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The Sociology of the Body

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In Tom Stoppard's (1967) play *Rosencrantz and Guildenstern are Dead* the two central characters lament the precariousness of their lives. Rosencrantz seeks solace in life's only certainty when he comments that "the only beginning is birth and the only end is death – if we can't count on that what can we count on." To this he might have added that he could reliably count on the fact that he had a body. The "fact" that we are born, have a body, and then die is of course something that does *seem* to be beyond question. It is something that we can hold on to, as we live in a world that appears to be ever more uncertain and risky (Giddens 1991; Beck 1992). But is this fact so obvious? Ironically, the more sophisticated our medical, technological, and scientific knowledge of bodies becomes the more uncertain we are as to what the body actually is. For example, technological developments have meant that boundaries between the physical (or natural) and social body have become less clear. With the development of assisted conception, when does birth begin? With the development of life extending technologies, when does the life of a physical body end? With the development of prosthetic technologies, what constitutes a "pure" human? It seems the old certainties around birth, life, bodies, and death are becoming increasingly complex. It is perhaps not surprising, therefore, that attempts to understand the social and ethical significance of the body have become central to recent sociological debates. Attempts to develop a sociological appreciation of the body have been especially important in the subdiscipline of the sociology of health and illness. The aim of this chapter is to delineate some of the key developments in the sociological theorizing of the body and to assess their significance for a number of substantive issues in medical sociology.

To meet this aim the chapter will first, review the main "perspectives" on the *sociology of the body* and the key social theorists who have informed each of these approaches. Second, the chapter will outline the parameters of the

sociology of embodiment. Two key concepts which have emerged from these sociologies of the body and embodiment – *body projects* and the *lived body* – will also be discussed. Finally, a number of substantive issues which are central to medical sociology will be discussed with a view to highlighting the value of incorporating the body into the analysis of issues associated with health and illness. These issues are: illness and injury; health care work; medical technology; and health inequalities.

Sociological Perspectives on the Sociology of the Body

There is now a copious literature on the sociology of the body which spans a range of perspectives. There are, however, alternative ways in which the body is understood and analyzed, with the most obvious approaches being rooted within the physical sciences, and classified as being part of a naturalistic perspective (Shilling 1993; Nettleton 1995). In this chapter, however, we will focus on three main *sociological* approaches. First, those which draw attention to the *social regulation* of the body, especially the way in which social institutions regulate, control, monitor, and use bodies. Our bodies are, of course, highly politicized; whilst we might like to think that we own and have control of our own bodies and what we do with them – we do not. This fact has perhaps become most strikingly evident as a result of feminist analyses of the ways in which medicine has controlled the bodies of women (Martin 1989; Oakley 1993). It is also evident in contemporary debates on topics such as euthanasia, organ transplantation, and abortion.

A second perspective within the sociology of the body literature is that which focuses on the ontology of the body. A number of theorists have asked the question – what exactly *is* the body? Their answer is that in late modern societies we seem to have become increasingly *uncertain* as to what the body actually is. For most sociologists the body is to a greater or lesser extent socially constructed. However, there are a number of variants of this view with some arguing that the body is simply a fabrication – an effect of its discursive context, and others maintaining that bodies display certain characteristics (e.g. mannerisms, gait, shape) which are influenced by social and cultural factors.

The third approach pays more attention to the way the body is experienced or *lived*. Whilst this *phenomenological* approach accepts that the body is to some extent socially fashioned it argues that an adequate sociology must take account of what the body, or rather embodied actor, actually does. In this sense it is perhaps more accurately described as a *sociology of embodiment* rather than a sociology of the body. This approach to the study of the body has gained much currency in recent years. It has to some extent emerged as a result of critical and creative debates within this field of study which have attempted to counter the dominant structuralist approach that concentrates on the social regulation of bodies. Some authors have become aware that this was a missing dimension of their earlier work. For example, in the Introduction to the second edition of his influential book *The Body and Society*, Turner (1996: 33) wrote that his earlier

work will "now be corrected by a greater focus on the phenomenology of experience." This said, research which has outlined the ways in which bodies are socially regulated and socially constructed remains central to our understanding of the body in society.

Social Regulation of Bodies

In his book, *Regulating Bodies*, Turner (1992) suggests that late modern societies are moving toward, what he refers to as a "somatic society"; that is, a social system in which the body constitutes the central field of political and cultural activity. The major concerns of society are becoming less to do with increasing production, as was the case in industrial capitalism, and more to do with the regulation of bodies. Turner (1992: 12–13) writes:

> our major political preoccupations are how to regulate the spaces between bodies, to monitor the interfaces between bodies, societies and cultures . . . We want to close up bodies by promoting safe sex, sex education, free condoms and clean needles. We are concerned about whether the human population of the world can survive global pollution. The somatic society is thus crucially, perhaps critically structured around regulating bodies.

The concerns of the somatic society are also evidenced by the concerns of contemporary political movements such as feminist groupings, pro-and anti-abortion campaigns, debates about fertility and infertility, disability, and the Green movement.

