenes nostalgically. The dominance of the doctor that was of such great concern is disappearing, taken over by corporate practices, a solution that few foresaw. As new photos are made of today's "we care" corporations, perhaps these old views of institutional life might also inspire second thoughts on where power lies. (Adapted from a longer version in *Contemporary Sociology*. John D. Stoeckle, Massachusetts General Hospital).

Frank, Arthur W. *At The Will of The Body - Reflections on Illness*. Boston: Houghton Mifflin, 1991, 144 pp., \$17.95.

At the Will of The Body is a book written with such eloquence, drama and insight that there is a danger in being swept up with the publicity blurbs which emphasize its "life-affirming" and "inspirational" aspects. It is no easy feat to survive and cope with a heart attack

at age thirty-nine and a year later a diagnosis of cancer. But Arthur Frank has done something more than create an incredibly rich first person account. He is pushing the boundaries of what some of us have labelled "socioautobiography" - an individual story to be sure but one which places that story in a larger social and political context. Most of us who have tread this path before have placed our analyses in separate chapters, extensive footnotes and intrusive afterthoughts. Arthur has written an almost seamless analytic manuscript. Only at the end is there a short bibliography which he modestly refers to as "Literary Debts."

And while he concludes on the very last page that this "is not a work of sociology," (p. 144). I would argue that it is profoundly "sociological." His chapter titles, vivid and dramatic in and of themselves, also set an agenda for a sociology/anthropology of the body. They emphasize, perhaps inadvertently, many of the important early works in illness behavior (e.g. "Becoming Ill" and "Stigma"), the long tradition of social-psychological coping (e.g. "Mourning What is Lost", "the Cost of Appearances" "Denial and Affirmation") and the newer explanatory emphases (e.g. "The Body as Territory and as Wonder," "Valuing Illness" and Ceremonies of Recovery.").

In his opening chapter he engages one of the current controversies in the study of chronic illness, disability and the body - the notion of their being wholly social constructed. The contrast between his heart attack which he could put behind him and his cancer which is always 'there,' is more than metaphor. The body, and illness as Turner reminds us in his essay *Reflections On Somatic Sociology* whatever else it is, it is a reality all its own, with its own voice and message. As Frank himself states "Illness taught me that beyond anything I can do, the body simply is. In the wisdom of my body's being, I find myself over and over again." And throughout the book he reflects on issues of communication (or the lack thereof) with himself, his loved ones, his health care providers. He questions the fruitfulness of many standard concepts and insightfully asks whether the over emphasis on stages in the process of illness or even dying categorizes and stultifies rather than opens up those experiences.

The book is not perfect. It tells me too

little (especially in her voice) of Arthur Frank's relationship with his wife or about the sensitive issue of sexuality (touched on quite honestly on page 24 but not elsewhere). I recognize the limits of this in writing a contemporary as opposed to reflective autobiography. For while one can push one's own limits, one's own boundaries of the personal and the private, it is not so easy to do when writing about living others, particularly when those others are in continuing intimate and/or important relationships. When confronted with this dilemma nearly twenty years ago. I realized I could not write a straight-forward autobiography. I thus 'chose' three different approaches: a slice of life where I purposefully did not supply other contexts (Missing Pieces Temple University Press 1982); a true analytic chronology but limited to a single life sphere (my 'intellectual auto biography' in Socio-Medical Inquiries, Temple University Press 1983); and so-called "fictional pieces" where the format permitted not only the omission of certain more personal contexts but the very omission of names (Ordinary Lives - Applewood Press 1982 as well as stories in magazines and journals). In the ensuing years I have come to think that this multi-modal approach was not merely the easy way out but perhaps the only way to deal with such lose-at-hand truths. A literary Rashomon has become a necessary analytic one.

Without meaning to pedestalize either Arthur Frank or his book, he has surely written a classic. By carefully stating that he has no answers-only questions, he provides a guideline to understanding oneself and ones illness far more useful than any manual. By disdaining formal analytic discourse, he has provided more challenges to academic concepts and paradigms about illness than most of our more detailed and dense treatises. This is a book I have already read three times and learned something new on each occasion. Although this may reveal more about me than I care to realize, I recommend that you read it a least once. (Irving Kenneth Zola, Sociology, Brandeis University).

Freund, Peter E.S. and Meredith B. McGuire. Health Illness and the Social Body: A Critical Sociology. Englewood Cliffs, NJ: Prentice Hall, 1991, 402 pp.

This well-written book provides a novel introduction to the sociology of health and

illness. While most of the important issues in medical sociology are covered in the book, it is written more in an essay style than as a textbook. Freund and McGuire cover a wide range of topics and document their presentation with nearly 1000 references in their excellent bibliography.

If this book has themes that tie it together, they cluster around the pole of "power as a key social-structural factor in health and in societal response to illness" and the impact of social meanings and social structures on the body. While these themes unevenly weave the book together, they provide an innovative and critical framework for presenting the sociology of health and illness. In addition to expected chapters on social epidemiology, the social meanings of sickness, seeking help, medical organization and the like, the book also has chapters on the social construction of the body, the social production of disease, illness experience the social construction of medical knowledge, and the economic interests in medical care.

Freund and McGuire present some compelling examples of the social bases for diseased bodies -- including such diverse maladies as obesity, auto injuries, and workplace pollution -- although they don't always conceptually tie them together, I was impressed with how well the authors shift from macro to microsociological levels. In one chapter (three) they present factors like world hunger and environmental pollution, while they smoothly move in the next chapter to the micro level of interactional stress and its impact on the neurochromosomal levels in the body. In a later chapter (ten) they show clearly how the social organization of professional dominance is repudiated in the doctor-patient encounter.

While not a text per se, the book includes some features that make it a more useful teaching tool. Each chapter is preceded by a chapter outline and ends with a brief summary and recommended readings. Also included are two useful appendices: one on sources in the literature of health and illness and the second on available visual resources.