This idea emerges from Turner's earlier work (1984) which examined the ways in which bodies are controlled within society and finds that it is the institutions of law, religion, and medicine that are most preoccupied with such regulation. The role of religion, law, and medicine are especially evident at the birth and death of bodies. Whilst the control of bodies by the church has gone into decline, the control of bodies by the medical profession is in the ascendancy. He argues, echoing the earlier writings of Zola (1972) and Conrad and Schneider (1980), that as society has become more secularized it has also become more medicalized with medicine now serving a moral as well as a clinical function:

> Medical practice in our time clearly does have a moral function, especially in response to AIDS and IVF programmes for unmarried, single women, but these moral functions are typically disguised and they are ultimately legitimized by an appeal to scientific rather than religious authority . . . medicine occupies the space left by the erosion of religion. (Turner 1992: 23)

Developing an analytical framework which works at two levels – the bodies of individuals and the bodies of populations – Turner identifies four basic, social tasks which are central to social order. We might refer to these as the four 'r's. First, *reproduction*, which refers to the creation of institutions which govern populations over time to ensure the satisfaction of physical needs, for example the control of sexuality. Second, the need for the *regulation* of bodies,

particularly medical surveillance and the control of crime. Third, *restraint*, which refers to the inner self and inducements to control desire and passion in the interests of social organization. Fourth, the *representation* of the body, which refers to its physical presentation on the world's stage.

Turner's conceptualization of these four 'r's owes a great deal to the ideas of Foucault, especially his writings on normalization and surveillance. These draw attention to the ways in which bodies are monitored, assessed, and corrected within modern institutions. A central theme which runs through Foucault's (1976, 1979) work is that the shift from pre-modern to modern forms of society involved the displacement of what he terms *sovereign power*, wherein power resided in the body of the monarch, by *disciplinary power*, wherein power is invested in the bodies of the wider population. Disciplinary power refers to the way in which bodies are regulated, trained, maintained, and understood and is most evident in social institutions such as schools, prisons, and hospitals. Disciplinary power works at two levels. First, individual bodies are trained and observed. Foucault refers to this as the anatomo-politics of the human body. Second, and concurrently, populations are monitored. He refers to this process as "regulatory controls: a bio-politics of the population" (Foucault 1981: 139). It is these two levels – the individual and the population – which form the basis of Turner's arguments about regulating bodies which we have discussed above. Foucault argues that it is within such institutions that knowledge of bodies is produced. For example, the observation of bodies in prisons yielded a body of knowledge we now know as criminology and the observation of bodies in hospitals contributed to medical science. In fact it was the discourse of pathological medicine in the eighteenth century which formed the basis of the bodies in western society that we have come to be familiar with today. The body, Foucault argued, is a fabrication which is contingent upon its discursive context (see Armstrong 1983).

Through these discussions we can see that the regulation of bodies is crucial to the maintenance of social order. This observation forms the basis of Mary Douglas's (1966, 1970) work on the representation of the symbolic body. The ideas of Mary Douglas – an anthropologist – have been drawn upon extensively by medical sociologists. She argues that the perception of the physical body is mediated by the social body. The body provides a basis for classification, and in turn the organization of the social system reflects how the body is perceived.

> The social body constrains the way the physical body is perceived. The physical experience of the body, always modified by the social categories through which it is known, sustains a particular view of society. There is a continual exchange of meanings between the two kinds of bodily experience so that each reinforces the categories of the other. As a result of this interaction the body itself is a highly restricted medium of expression. (Douglas 1970: xiii)

Thus, according to Douglas, the body forms a central component of any classificatory system. Working within a Durkheimian tradition she maintains that all societies have elements of both the sacred and the profane, and that

demarcation between the two is fundamental to the functioning of social systems. Thus societies respond to disorder by developing classificatory systems which can designate certain phenomena as "matter out of place." "Where there is dirt there is system . . . This idea of dirt takes us straight into the field of symbolism and promises a link-up with more obviously symbolic systems of purity" (Douglas 1966: 35). Anything which transcends social, or bodily, boundaries will be regarded as pollution. Ideas, therefore, about bodily hygiene tell us as much about our cultural assumptions as they do about the "real" body and our medical knowledge of it. Furthermore any boundaries that are perceived to be vulnerable or permeable will need to be carefully regulated or monitored to prevent transgressions (Nettleton 1988).

Social changes have bodily correlates in that what bodies are permitted to do, and how people use their bodies, is contingent upon social context. The work of Elias (1978, 1982) demonstrates this on a very grand scale. Elias is concerned with the link between the state and state formations and the behaviours and manners of the individual. He offers a *figurational sociology*; this means that he works at the level of social configurations, rather than societies. In fact, for Elias, societies are the outcome of the interactions of individuals. In his studies of *The Civilizing Process* (first published in 1939 in German) Elias (1978) examines in detail changes in manners, etiquette, codes of conduct, ways of dressing, ways of sleeping, ways of eating, and changing ideas about shame and decency associated with bodies.

According to Elias, the civilizing process began in the middle ages within court societies where social mobility became more fluid and peoples' futures could be determined not only by their birthrights, as had been the case under the feudal system, but also by the extent to which they were in favour with the sovereign or his/her advisers. In short, people were more inclined to be on their "best behaviour." Medieval personalities were characteristically unpredictable and emotional, they were inclined to be indulgent, and there were virtually no codes surrounding bodily functions. However, within court, societies codes of body management were developed and copious manuals were written on how to and where to sleep and with whom, how to behave at meals, appropriate locations for defecation, and so on. Changes in behavior impacted on social relations and, as social relations transformed, so the compulsions exerted over others became internalized. This process, according to Elias, was accelerated in the sixteenth century. People came to have greater self-control over behaviors associated with the body and a heightened sense of shame and delicacy:

> The individual is compelled to regulate his [sic] conduct in an increasingly differentiated, more even and more stable manner . . . The more complex and stable control of conduct is increasingly instilled in the individual from his earliest years as an automatism, a self compulsion that he cannot resist. (Elias 1982: 232–3)

This civilizing process involves three key progressive processes (Shilling 1993: 164–7): *socialization*; *rationalization*; and *individualization*. *Socialization* refers to the way in which people are encouraged to hide away their natural functions.

Thus the body comes to be regarded more in social rather than natural terms. In fact we find many natural functions offensive or distasteful; for example, if someone sitting next to us on a bus vomits over our clothes or if someone willingly urinates in an "inappropriate" part of our house. *Rationalization* implies that we have become more rational as opposed to emotional and are able to control our feelings. Finally, *individualization* highlights the extent to which we have come to see our bodies as encasing ourselves as separate from others. It is important therefore that we maintain a socially acceptable distance between ourselves and others. Furthermore how we "manage" and "present" our bodies (cf. Goffman 1959) has become especially salient in a late modern context. Some argue that this is because the body has become a prime site for the formation and maintenance of the modern self and identity.

Uncertain Bodies in Late Modern Societies

Giddens (1991) and a number of other commentators such as Beck (1992) and Douglas (1986) have argued that a key feature of such contemporary societies is *risk*. Doubt, Giddens argues, is a pervasive feature which permeates into everyday life "and forms a general existential dimension of the contemporary social world." Within our posttraditional societies, our identities and our sense of self are not givens. We can no longer hang on to our "traditional place" in society with respect to our social class, family, gender, locality, and so on. Rather, our self and identity becomes a "reflexively organised endeavour." Less and less can we rely on continuous biographical narratives but these tend to be flexible and continually revised (see also Featherstone and Hepworth 1991). The reflexive self is one which relies on a vast array of advice and information provided by a myriad of sources.

What has all this got to do with the body? Well a number of theorists have suggested that the body has come to form one of the main sites through which people develop their social identities. Whilst the environment and the social world seem to be "out of control," the body becomes something of an anchor. Giddens points out that the self is embodied and so the regularized control of the body is a fundamental means whereby a biography of self-identity is maintained. Giddens (1991:218) states:

> The body used to be one aspect of nature, governed in a fundamental way by processes only marginally subject to human intervention. The body was a "given," the often inconvenient and inadequate seat of the self. With the increasing invasion of the body by abstract systems all this becomes altered. The body, like the self, becomes a site of interaction, appropriation and re-appropriation, linking reflexively organised processes and systematically ordered expert knowledge. [...]. Once thought to be the locus of the soul ... the body has become fully available to be "worked upon by the influences of high modernity" [...] In the conceptual space between these, we find more and more guidebooks and practical manuals to do with health, diet, appearance, exercise, lovemaking and many other things.

According to this thesis, therefore, we are more uncertain about our bodies, we perceive them to be more pliable and are actively seeking to alter, improve, and refine them.

The idea that contemporary societies are characterized by change and adaptability has also been articulated by Emily Martin (1994) in her empirical study of contemporary ideas about immunity in North America. By way of data collected via interviews, analyses of documents, participant observation, and informal exchanges, she (Martin 1994: xvii) found that "flexibility is an object of desire for nearly everyone's personality, body and organisation." Flexibility is associated with the notion of the immune system which now underpins our thinking about the body, organizations, machines, politics, and so on. In her interviews with ordinary men and women the idea of developing a strong immune system appeared to be in common currency. To be effective, that is to protect the body against the threats of disease and illness, the immune system must be able to change and constantly adapt. Martin's study not only provides a valuable analysis of late modernity but also reveals how our accounts and interpretations of our bodies are historically and socially contingent, and that they are not "immune" from broader social transformations (see also the discussion about the work of Elias above). How we experience our bodies is invariably social, and one of the central thrusts of modern times is that we feel compelled to work at creating a *flexible* and therefore adaptable and socially acceptable body.

Shilling (1993) also argues that the body might best be conceptualized as an *unfinished* biological and social phenomenon, which is transformed, within limits, as a result of its participation in society. The body is therefore in a continual state of "unfinishedness"; the body is "seen as an entity which is in the process of becoming; *a project* which should be worked at and accomplished as part of an individual's self-identity" (Shilling 1993: 5 – my emphasis). *Body projects* become more sophisticated and more complex in a context where there is both the knowledge and technology to transform them in ways that would have been regarded as the province of fiction. There is now a vast array of medical technologies and procedures to choose from if we want to shape, alter, and recreate our bodies – from various forms of assisted conception, to gene therapy, to forms of cosmetic surgery and so on. Shilling points out that there is of course an irony here. As we expand our "knowledge" and "expertise" the more uncertain we become as to what the body actually is and what its boundaries are. Reviewing the impact of medical technologies and the body, Williams (1997: 1047) suggests: "From plastic surgery to virtual medicine, our previously held and cherished beliefs about the body and the 'limits' of corporeality are being 'placed in brackets' and the body has thus become 'ever more elusive and problematic'."