Although there is only a small section specifically on disability (pp. 168-177), the book's focus on social power and the body means there is a great deal of material here related to the

production, care and meaning of illness and disabled bodies.

Given its interpretative and critical orientation, this book probably has limited appeal to readers with a strong positivist orientation. But for those of us who believe that the interpretative - critical orientation is just what is needed to understand the sociology of health and illness, this book provides an interesting alternative to the standard medical sociology textbook. (Peter Conrad, Sociology, Brandeis University).

Johnson, Joy L., and Janice M. Morse (eds.). The Illness Experience: Dimensions of Suffering. Newbury Park, Ca: Sage Publications, 1991, 350 pp., \$36.00 hardcover, \$17.95 softcover.

In three striking ways, The Illness Experience: Dimensions of Suffering is a remarkable book. First, it is remarkable in that the substantive chapters are derived from master's theses of nursing students using a grounded theory approach. Second, the volume is remarkable in that it consists of the products of a type of coordinated teaching and learning effort between a group of faculty members and students at an early point in their graduate studies. Although the editors do not elaborate, it seems that they might have further developed the kind of teaching and collective participation in the analytic process that Strauss (1987) describes. Third, this book is remarkable in the conceptual clarity and usefulness of each student's contribution.

The editors preface their remarks by dispelling the myth that beginning graduate students lack the theoretical sophistication, methodological rigor, and talent to use qualitative methods for their research. The editors report that they were awed by the quality of these students' work. The chapters provide good reason for awe. The quality of these students' work testifies both to the conceptual incisiveness and the practical value of a systematic application of the grounded theory method. When followed carefully, this approach can yield useful results for almost any diligent researcher.

A short introductory chapter lays out the editors' quest for an illness experience model for use by health professionals and a short exegesis of the grounded theory method. The following

five substantive chapters focus on adjusting to life after a heart attack, having a hysterectomy, leaving a psychiatric hospital, maternal involvement in daughters' abortions, and husbands' experience during their wives' chemotherapy. The last chapter by Morse and Johnson describes an "illness-constellation model," which takes into account the sick person and his or her intimates. They define four stages of the model, including uncertainty, disruption, striving to regain self, and regaining wellness with efforts to minimize suffering as underlying the entire process. All the substantive chapters relate in one way or another to the model. The editors end by arguing that chronic illnesses are similar to acute illnesses when examined from an experiential perspective. Yes, but only for those illnesses which flow between flare-ups or crises and then back to routine regimens and ordinary life. And even those illnesses can get worse--considerably worse--as years go by. Subsequently, someone who defines self as essentially "well" when he or she experiences only occasional crises may define self as mostly "ill" a decade later.

Joy L. Johnson's chapter on learning to live again after a heart attack provides an exceptionally clear exposition of that experience. Like Cowie (1976), she discovered that heart patients often minimize their discomfort and explain it as being an ordinary ailment. Her findings about the efforts to gain control resonate with my own, as did Chasee's depiction of women who had hysterectomies learning to read the body (ed. Charmaz 1991). Lorencz offers insights into the perceptions of mental patients. Her discussion of becoming ordinary is reminiscent of Biernacki's (1986) depiction of being and becoming ordinary among ex-heroin addicts. Norris discovers the strategies that mothers' use through the stages of providing sexual socialization to their daughters. Wilson demonstrates the feelings and tactics of husbands as their wives undergo chemotherapy. She analyzed it as a three-stage process of "identifying the threat, engaging in the fight, and becoming a veteran." Each author tried to identify basic social processes and to define strategies participants used to handle each step in the process. The results provide strong conceptual handles on the various experiences.

I have several criticisms of the overall volume. In the past, similar criticisms

occasionally have been tied to the grounded theory approach itself. But they do not derive from any inherent part of the grounded theory approach, rather they reflect how researchers choose to use it. First, many of the chapters are based on a regrettably small sample size, despite some use of multiple interviews. Possibly, these students had lengthy visits with the people they studied or sustained clinical as well as research contact and gained more data from that, but it is not always clear how many interviews were conducted, how detailed they were, what was asked, and what the criteria were for the sequential interviews. The grounded theory approach does not necessarily lead to small sample size or limited exposure to research participants. However, when skillfully employed as evidenced here, the likelihood of gaining valuable insights to social processes increases and with it, I suppose, a proclivity for premature closure.

Second, despite the sensitivity to the social processes studied, the researchers did not reveal a commensurate awareness of the extant literature. Although the editors stated that the students reviewed the literature before embarking on their work unlike some of us who do so afterwards, the chapters remain almost devoid of integration with earlier research findings. The editors argue that the literature on the experience of illness remain in its infancy. That literature might be emerging from several different fields but that is no reason not to draw upon it. A woeful lack of citation is apparent throughout the chapters despite the growing literature about chronic illness in general and about grounded theory studies of it in particular in medical sociology, medical anthropology, and nursing. Surprisingly, beyond the editors' opening chapter, not one author cites Anselm Strauss and his colleagues' methodological or substantive contributions to the study of chronic illness. The style of collaborative research, the type of grounded theory, and the kinds of questions brought to bear on the topic in this book lie squarely within the tradition that Strauss and his colleagues have developed. Why not acknowledge and extend that tradition within the substantive chapters?

Despite these limitations of the book, it certainly fulfills the editors' objective of offering longer, more complex and complete analyses of

significant dimensions of the experience of chronic illness than is possible with the current obligatory 15-20 page format of journal articles. The volume should be useful to educators and students in the behavioral sciences and nursing. Individual chapters will be of interest to patients and family members who must manage the effects of illness described cogently here. (Kathy Charmaz, Department of Sociology, Sonoma State University).

Biernacki, Patrick 1986. Pathways from Heroin Addiction: Recovery Without Treatment. Philadelphia, Temple.