Whilst the above discussion has highlighted the body as an unfinished and malleable entity which has become central to the formation of the late modern *reflexive* self, other more postmodern analyses have suggested that the body is not so much *uncertain* as *un/hyperreal*. In other words the body has disappeared – there is no distinction between bodies and the images of bodies. Drawing of the work of Baudrillard, Frank (1992) challenges the

conventional idea that the body of the patient forms the basis of medical practice. It is the *image* of the body which now forms the basis of medical care.

> Real diagnostic work takes place away from the patient; bedside is secondary to screen side. For diagnostic and even treatment purposes, the image on the screen becomes the "true" patient, of which the bedridden body is an imperfect replicant, less worthy of attention. In the screens' simulations our initial certainty of the real (the body) becomes lost in hyperreal images that are better than the real body. (Frank 1992: 83)

There is a myriad of such images in the medical centre – CAT scan images, x-rays, angiograms, magnetic resonance imaging (MRI) videotapes, and so on. Although seeking to root ideas in empirical evidence is sometimes regarded as antithetical to postmodern ideas, a study of the use of these types of diagnostic tests for people with chronic back pain did seem to support the fact that medical practitioners rely on test results rather than the patients accounts of their pain. The image of the body is more legitimate than the body itself. For example, one participant in their study who experienced chronic back pain said that the doctors –

> are not listening to what you say... [they] try to tell you backaches are psychosomatic and your back couldn't be hurting, [that] there's nothing, no reason for it to hurt. X-rays don't show anything and you don't really have a backache. Oh yes I do, yes I do... but backaches are hard to see. Unless there's something that's a visible thing, it's kind of your word against who's looking. (Cited in Rhodes et al. 1999: 1191)

Perhaps more profound impact of the production of images is in relation to pregnancy. Writing in German from a historical perspective, Barbare Duden (1993) argues that the use of technologies which enable the fetus to be visually represented has contributed to the transformation of an unborn fetus into *a life*. The imagining of the unborn has meant that the fetus has become an emblem, a "billboard image," which has come into the limelight. Her (Duden 1993: 7) study addresses the following puzzle:

> How did the female peritoneum acquire transparency? What set of circumstances made the skinning of women acceptable and inspired public concern for what happens in her innards? And finally, the embarrassing question: how was it possible to mobilize so many women as uncomplaining agents of this skinning and as willing?

The images which are produced by a scanning ultramicroscope produce images which those who are trained appropriately can "read." However, this is something that has to be learned. Duden (1993: 29) describes the experience of a Puerto Rican woman, new to New York, who is asked to look at such images when she visits the antenatal clinic:

> The graph that she is asked to look at during her visit to the clinic only serves to mystify her experience. In ways that she cannot fathom, expert professionals claim to know something about her future child, much more, in fact, than she could ever find out by herself.

In an amazingly short space of the time "the scan" has become a routine and ubiquitous experience for most pregnant women in many western societies. In popular discourse, women – and especially men – can be heard to say that "it was only then," when they saw the image of the fetus, did they feel that it was "real."

There is a tension here then, between the way the body is experienced or *lived* and the way the body is observed and described by "medical experts." In those circumstances where the voice of the body is silenced the person is likely to become alienated from those who aim to "practice" upon his or her body. In some respects this tension captures the difference between a sociology of the body and a sociology of embodiment. This difference is described neatly by Bendelow and Williams (1998: 123) who write:

> Whilst the former translates, in corporeal terms, into a treatment of the body as simply one amongst many topics which sociologists can study from "outside" . . . the latter, in contrast, refuses to slip into this deceptive Cartesian view of the world – one which treats mind and body as distinctly separate entities – taking the embodiment of its practitioners as well as its subjects seriously through a commitment to a lived body and its being in the world.

Sociology of Embodiment

A sociology of embodiment has developed out of a critique of the literature on the body which has failed to incorporate the voices of bodies as they are experienced or lived (Nettleton and Watson 1998). Drawing on phenomenological analyses this approach has argued that much of the existing literature has failed to challenge a whole series of dualisms such as: the split between mind and body; culture and nature; and reason and emotion. Such socially created dualisms are pernicious, it is argued, not only because they are false, but also because they serve to reinforce ideologies and social hierarchies. "These dualisms," Bendelow and Williams (1998: 1) argue, "have been mapped onto the gendered division of labour in which men, historically, have been allied with the mind, culture and the public realm of production, whilst women have been tied to their bodies, nature, and the private sphere of domestic reproduction." But most important, from a sociological point of view they hinder any effective theorizing which must assume the inextricable interaction and oneness of mind and body. Studies of pain and emotion have, perhaps more than any other, revealed that the body and the mind are not separate entities (Morris 1991; Burkitt 1997; Bendelow and Williams 1998).

Phenomenology: the "lived body"

The phenomenological perspective focuses on the "lived body"; the idea that consciousness is invariably embedded within the body. The human being is an

embodied social agent. The work of Merleau-Ponty, in particular his text *The Phenomenology of Perception*, has been revisited, and it is regarded by many as critical to our appreciation of embodiment (see for example, Csordas 1994; Crossley 1995). Essentially he argued that all human perception is embodied, we cannot perceive anything and our senses cannot function independently of our bodies. This does not imply that they are somehow "glued" together, as the Cartesian notion of the body might suggest, but rather there is something of an oscillation between the two. This idea forms the basis of the notion of "embodiment." As Merleau-Ponty (1962) writes:

> Men [sic] taken as a concrete being is not a psyche joined to an organism, but movement to and fro of existence which at one time allows itself to take corporeal form and at others moves toward personal acts. . . . It is never a question of the incomprehensive meeting of two casualties, nor of a collision between the order of causes and that of ends. But by an imperceptible twist an organic process issues into human behaviour, an instinctive act changes direction and becomes a sentiment, or conversely a human act becomes torpid and is continued absent-mindedly in the form of a reflex. (Merleau-Ponty 1962: 88, cited by Turner 1992: 56)

Thus while the notion that embodied consciousness is central here, it is also highlighted that we are not always conscious or aware of our bodily actions, we do not routinely tell our body to put one leg in front of the other if we want to walk, or to breath in through our nose if we want to smell a rose. The body in this sense is "taken for granted," or as Leder puts it, the body is "absent."

> Whilst in one sense the body is the most abiding and inescapable presence in our lives, it is also characterised by its absence. That is, one's own body is rarely the thematic object of experience . . . the body, as a ground of experience . . . tends to recede from direct experience. (Leder 1990: 1)

Within this perspective, the lived body is presumed to both construct and be constructed by, and within, the lifeworld. The lived body is an intentional entity which gives rise to this world. As Leder (1992: 25) writes elsewhere:

> in a significant sense, the lived body helps to constitute this world as experienced. We cannot understand the meaning and form of objects without reference to bodily powers through which we engage them – our senses, motility, language, desires. The lived body is not just one thing *in* the world but a way in which the world comes to be.

We can see therefore that it is analytically possible to make a distinction between *having* a body, *doing* a body, and *being* a body. Turner (1992) and others have found the German distinction between *Leib* and *Korper* to be instructive here. The former refers to the experiential, animated, or living body (the body-for-itself), the latter refers to the objective, instrumental, exterior body (the body-in-itself).

This approach highlights that the concepts of the "lived body" and the notion of "embodiment" reminds us that the self and the body are not separate and that

experience is invariably, whether consciously or not, embodied. As Csordas (1994: 10) has argued, the body is the "existential ground of culture and self," and therefore he prefers the notion of "embodiment" to "the body," as the former implies something more than a material entity. It is rather a "methodological field defined by perceptual experience and mode of presence and engagement in the world." This idea that the self is embodied is also taken up by Giddens (1991: 56–7), who also emphasizes the notion of day-to-day *praxis*. The body is not an external entity but is experienced in practical ways when coping with external events and situations. How we handle our bodies in social situations is of course crucial to our self and identity and has been empirically and extensively explored by Goffman and other symbolic interactionists, as well as Garfinkel (Heritage 1984) and other ethnomethodologists. Indeed, the study of the management of bodies in everyday life and how this serves to structure the self and social relations has a long and important history within sociology. It highlights the preciousness of the body as well as the remarkable ability of humans to sustain bodily control through day to day situations. Many of these themes have been explored by sociologists who have studied how people *experience* illness.

The Sociology of the Body: Some Illustrative Issues

Illness and Injury and Lived Bodies

The literature on the experience of chronic illness and disability had drawn attention to many of the themes discussed above prior to the more recent emergence of the body and embodiment literature; most particularly the fundamental link between the *self* and the body. A number of researchers (e.g. Charmaz 1987) have documented how this occurs in the case of chronic illness. Here the relationship between the body and self is seriously disrupted. As we have just seen Leder, in his book *The Absent Body*, has argued how ordinarily we do not consistently reflect on our bodies; we take for granted the fact that they can function as we require them to. However, for the sick person the body, as Toombs (1992) suggests, undergoes a metamorphosis and becomes a "diseased body," which is separated and alienated from the self. Toombs, when describing her own experience of multiple sclerosis, reveals how, when living with a chronic illness, "one feels inescapably embodied" (Toombs 1992: 134). What is more, she (Toombs 1992: 127) says that "the breakdown in body is experienced as a fundamental transformation in one's whole way of being," thus, there is "an alteration of one's sense of self."

A number of writers have emphasized that in our day-to-day lives our bodies are "absent" (Leder 1990) or are taken for granted. We only become aware of them when they are in pain or suffer from disease or illness – when they are *(dys)*functional. Simon Williams (1996) has illustrated this well by drawing on the findings or research into chronic illness. He demonstrates how the experience of chronic illness involves a move from an "initial" state of embodiment (a state in which the body is taken for granted in the course of everyday life) to an oscillation between states of *(dys)*embodiment (embodiment in a dysfunctional state) and

"re-embodiment." Attempts to move from a dys-embodied state to a re-embodied state require a considerable amount of "biographical work," or what Gareth Williams (1984) terms "narrative reconstruction." This theme is also demonstrated by Seymour (1998) in her empirical study of 24 men and women who experienced profound and permanent body paralysis as a result of spinal injuries. As the title of her book, *Remaking the Body*, suggests, as men and women go about remaking their bodies they "remake their worlds." Through listening to the accounts of these men and women she argues that she was able to appreciate the crucial role of embodiment in the reconstitution of the self. Whilst the participants she spoke to have had to endure profound bodily changes and difficulties, she maintains that they have retained their "selves." Seymour (1998: 178) states:

> this damage [the spinal injury] has disturbed, but not destroyed, their embodied selves. These people still inhabit and possess their bodies; their bodies are still resources with which they may explore new possibilities and opportunities for re-embodiment.