Cowie, Bill. 1976. "The Patient's perception of His Heart Attack." Social Science and Medicine 10:87-96.

Charmaz, Kathy. 1991. Good Days, Bad Days: The Self in Chronic Illness and Time. New Brunswick, NJ, Rutgers University Press.

Kellehear, Allen. Dying of Cancer: The Final Year of Life. New York, NY: Harwood Academic Publishers, 1990, 246 pp.

Traditionally in America, dying was a family affair. Death was discussed publicly only indirectly through community (usually church) representatives. In the 1960s and 1970s, a plethora of explorations began into the interpersonal dynamics of this mysterious process. However, according to Kellehear, much of this work has focused primarily on the intrapsychic and existential impact of this experience on the dying person and his/her caretakers. Study of the sociological nature of the dying process, its change over time, and its potential variance cross-culturally however is lacking. The author offers his study as a necessary analysis of these three areas.

Kellehear draws his information from interviews with 100 terminally ill cancer patients who had less than 12 months to live and knew they were dying. He identifies a general pattern of the experiences and interpretations of dying through a conceptual model of the "Good Death" which is derived from the Western literary concept of "Kalos Thanatos" or "beautiful death", the ideal or exemplary death. It is defined as a "set of culturally sanctioned and prescribed behaviors set in motion by the dying and

designed to make death as meaningful for as many concerned as possible within the social life (in the ethnographic sense of one's place in the larger society) of the dying person. The model purportedly contains five cross-culturally and cross-temporally valid features: 1) personal and preferably public awareness of dying which becomes part of the dying person's identity and social relations; 2) social adjustments and personal preparations that occur in the individual's close relationships; 3) public preparations for death involving formal public social agencies (e.g., legal wills, taxation matters, funeral arrangements); 4) relinquishment of formal work/employment duties and responsibilities (in the traditional sick role, this is expected by the employer, but this view is not always shared by the dying employee); and 5) formal and informal farewells to people in the social network.

The first four chapters of the book present the medical, epidemiological, historical, and sociological circumstances which determine the shape and expressions of the "Good Death" in today's society. The next five chapters expand on each of the five features with specific study findings. Chapter 10 describes the historical basis for the development of the three major changes in practice and ideology of the "Good Death" from pre-industrial times to today: 1) awareness of death via the physician as compared to self, 2) focus of public preparations upon material welfare of the survivors as compared to the salvation of the self, and 3) placement of primacy upon the ability to continue work as a validation of moral and social character despite illness and a radically shortened future. The final chapter discusses directions for future work. The author also includes the interview schedule and statistical results in the appendices.

As a practitioner and researcher in cancer care, the subject matter and premise of this book were very enticing. However, the content did not meet the standards offered. Although he promised a theoretically based study, he instead provided a conceptual model of the "Good Death" as the framework, and phenomenology "without the weaknesses" as the methodology. Additionally, the author chose not to collect verbatim accounts of the study participants, because he felt that collection of this form of information would have been too

intrusive and would have created unjustified respondent burden. This is unfortunate because it would have vitalized his results with the human dimension of this very intimate time of life and capitalized on the strengths of the phenomenological approach used. Neither was the cross-cultural validity of his premise supported. Only one highly ritualized and relatively elite ceremony was chosen (Hara-Kiri) as exemplary of one non-Western society (ancient Japan). Although the historical perspective of the current trends in the dying process presented in this volume is informative, the purpose of the societal forces modeling these transformations over time was unclear. Had the ritual aspects of the "Good Death" been emphasized, we would understand why these rituals have the form they do today, the function they serve, and the reason these current social rituals might be supported for those who need them in their present form.

Due to the limitations discussed above, this book appears best suited for experienced clinicians, researchers, and advanced students who are already familiar with the literature in this area to understand the dual purpose of dying rituals to meet both individual needs for a sense of personal continuity within their existential concerns and greater social needs for cohesion and affirmation of the social order. (Marjorie Kagawa Singer, RN, University of California, Los Angeles).

Kriegel, Leonard. Falling into Life--Essays San Francisco: North Point Press, 1991, 195 pp., \$19.95.

I have never met Leonard Kriegel. I know him only through his published writings. We share, however, a remarkable biographical kinship. We are of approximately the same age, edging up on 60, grew up in the Jewish ghettos of our respective cities, went on to become professors at Jewish based universities, spent a sabbatical year in the Netherlands living in Leiden, and fathers of two children from a first marriage (somehow I think, like myself, he separated from that wife and life.) What makes these coincidences significant is the link of our polio heritage. Polio struck us six years apart, he in 1944, me in 1950, he at age 11, me at 16 and it worked its way through our bodies similarly. We lost strength in our lower bodies and

compensated with over-developed upper bodies. We spent most our adult lives avoiding wheelchairs, ambulating on our braces, he with crutches, I on canes, defying anyone and anything as we climbed our way (literally and figuratively) out of polio. And we have paid a similar physical price. We have fallen and broken our wrists and our hands, had a shattered femur requiring the insertion of a steel plate, endured carpal tunnel syndrome necessitating surgery (though different) and been diagnosed as having degenerative (awful term) arthritis.

Having read virtually everything he has written, I have always had a split identification with him. I continually see the concrete behavioral parallels--our adolescent 'adventures' in wheelchairs at our rehabilitation centers, our awkward sexual encounters, our 'fear of falling,' including the pride in doing it successfully and getting up and the dawning recognition (real and metaphorical) when we could no longer get up by ourselves. And it is clear to me as he so eloquently states that we are both continually drawn back to our polio experience as the well-spring for much of our writing.

"...There was, I admit, a time I thought the day would come when I would discover I had written the virus out of me, when I could see clearly, the mote having been wiped away. That would be when the virus could be relegated, as Freud tells us all parents should be relegated, to that benign but skeptical indifference which remains the imprimatur of the free man. Now I understand that such a time will never come. For no matter what I am writing, my virus is still with me, still the mote in my eye, still forcing me to look where I didn't plan to look and to see what I did not think I wanted to see. And the reason, finally, why I write. A simple revenge, at best." (p.94-5)

But this 'mote in our eye' seems ultimately to have driven us down different pathways. All the essays in this book brilliantly illuminate the myriad outrages in both literature and life inflicted on people because of their disabilities but his rage seems to sputter, hitting the nearest targets, often himself. I too indeed miss what he misses as I recorded recently in a short story about me and my youngest daughter

Kyra (Is It All Right To Be Sad--Western Journal of Medicine 1991 May: 154: p.559). Yet I do not think of myself as either enraged or bitter--nor am I sure I ever was. I still get very angry and occasionally depressed over my polio legacy but it is almost always in regard to a specific event or barrier not "the enduring loss." Moreover, when I do get angry, both in my writings and my actions, I turn it outward to analyze and bring down the social and physical barriers which oppress us.

This may be best illustrated in our use of language. As I have stated in many forums anyone has the right to call themselves what they want. I also realize that there is much controversy in the disability community as to the political correctness of certain terms. In this context, Kriegel can call himself "a cripple" or anything else he wants. I must, however, declare that whatever else this word is, it is not a "more honest" declaration, even to the extent, as he once claimed, that this is how others thought of and treat him. It is not more honest to call me "a kike" nor my daughter "a nigger" just because others think of us that way.

I recognize that Leonard Kriegel speaks for many. But it is not as the publicity blurbs would have you believe that this is the essence of 'what cripples know.' He presents a truth, a vibrant eloquent enduring one, a personal one but alas not in his writings - a political one. Like Kriegel, I will continue to be enraged and rage against injustice but our ultimate targets seem to be different. (Irving Kenneth Zola, Sociology, Brandeis University).

Lifshitz, Leatrice H. (Ed). Her Soul Beneath the Bone. Urbana and Chicago: University of Illinois Press, 1988, 78 pp., \$19.95 hardcover, \$8.95 softcover.

Her Soul Beneath the Bone is a collection of poetry on women's experience of breast cancer. Over two dozen women write about their journeys through diagnosis, mastectomy, chemotherapy, and adjustment to breast cancer. In the forward, Rose Kushner herself diagnosed with breast cancer in 1974, notes that a book of poetry in this area is unusual, but provides an artistic and moving expression of the anguish, pain and terror that women experience. Most of the women had mastectomies, which leads me to wonder how

women who are now choosing lumpectomy and radiation would respond.

The collection of poems brings women's voices into public view. By doing so, the book helps negate the silence that has long accompanied breast cancer. With 1 in 9 women being diagnosed with breast cancer, women must talk to each other, share their experiences and their feelings to make the disease more visible. This increased visibility, just as in the Disability Rights Movement and the Gay Rights Movement will increase public awareness and attract greater interest in research funding, while also asking basic questions, such as why the incidence is rising at the same time that mortality rates have not changed in 25 years. Leatrice Lifshitz is right on target when she says, "silence encourages denial, trivialization, and ignorance" (p. xvii).

The poems are not painless reading, particularly for those of us who are either close to women with breast cancer, or are women with breast cancer. The raw emotions of anger and pain are honest and forthright in confronting the health care system, providers, society, life and death, adjustment to disfigurement and amputation. Mastectomy is not only the amputation of a body part, but one which has historically symbolized "womanliness." The beauty of the poetry is that as women come to terms with loss, they learn that their sense of sexuality and femaleness reside in their whole being, not solely in their breasts.

I am intrigued by the concepts of wholeness and the need to replace lost body parts, and what that means as women think about reconstruction. Several poems address this complex issue. Deena Metzger celebrates her "amazon" like body, she has become "a warrior who does not kill or wound. On the book of my body, I have permanently inscribed a tree" (p. 71).

Through hearing these women's voices, I am reminded that individuals respond very differently to illness, and as social scientists study the experience of illness, we must attend to difference and uniqueness, rather than concentrating generalizability.

Kushner points out that she read the book looking for changes in women's reactions now that biopsy and definitive surgical procedures are separate. Although she sees the anger as "subtle" and less aimed at physicians

who mutilated unconscious women, and more at breast cancer as a disease, I find the anger aimed in many directions: surgeons and other health care providers, the body that failed women, the support from family or partner that did not materialize.

There is also humor as women learn to adapt to an altered body. Despite dealing with loss and anger, the book as a whole resounds with hope, resilience, and strength. (Linda C. Andrist, Mass General Hospital, Institute of Health Professions, Boston, MA).

Seymour, Wendy. Bodily Alterations: An Introduction to a Sociology of the Body for Health Workers. Sydney, Australia: Allen and Unwin, 1989, 145 pp., \$17.95 softcover.

This short book is a sociological examination of the ways people who have experienced severe "bodily alterations" and loss restructure their self-identities. The extensive and permanent alterations of the body associated with quadriplegia and paraplegia bring about a dramatic separation of the body and the self, thus necessitating a reconstitution of the self and one's social identity. Using qualitative data gathered in interviews with quadriplegics and paraplegics both outside and inside rehabilitation institutions, Seymour analyzes the social processes that influence the deconstruction and subsequent reconstitution of self identity. She bills her study as an "introduction to a sociology of the body for health workers" as it explores the relationship between body, self and society by exposing the taken for granted nature of social categories and forces which define quadriplegia and paraplegia. The ultimate aim of the author, a physiotherapist now teaching social medicine to health professionals at the South Australian Institute of Technology, is to encourage a wide range of health workers to become aware of the need to move beyond the traditional medical model of rehabilitation that focuses on physical and vocational needs to a much broader approach, "true rehabilitation," which attends intensively to the body, self and society relationship.