The problem with the literature on the lived body (from within the sociology of embodiment), and the notion of body projects and the reflexive self (from within the sociology of the body), is that they both assume a competent mind. In a moving paper by David Webb, he describes the impact on individuals and their families of traumatic brain injury (TBI) which he describes as a silent epidemic of our modern times. In Britain, 15 people are taken to the hospital every hour with a head injury. Most are the result of traffic accidents, and young men are the most common victims. This modern epidemic ironically means that the victims are unable to participate in one of the key aspects of late modernity. As Webb (1998: 545–9) explains:

> Indeed the case here is that with a physiologically damaged brain comes the likelihood of a fractured mind, and that consequently this will have a bearing on the person's capacity to existentially "live their body" – to reflexively experience it [. . .] [H]igh modernity revolves around a mentalist discourse in which greater importance is given to the mind than the sociological talk of "body matters" suggests.

Many assumptions are made, therefore, that when we reflect upon the following – how we feel about ourselves; how we view our past; how we assess and plan our futures – we have a socially acceptable – competent – mental capacity to do so. Our mental capacity depends upon our "normal" functioning of the brain, which in turn may also be contingent upon the "acceptable" functioning of the rest of our bodies. This issue is explored in the context of hospice care and is discussed in the next section of this chapter.

HEALTH CARE WORK

How can these theorizations on the body and embodiment help us to make sense of health care in practice? The most obvious and extensively researched areas

concern the ways in which bodies have become regulated, controlled, and medicalized in areas of pregnancy and childbirth (Oakley 1993) and death and dying (Seale 1998). But more recently, qualitative studies of health caring work within formal settings have revealed the analytic value of the conceptual developments outlined above. For example, Julia Lawton's (1998) study of care within a hospice attempts to understand why it is that some patients remain within the hospice to die whilst others are more likely to be discharged and sent home to die. To address this health policy puzzle, Lawton argues that we need to focus on the *body* of the dying person. She found that those patients cared for within the hospice were those whose bodies became "*unbounded*." By this she means that the diseases they were suffering from involved a particular type of bodily deterioration and disintegration which required very specific forms of symptom control. The most common examples being:

> incontinence of urine and faeces, uncontrolled vomiting (including faecal vomit), fungating tumours (the rotting away of a tumour site on the surface of the skin) and weeping limbs which resulted from the development of gross oedema in the patient's legs or arms. (Lawton 1998: 128)

It is these forms of bodily (dys)functions that people living in western society cannot tolerate rather than the process of dying itself. Indeed in those cases where the boundedness of their bodies could be reinstated, patients would be discharged. To address the question, Why are unbounded bodies unacceptable in western societies?, Lawton draws upon much of the sociological theorizing outlined above – especially the work of Douglas and Elias. The unbounded body is perceived symbolically, according to Douglas, as a source of dirt – it is "matter out of place." The increasingly "civilized" body, according to Elias, has become "individualised" and private, and the "natural" functions of the body are removed from public view.

The fact that natural or intimate bodily functions are problematic for health care practitioners has also been explored by Lawler (1991), who again draws upon the ideas developed by Elias and Douglas in her study of nursing care in an Australian hospital. Quintessentially, the work of nurses is about caring for bodies. This becomes a problem when nurses have to attend to those bodily functions (defecating, grooming, etc.) which in a "civilized" society have become taboo. Consequently, nurses have to learn how to negotiate social boundaries and create new contexts so that both the patient and the nurse can avoid feelings of shame and embarrassment.

There is a further fascinating finding highlighted in Lawton's study, and this relates to the link that we have discussed above between the notion of self and physical body. The two are meshed together. We saw in our discussion of Webb's (1998) paper that the functioning reflexive self relied on the competent mind. Lawton's work demonstrates that even where there is a "competent" mind, the lack of bodily controls (see also Featherstone and Hepworth 1991 and Nettleton and Watson 1998: 14–17) affects a person's capacity to continue with their life projects or their reflexive self. In fact, patients who had the least control over their bodily functions exhibited behavior which suggested a total loss of self and

social identity, once their bodies became severely and irreversibly unbounded. Take Lawton's account of Deborah for example:

> When Deborah's bodily deterioration escalated, I observed that she had suddenly become a lot more withdrawn. After she had been on the ward for a couple of days she started asking for the curtains to be drawn around her bed to give her more privacy. A day or so later she stopped talking altogether, unless it was really necessary (to ask for a commode, for example), even when her family and other visitors were present. Deborah spent the remaining ten days of her life either sleeping or staring blankly into space. She refused all food and drink. . . . One of the hospice doctors concluded that "for all intents and purposes she [had] shut herself off in a frustrated and irreversible silence." (Lawton 1998: 129)

Both Webb and Lawton's papers are pertinent to late modern societies, in that the salience of the loss of self is linked to features of contemporary societies. The emphasis was on bodily controls and the boundedness of the body in Lawton's study. In Webb's analysis, by contrast, TBI would clearly alter who a person "is" and their capacity to "act" in any context. But its prevalence is related to modern ways of living (fast cars). Webb (1998: 548–50) comments:

> In high modernity the body has a diminishing *productive* significance, and it becomes increasingly a site more of recreational indulgence than labour power as such. In this context, it is catastrophic to be denied the opportunity to participate in the identity constituting reflexivity of late modernity (Giddens 1991). [. . .] There is, in short, no clarity about the categorisation of those who are head injured. The person becomes "someone else," an everyday recognition that it is the mind (more than the body) which signifies what it is to be a person. If the mind itself is seriously impaired then it is no longer able to mobilise the body to create the *physical capital* which might compensate for the run on *mental capital* occasioned through head injury.