In her analysis, Seymour employs a moderately heavy dose of social phenomenology and symbolic interaction theory to help interpret her data and provide insights about the empirical world of her respondents. Seymour's

explanations of her concepts and theoretical orientation in the first third of the book are brief, yet adequate. Further, as she goes on to explore the everyday world of her paralyzed respondents, her use of the two theoretical paradigms is clear and careful. Yet, as she continues by skillfully discussing the social processes of going from a person to a paralyzed patient through an institutional setting and back again to a newly reconstituted social self the amount of empirical data used is disappointing. Seymour's initial chapter is entitled "Listening to the Patient," but in fact the reader does not "hear" enough first-hand comments from the respondents. Rather, much of what is presented is the author's reconstruction of her respondents' life stories and only brief excerpts at that. Seymour spent three months conducting participant observation research in a spinal rehabilitation unit and completed "lengthy and detailed" conversations over several weeks with her seven main respondents living outside of rehabilitation institutions. It is important, especially in studies with few respondents, to let them speak in their own words so that readers may judge for themselves the appropriateness of the generalizations drawn by the researcher. I believe the quality of Seymour's data is very good. The lack of first-hand data presented, however, is an important problem with this otherwise very insightful and useful study.

Of course, Seymour's social constructionist view is not new to sociologists who study health and illness. However, the great strength of Seymour's work is that it is distinctively sociological and revealing, and yet, is written in a manner that will communicate well with health professionals in a variety of rehabilitation settings who may not be steeped in the writings of Schutz, Berger and Luckman, Goffman and the social constructionist view of social order. This should increase the awareness among health professionals of the need to broaden the goals of rehabilitation. The prevalent clinical model of rehabilitation attempts to normalize disabled people by repairing broken body parts while downplaying the equally crucial social process of the reconstitution of the self. This only serves, concludes Seymour, to perpetuate social roles for the disabled which have them leading "narrowly defined, passive, apologetic lifestyles" and

"aspiring to unrealistic goals . . . on the inequitable terms of the able bodied world." In this way the rehabilitation community perpetuates and helps construct confining social roles for disabled individuals. Until health workers realize this and begin to employ a broader rehabilitative approach geared, at least, in part to empowering disabled people to challenge and "break the bounds of their narrowly defined role", the alienation and frustration Seymour found among her respondents will continue to plague many disabled people.

This book is very respectful of the dedicated, skillful and enthusiastic work performed by health professionals. But, it does challenge the existing values, assumptions and limited expectations of clinical rehabilitation. I hope health professionals as well as interested sociologists will read this book. I certainly plan to use it in my medical sociology course. (Bill Hanson, Sociology, Mary Washington College, Virginia).

Smith, G.R., Jr., Somatization Disorder in the Medical Setting. National Institute of Mental Health, DHHS Pub. No. (ADM) 90-1631. Washington, DC: Supt. of Docs., U.S. Govt. Print Off., 1990, 98 pp.

Persons who experience and express their personal problems in body language confuse and confound doctors, family, medical insurers and themselves. They have been labeled witches, saints, hysterics, hypochondriacs and crocks among other unflattering names. Contemporary psychiatry designates these people as suffering from Somatization Disorder. the diagnosis requires a lifetime history of 13 unexplained somatic (bodily) symptoms from a list of 37 possible symptoms affecting a wide range of organs and systems. To qualify, these symptoms must begin before the age of 30 and be of sufficient severity to require the patient to consult a physician, take medicine, or change her lifestyle.

One person in 1000 are estimated to have this disorder. Some investigators believe that it is even more common (.4% - 2%). These patients, not surprisingly, consult non-psychiatric physicians exclusively. It is only after exhaustive laboratory tests have failed to turn up explanatory findings does the frustrated internist

or surgeon "turf" these patients to the psychiatrist. Somatizers are also the ones who go in droves to fringe practitioners such as clinical ecologists and receive controversial diagnoses such as fibromyositis, chronic fatigue syndrome, and are subjected to many, unnecessary x-rays, MRIs and other high tech, expensive tests and undergo a variety of exploratory procedures and surgeries. Of course none of these interventions are beneficial and many carry risks of complications and death. The cost of unnecessary tests, procedures and surgery are most likely in the billions (S.D. patients have a history of 5 surgical procedures, on average, and visit the doctor 6 times every six months). In a survey of 43 patients with Somatization Disorder, 86% reported that they were disabled from work. Add to the huge medical bill the enormous societal costs that are incurred for disabled workers, and the total cost to society is indeed staggering.

This book, commissioned by the NIMH, is written for non-psychiatric physicians although it should prove valuable to medical sociologists, anthropologists and economists/ This slim volume contains all that is known about Somatization Disorder and is enhanced by extensive references and an annotated bibliography.

An interesting peculiarity about S.D. is that it, like anorexia nervosa and bulimia, a condition that almost exclusively affects women. Because Dr. Smith approaches this condition as a disease, the gender discrepancy is attributed to genetic loading. It is postulated that in males the same gene may have its phenotypic expression in Anti-social Personality Disorder, which occurs almost exclusively in males. It is, of course, possible and in my view probable, that this gender dimorphism has little to do with genetics and much to do with the socialization process that males and females undergo in our culture and the power differential between the sexes. Thus S.D. may not be a disease at all. However, since patients themselves define the problem as medical, the disease model has heuristic value. There is no treatment for this disease.

Psychotherapy has not proven effective although it does cut down on visits to other doctors. The therapeutic approach promoted by the author is one of conservatism. Early diagnosis, the fewest medical tests and procedures possible, emotional support and sparing use of medications stand the best chance of keeping these patients alive and

functioning without depleting our medical resources. (Irwin N. Hassenfeld, Albany Medical College, Albany, N.Y.)

Stewart, Jean. The Body's Memory. New York: St. Martin's Press: 272 pp., \$16.95.

"Peter says I should write everything down. He says it will save me." So opens Jean Stewart's novel The Body's Memory. It was good advice for Kate Meredith the protagonist of the story. It is good advice for us all. For in knowing where we are going, have been, and reflecting on it, we have a better chance of sorting out where we can go from there. For Kate it was to help her face "the real thing." She thought that only meant life threatening cancer which would eventually lead her into a wheelchair and a changing, disintegrating body. The book, thank God, does not end with her cured but changed, really transformed. Over a three year period through her journal entrees, poems, third-person narratives, letters to and from herself and between others, and a number of personal 'voice-overs' we travel with her and her body's memory.

To those who have been there it has a painful familiarity. There are places but more importantly people who are now closed to us; few things can ever be taken-for-granted; everything seems to take longer and more planning. Eventually too there are the new pleasures (yes there are things one can do in and with wheelchairs far better than on two legs). It is a bumpy tour-three times she is operated on for cancer and each time they think they got it all. She is ultimately loved on her own terms but she is also raped. Not surprisingly outsiders - Ellen a cellist, black and an incest survivor; Peter, a guitarist, itinerant musician and double amputee - are the ones who sustain her until Sheba, who Kate affectionately calls Respirator Woman will help her enter the world that all others have denied existed - a meaningful life with a disability shared with others who have a disability.

While this insight is itself not unique its applicability to cancer is. With the possible exception of Audre Lorde's Cancer journals, The Body's Memory is one of the first to politicize coping with cancer. "Kate had hidden her demons away, believing they were a private matter, vaguely ashamed that ordinary living had

become so difficult. The Respirator Woman, on the other hand, had not; her ghosts had been transmitted through her own gift of vision, into the public domain, where they acquired the properties of a common historic legacy with a name: discrimination. To which the only appropriate response was a just, pure anger, coupled with the will to change that which, as anyone could plainly see, was the cause of her pain, far more than having a body that 'didn't work.' (p. 272-3). (Irving Kenneth Zola, Sociology, Brandeis University).

Etc, Etc.

Irving Kenneth Zola

In trying to keep up with so fast a developing field of inquiry as "the body", it is inevitable that this issue of DSQ has missed some important historical references and far too many contemporary ones. As a partial corrective, I add my set of "not to be missed" citations.

Literature on women and the body is to use the cliched term "on the cutting edge" and is especially relevant for disability studies. Our struggle to separate from "the medical model" has been part of their ongoing struggle for many years (Jane M. Usher. The Psychology of the Female Body London and New York: Routledge 1989). The necessity as some argue (Boston Women's Health Book Collective, The New Our Bodies Ourselves, New York: Simon & Shuster, Rev. Ed Forthcoming 1992) is not to deny the existence of their bodies and bodily processes as mere social construction but to integrate, acknowledge and appreciate these cyclical and often unique (i.e. to women) changes. This dilemma is very well articulated by Anne Balsamo in her "Reading the Body in Contemporary Culture: An Annotated Bibliography" (Women and Language 1990 Vol. 13, No. 1, 64-85). "I want to suggest that although the body serves as an important terrain for feminist work, it is not to be constituted as an essentialized object. In this sense, the more interesting question to ask then is not, what is the female body, but rather, how is the body female, that is, how is the body gendered." (p. 65). Her 200 entries and critical comments span an enormous ranges of sources - citing people

and places that many of us might unwittingly ignore. Barbara Duden whose two recent books, The Woman Beneath the Skin - A Doctor's Patients in Eighteenth Century Germany (Harvard University Press; Cambridge, 1991) and Woman's Body as Public Space (forthcoming 1992) challenge current historical interpretations with an almost revisionist radicalism, has also compiled a 1000 item annotated bibliography of historical and non-English sources (Barbara Duden, "A Repertory of Body History" in Michel Feher, Ramona Naddaff, Nadia Tazi, editors Fragments for a History of the Human Body, Part Three. New York: Zone, 1989).

An excellent start to deconstructing as well as constructing this gendering of the body is a special issue of Hypatia - A Journal of Feminist Philosophy (Vol 6. No. 3, Fall 1991 - Indiana University Press, 10 & Morton Sts., Bloomington, IN 47405). Edited by Elizabeth Grosz, "Feminism and the Body" brings the keen eye of critical philosophy to bear in eleven distinctly argued chapters. The papers are very theoretical, arguing against various men's conceptions of the body (including Merleau-Ponty, Freud, Lecan, Foucault, Levinas, Hegel) while drawing insights from them and building alternative models based on the work of Iris Young, Monique Wittig, Luce Irigaray and French feminists. It is especially necessary to bring these theorists in touch with disability studies because our work is so invisible to them (and probably them to us, though not as markedly). Thus the authors in Hypatia seem unaware of one of their own, Susan Wendell, who but two years previously published her most insightful article, "Toward a Feminist Theory of Disability" in these very pages (Hypatia Vol. 4, No. 2, Summer 1989, P. 104-124).

A second collection cited in several of the Midsection essays is The Body - Social Process and Cultural Theory (Newbury Park, CA: Sage, 1991) edited by Mike Featherstone, Mike Hepworth, and Bryan S. Turner. This too grows out of the publications of a journal, Theory, Culture, & Society between the years 1982 and 1990. Though their disciplinarian background is primarily sociology they have cast their net widely. As they state in their introduction, "From its very first issue, Theory, Culture, & Society...fostered interest in the Sociology of the Body as one of the crucial instances of the

complex interrelations of nature, culture, and society..." While admittedly non-exhaustive the papers draw on a wide variety of theoretical perspectives and even wider range of representations of the body such as: the expressions of emotions, romantic love, dietary practices, consumer-culture images of youth, fitness and beauty, martial arts, social welfare, modernism, postmodernism and old age, media images of women and sexuality." While insight can indeed be drawn from any of these essays and their working bibliographies I found especially useful Bryan Turner's ostensible introduction on "recent developments" and Arthur Frank's "analytical review" and six-page "partially annotated bibliography."