The experience of TBI also brings into sharp relief another feature of late modernity and that is the fact that (medical) technologies have their limits. As Webb points out, in cases of physical impairment very often technology can offer something – some means by which motor coordination or whatever can be facilitated. This is not so when physical injury impairs the mind; here, technological resolutions to disability are almost invariably impossible (Webb 1998: 547).

Technology and the Body

Whilst technological "advances" do have their limits, there is no do doubt that they have served to contribute to our reconceptualization of what constitutes the "body." The boundaries between the physical and the social body become increasingly fuzzy, and, as we have suggested above, we are less certain as to what the body actually is, or has the potential to do. During the last few decades developments in a number of areas of medical and related technologies have

contributed these uncertainties. For example, bodies have bits added to them to enable them to function more effectively. Prosthetics – the use of artificial body parts, such as limbs – of course has a long history. But the list of body parts has grown in recent decades to include cardiac pacemakers, valves, ear implants, and even polyurethane hearts (Synnott 1993). Such developments have become increasingly sophisticated as they have developed in concert with advances in molecular biology. This has led some authors to talk about the emergence of *cyborgs* – the marriage between a human organism and machines (Featherstone and Hepworth 1991) which has been defined thus:

> Cyborgs are hybrid entities that are neither wholly technological nor completely organic, which means that the cyber has the potential to disrupt persistent dualisms that set the natural body in opposition to the technologically recrafted body, but also to refashion our thinking about the theoretical construction of the body as both a material entity and a discursive process. These bodies are multiple constituted parts of cybernetic systems – what we now recognise as social and informational networks. (Balsamo 1996: 11)

Thus the cyborg is neither a "natural body" nor simply a machine.

New reproductive technologies (NRTs) comprise a range of methods to assist conception which have been around for some decades. However, more recent technological developments, in conjunction with the more extended use of technologies such as GIFT, hormonal treatments, and so on, have altered the boundaries of what was or was not physically possible for a growing number of women (Edwards et al. 1999). People are presented with more choices than ever before, people are presented with a wider array of possibilities, and people are also having to learn how to negotiate and deal with new identities. For example, as Edwards et al. (1999: 1) point out:

> To a greater or lesser extent, part of everyone's identity as a person is derived from knowledge about their birth and about how they were brought up [. . .] The late twentieth-century development of the means to alter what many would have said were immutable processes of birth has created a new and complex vehicle for conceptualising connections.

The certainties of "birth" as an immutable process are therefore altered. This can make the negotiation of a reflexive identity very complex indeed.

A further "technological" development, that impacts upon our notions of who and what we are, is in relation to the, so called, *New Genetics*. The Human Genome Project is an international initiative that identifies particular genes which are associated with diseases and, more controversially, behaviors (Conrad and Gabe 1999). This project, completed in 2000, gives rise to a new discourse within which we can come to talk about our selves. It comprises a new twist to the notion that our "biology is our destiny." The prospect is that medical science will be able to predict with a significant degree of precision our *predisposition* to a wide range of diseases such as cancers, heart disease, diabetes, and so on.

More knowledge, more information, and yet ever more uncertainty. Although the degree of accuracy, or rather certainty, associated with molecular genetic predictive testing is greater than that of traditional probablistic clinical genetics, many uncertainties still remain and, in large measure, predictive tests can rarely ever be completely certain. They also raise a host of social and ethical considerations (see Davison et al. 1994 for a thorough exploration of these issues for social researchers). In relation to our discussion here, the main point is that the language of the new genetics has implications for how we think about, talk about, and experience our bodies. When we reflect upon our selves and our identities, we increasingly do so with recourse to our genes. As Spallone (1998) has pointed out, the word "gene" has replaced the looser notions of "the biological" and "hereditary." So rather than say, as we might have done 15 years ago, "it runs in the family," or "it's inherited," we hear ourselves saying, "it must be in their/my genes" (Spallone 1998: 50). Spallone also cites James Watson, the first director of the US Human Genome Initiative, who said: "We used to think our fate was in the stars. Now we know, in large measure, our fate is in our genes."

We noted above how "bits" are added to bodies, but another salient issue is the fact that body organs can be transplanted from one body to another due to advances in *organ donation and transplantation* surgery. In the summer of 1999 in England, a 15-year-old girl who refused consent to a heart transplant had her case overruled by the high court. She was reported to have said: "Death is final – I know I can't change my mind. I do not want to die, but I would rather die than have the transplant and have someone else's heart." Again, as with medical practices associated with the new genetics, this issue raises ethical issues. Who should make decisions about people's bodies – should it be lawyers, medical practitioners, relatives, or the "owner" of the body itself? But this issue also highlights the malleability of bodies in the modern age. Is it my body if parts of it belonged to someone else? A study of patients who had undergone organ transplant surgery found that patients felt that they needed to work at "restructuring their sense of self" (Sharp 1995). The author reports that there was a tension between the need to both personalize and the need to objectify bodies and organs. Thus, as Williams (1997) has pointed out, organ transplantation poses many questions about self-identity:

> Medical personnel put great stress on objectification; the heart, for example, is "only a pump." Yet recipients experience conflict between this mechanistic/reductionist view of the body and their wider cultural beliefs about the embodied nature of self identity and the "sacred" nature of the heart as the very core of the person. (Williams 1997: 1044)

This albeit brief and partial discussion of medical technological developments and the body serves to highlight a key theme running throughout this chapter. That is the idea that in late modern contexts there is a growing array of uncertainties associated with the body. The emergence of sophisticated medical knowledges and practices in fields associated with reproduction, genetics, and immunology have increased the complexities and choices which people face

when reflecting upon their bodies and their *embodied* identities. Thus it is perhaps not surprising that sociologists have become increasingly preoccupied with the embodied basis of social action.

There is a further twist to the emerging debates within the sociology of the body and embodied sociology, and this relates to an area of medical sociology which has a much longer history – the study of health inequalities. A vein of research and debate is emerging within this area of study which draws upon: the lived body; the physiological basis of the body; and social structure.

Social Inequalities and the Sociology of Embodiment

A basic tenet of medical sociology is that social circumstances – in particular material and social deprivation – become inscribed upon people's bodies. In other words, it is argued that health status is socially determined. The reasons why social circumstances, and more especially social inequalities, impact upon health status has been researched and debated for over a century. Surprisingly, perhaps, the literatures on the sociology of the body and the sociology of embodiment are providing some important clues as to why health is socially patterned in this way. It seems then that "unhealthy societies" (Wilkinson 1996), or rather unequal societies, are associated with unhealthy bodies. This is not just a result of *material* deprivation and poverty – the harmful effects of poor housing, poor food, and living conditions *per se* – though these are undoubtedly important. But what is also important is one's class position. Essentially those people who are lower down the social hierarchy, and have the least control over their circumstances, are more likely to be ill. The reason for this is that they are more likely to experience prolonged stress and negative emotions, which in turn have physiological consequences. This psychosocial perspective on health inequalities has been summarized by Elstad (1998) who points to a growing body of research which demonstrates how certain aspects of social life such as: a sense of control; perceived social status; strength of affiliations; self esteem; feelings of ontological insecurity, and so on, lead to variations in health outcomes. This has been most fully explored in relation to male paid employment but also in relation to the housing circumstances of men and women (Nettleton and Burrows 2000).

It seems that how people reflect upon, feel about, and internalize their social position or their social circumstances is critical. Drawing from work in physiological anthropology, in particular studies of non-human primates, researchers have found that primates who were lower down the social hierarchy, and most importantly had least control and power, exhibited more detrimental physiological changes in times of stress. Authors have argued that this may help to explain the fact that numerous studies have consistently found that people in social environments who have limited autonomy and control over their circumstances suffer proportionately poor health. The key issue here is the degree of social cohesion. Greater social cohesion means that people are more likely to feel secure and "supported" and are less likely to respond negatively when they have to face difficulties or uncertainties. In turn, it is social inequality that serves to

undermine social cohesion and the quality of social fabric. Freund (1990) has argued that people express "somatically" the conditions of their existence. What he calls "emotional modes of being" are very likely to be linked to ones structural position. He (Freund 1990: 461) writes:

> Subjectivity, social activity and the social structural contexts interpenetrate. It is this relationship that comes to be physically embodied in many ways. Irregularity of breathing may accompany muscular tension and experiences of ontological insecurity and the anger or fear that is part of this insecurity.

Thus, for example, if we are in a social environment which is threatening we may be "scared stiff." Freund (1990: 471) is able to postulate this theory because he believes that:

> Emotions and the feeling they express are embodied in neurohormonal and other aspects of bodyliness. They form communicative "fields" between the body and between body–mind and social existence.[1]

This link becomes evident when we mesh together the "lived body" and the structural perspectives on the body. How people experience their structural context, the meanings and interpretations they ascribe to it, in turn impacts upon their physical bodies. This is the new development here. Hitherto, the literature on health inequalities has tended to be limited to the physical body and so works within a Cartesian model which brackets off the mind. Experience and meanings were only elicited to try and understand why people might engage in "unhealthy" activities such as smoking (e.g. Graham 1987). The lived body approach which collapses these dualisms therefore provides us with fresh insights into one of the main concerns for sociologists of health and illness. This said, hitherto the empirical studies have been restricted to class and socioeconomic inequalities rather than others associated with gender and race – where issues of social control and ascribed social status are particularly salient.

Conclusion

This chapter has reviewed some of the key theoretical perspectives within the literature on the sociology of the body and the sociology of embodiment. Drawing on these approaches it has discussed a number of substantive issues which are of interest to those working within medical sociology. Thus it has attempted to show that a "sociology of the body" has added a new dimension to matters which have traditionally been of interest to this field of study. A key theme running throughout this chapter is that the more knowledge and information we have about bodies, the more uncertain we become as to what bodies actually are. Certainties about seemingly immutable processes associated with birth and death, for example, become questioned. Furthermore, how we experience and live our bodies has also become central to how we think about our

selves. Thus any comprehensive analysis of the experience health, illness, or health care should take cognisance of the body (what ever that is!) itself.

Note

1 Of course, for sociologists working within a social constructionist perspective, the interest here might be more to do with the current rise and salience of these psycho–physiological discourses within medical sociology.

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