Anthropologists have a long standing interest in the body and bodily rituals. Robert Murphy brought this tradition to bear on his autobiographical account of his own disability in the Body Silent (New York: Henry Holt, 1987). Taking off from this work, he wrote a focus column (DSQ, Spring 1989, Vol. 9 No. 2), "Subjects and Objects" where he reflected on first-person accounts. The Medical Anthropology Quarterly, an International Journal for the Cultural and Social Analysis of Health (American Anthropological Association, 1703. New Hampshire Ave., N.W. Washington, D.C. Tel (202) 232-8800) is likely in any given issue to have a body-relevant article. From April 26-29, 1990 The American Ethnological Society held it annual convention on the theme "The Body in Society and Culture." Unfortunately I have not heard of any publication of the proceedings. You might call/write Lucille Horn at the American Anthropological Association office for more information. If all else fails, I have made a 3 page mock-up of the program available for a \$1 to cover xerox, postage, and mailing.

DSQ has itself directly and indirectly addressed issues of 'the body'. Our previous media issues (Summer 1986 and Fall 1990), on women (Spring 1986 and Summer 1989) as well on the "Experience of Illness and Disability (Spring 1989) have much to say on this topic. My own work has been catalyzed most recently by the writings of Harlan Hahn (see his essay in the MidSection), Emily Martin's The Woman in the Body (Boston: Beacon 1987), any of several works by Nancy Mairs (Remembering The Bone House - An Erotics of Place and Space, New

York: Harper and Row 1989 or Plaintext Deciphering A Woman's Life, Tucson: University of Arizona Press 1986 and her most recent Carnal Acts) and my own attempt to deal with her; the state of the art collection, Women with Disabilities ("To Our Innermost Parts, Kaleidoscope, Winter/Spring, 1991, #22, 48-51) by Adrienne Asch and Michelle Fine (Philadelphia: Temple University Press 1988); and the "burst-upon-the-scenes work of Arthur Frank (cited in the Mid Section and in Booknotes). His provocative "Bringing Bodies Back In: A Decade Review (Theory, Culture, and Society, 7(1): 131-61) was the stimulus for my most recent set of formal reflections, "Bringing Our Bodies and Ourselves Back in - Reflections on Past, Present, and Future 'Medical Sociology'" (Journal of Health and Social Behavior Vol 32, No.1. 1991, p. 1-16).

Although there can be no final word visual images of the body have long been a source of public interest, particularly changing views of the female body. In light of the emphasis in this DSQ issue on cancer a particularly vivid, provocative and often disturbing set of images is provided in Jo Spence's autobiographical account, "Identity and Cultural Production - or on deciding to become the subject of our own histories rather than the object of somebody else's" (Views - the Journal of Photography in New England Vol 11, No. 3, Summer 1990, p. 8-11).

THE SOCIETY PAGES

Elaine Makas, Secretary
Society for Disability Studies

Before bringing you up to date on the latest news from the Society for Disability Studies, we would again like to encourage those of you who are not yet members to consider joining our group. For further information on SDS, contact Sharon Barnartt, Membership Chair, Department of Sociology, Gallaudet University, 8th and Florida, NE, Washington, DC 20002; or call her at 202/651-5160 or Bitnet: SNBARNARTT@GALLUA.

1992 Annual Meeting

The 5th Annual Meeting of the Society for Disability Studies will be held at the Crown Plaza Hotel in Rockville, MD (just outside Washington, DC), June 17-20, 1992. An exciting program is planned with paper sessions on topics ranging from policy analyses of the ADA to surveys of representations of physical disabilities in literature, and with panels on disability data sources and on publishing opportunities in disability studies. In addition, there will be a keynote address by William Graves, Director of the National Institute on Disability and Rehabilitation Research; the annual, now traditional, Teaching Disability Studies Workshop given by Irv Zola (focusing this year on being an expert witness); and entertainment provided by the Gallaudet Dance Company. Opportunities for meeting people and for networking will abound: there will be a reception following Dr. Graves' address, a members breakfast, and an SDS-sponsored luncheon. (For more details see the outline of the preliminary program at the end of the Society Pages).

Registration materials will be mailed to all SDS members the first week of March. For further information on the conference or to receive registration materials (if you are not a member of SDS), contact Barbara Altman at 301/227-8400 during the day; or write to her at 14608 Melinda Lane, Rockville, MD 20853.

Book Exhibit

There will be a book exhibit again this year at the Society's annual meeting. This is an

excellent opportunity to share information on recent publications in the field of disability studies. To suggest relevant titles or to request further information about the book display or conference program advertising, contact Harve Horowitz, SDS Book Exhibit Coordinator, 11620 Vixens Path, Ellicott City, MD 21042-1539 (410/997-0763; fax 410/997-0764; in the District of Columbia, direct dial 301/596-0328).

Emerging Scholar Award

Each year the Society presents an Emerging Scholar Award which consists of a certificate and a cash award. It is intended for a student, a junior faculty member, or someone who is just beginning her/his research career. Papers can cover any topic in the field of disability studies. Send two copies of the paper to Professor Paul Longmore, Department of History, Stanford University, Stanford, CA 94305-2024. The author's name must not appear on the paper itself. At least two readers will referee each paper, and the author will receive the critiques from these referees. The winner will be announced at the June 1992 meeting of the Society.

Policy Issues

Beginning with the next issue of DSQ, SDS policy activities will also take the form of a new column on public policy. This column will be written by Kate Seelman, Chair of the Policy Committee, and will explore a wide range of areas including meta issues such as "What constitutes a researchable question?" and "What should be the connection between research and advocacy?" The Policy Committee looks forward to your involvement in this column.

Membership Directory

Again this year, the Society will publish a membership directory including the names, addresses, phone numbers, positions/affiliations, research interests, and areas of professional training of the more than 300 SDS members who wish to be listed. This valuable networking resource will be available free of charge to all Society members in time for the annual meeting. The Secretary will mail requests for updates of Directory listings to all SDS members during the month of March.

By-law Changes

As a result of discussions at last year's Board of Directors Meeting and a subsequent vote by the Board, a number of changes have been made in the SDS By-laws. With the exception of a few minor alterations and corrections in wording, all changes relate to the establishment of three distinct categories of Board Members: Directors, Board Members Emeriti, and Ex-officio Board Members. The Directors are the eleven members of the Board elected by Society members in the annual elections. Directors serve three year terms and are the only voting members of the Board. The Board Members Emeriti are the five founding members of the Society: Daryl Evans, Stephen Hey, Gary Kiger, John Seidel, and Irv Zola. Board Members Emeriti have lifetime membership on the Board but do not vote (unless they are also Directors). Ex-officio Board Members are those who served as Chairperson of the Board, Secretary, or Treasurer during their last year as Directors. They have one-year non-voting membership on the Board.

And Last But Not Least

-- The National Center for Health Statistics has contacted the Society for input on their 1994 health and disability survey. This survey instrument is being reviewed.

-- Steps are being taken to list the Society in the "National Trade and Professional Associations of the United States" and in the "Encyclopedia of Associations" so that persons who hear of us can make contact. We would appreciate knowing of other data bases in which the Society should be listed. Please send the names and addresses of such resources to David Pfeiffer, Suffolk University, Boston, MA 02180-2770, so that he may contact them.

-- For further information on these "Society Pages," please feel free to contact Elaine Makas, Secretary, Society for Disability Studies, c/o Department of Psychology, Bates College, Lewiston, ME 04240 (h:207/784-5726).

-- We look forward to seeing you in

Rockville in June!

Preliminary Program for the SOCIETY FOR DISABILITY STUDIES June 17-20, 1992 ROCKVILLE, MD

Wednesday, June 17, 1:30-3pm,
DISABILITY, ATTITUDES, & PROBLEMS
OF METHOD; 3:30-5pm, Panel: POLITICAL
DIMENSIONS OF DISABILITY POLICY;
3:30-5pm, APPLICATIONS OF THE
MODIFIED ISSUES IN DISABILITY SCALE
(MIDS); 6-7:30pm, Workshop: TEACHING
DISABILITY STUDIES.

Thursday, June 18, 7:30-8:30am,
MEMBERS BREAKFAST; 8:30-10am, Panel:
IMPLICATIONS OF THE HUMAN GENOME
INITIATIVE FOR PEOPLE WITH
DISABILITIES; 10:30am-Noon, Panel:
REPRESENTATIONS OF PHYSICAL
DISABILITY IN BRITISH & AMERICAN
LITERATURE; 10:30am-Noon, DISABILITY
AND HEALTH-INSURANCE CONCERNS;
1:30-3pm, DISABILITY, FAMILY DYNAMICS,
& THE LIFE COURSE; 1:30-3pm,
DISABILITY, LEGAL RIGHTS, & SOCIAL
JUSTICE; 3:30-4:45pm, Panel: PUBLISHING
OPPORTUNITIES IN DISABILITY STUDIES;
5-6pm, Keynote Address: THE FUTURE OF
DISABILITY-STUDIES RESEARCH; William
H. Graves, Ed.D., Director, National Institute of
Disability and Rehabilitation Research
(Reception Immediately Following Dr. Graves'
Address).

Friday, June 19, 8:30-10am, WORKING-
AGE PERSONS WITH DISABILITIES; 8:30-
10am, DISABILITY AND PSYCHO-SOCIAL
ISSUES; 10:30am-Noon, Panel: THE
CHANGING FOCUS OF SERVICES FOR
YOUNG CHILDREN WITH DISABILITIES
AND THEIR FAMILIES: A
MULTIDISCIPLINARY PERSPECTIVE;
10:30AM-Noon, A CRITIQUE OF
INSTITUTIONAL RESPONSES TO
DISABILITY; Noon-1:30pm, SDS LUNCHEON;
1:30-3pm, Panel: DISABILITY AND
MINORITY GROUP STATUS; 1:30-3pm,
DISABILITY, SUPPORT, AND
EMPOWERMENT; 3:30-5pm, Panel:

**DISABILITY DATA SOURCES; 3:30-5pm,
SOCIAL MOVEMENTS, SOCIAL CHANGE;
5:15pm-6:30pm, SDS BUSINESS MEETING.**

**Saturday, June 20, 8:30-10am, IMAGES,
PERCEPTIONS, & MORAL MEANINGS OF
DISABILITY; 10:30am-Noon, Panel:
DISABILITY DEFINITIONS.**

ENDNOTE

**In Memoriam - Timothy M. Cook
August 14, 1953 - October 21, 1991**

I knew of the work of Tim Cook long before I met him. Whenever there was an opportunity to use the legal system in defense of our rights as people with disabilities, he was there: a lawyer with the Civil Rights Division of the Department of Justice, an attorney with the Disabilities Project at the Public Interest Law Center of Philadelphia, former director of the Western Law Center for the Handicapped in Los Angeles, and finally founder of the National Disability Action Center in Washington, D.C.

His phone calls to many of us often began with a plea and a promise: "I've got this case ... no one seems to want to touch it ... I can't promise when we'll pay ... but we need your help ... this is a chance to make a difference." And he was right. The cases were tough. There was never enough money to pay for his services let alone our expenses. And the cases were all worth it. Even, when we lost, we all felt the fight itself was making a difference.

Tom Harkin told his fellow Senators that "Tim was a hard-nosed uncompromising advocate." As Cyndi Jones of Mainstream Magazine said for us all, "We will miss him, but we will not forget him."

Irving Kenneth Zola

To remember him, his work and help support his family please send a contribution payable to the Tim Cook Fund, c/o The Mental Health Law Project, 1101 15th Street, N.W., Suite 1212, Washington, D.C. 20005.