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BEING HEALTHY: A SOCIAL PSYCHOLOGICAL EXPLORATION OF SELF, BODY, AND GENDER

by

ROBIN LEE SALTONSTALL

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

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of the

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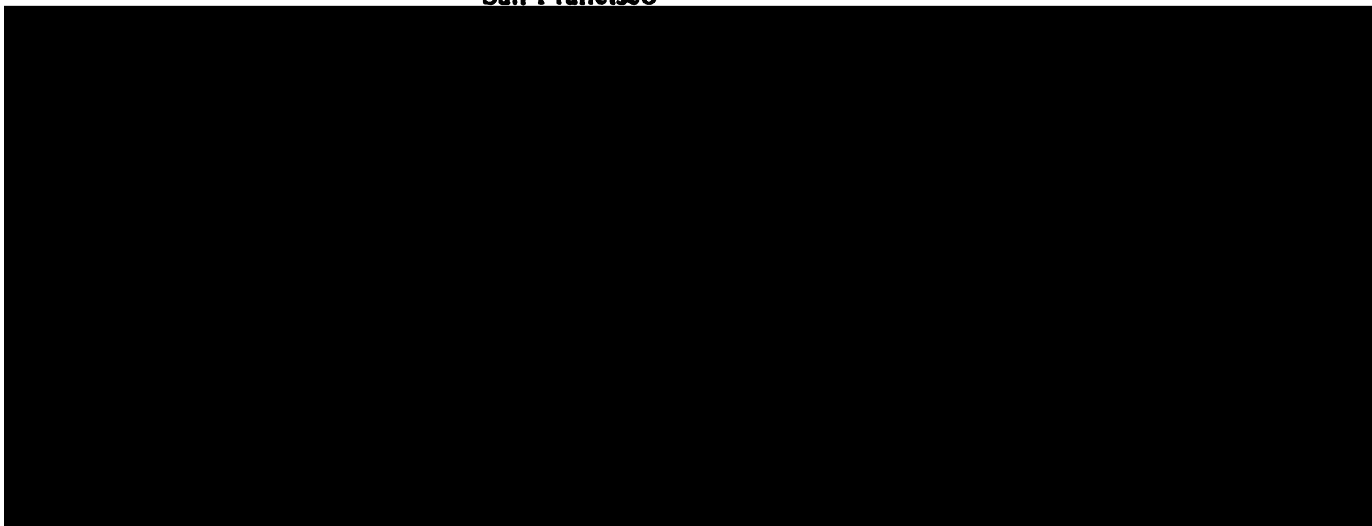

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ABSTRACT

Being Healthy: A Social Psychological Exploration
of Self, Body, and Gender

Robin Lee Saltonstall

This research uses a grounded theory approach to examine men's and women's concepts of health and how these are constituted in everyday life. The data suggest that health is both an idea and a lived reality, and that healthiness is a social phenomenon, not a biological essence.

I argue that the experience of being healthy involves a sense of self and a sense of body, which are emergent in an *intra*subjective process called "the selfsoma process." The *intra*subjective selfsoma process parallels the *inter*subjective self-as-social process.

The data suggest that health is an interpretive framework, informed by discourse and related to the body, for making sense of daily phenomena, and that individuals' conceptualizations and practices of health also inform discourse through the continual refinement of ideas in light of personal experience.

The body is explicitly problematic as both an object and a medium of health. As an interpretive framework, health overlaps with other interpretive frameworks related to the body, such as gender. In lived experience, the sense of self as healthy, as gendered, and as body are intertwined, and are realized simultaneously in concrete habits and practices of daily life.

Thus, at the social level, health actions are instances of social interaction in which social order is negotiated, produced, and reproduced through interpretation and construction of selves as healthy and as bodies.

In sum, health is not a universal fact, but is a constituted reality crafted out of the particulars of time, place, and body. Even though health comes to be seen as an organic and inherent reality independent of selves, it is a creation of those selves. Being healthy is a lived experience of being bodied involving practical activity in the world and an on-going intrasubjective negotiating process between self and body. Gender is an emergent aspect.

These findings refocus analytic attention on the actual everyday ways and means that discursive ideas about health are enacted and the social order is sustained in an array of practices in the everyday lived world. Meanings of self,

body, and health, while appearing to be universal, are constituted and materialized through interpretation and enactment by historically located, embodied selves.

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INTRODUCTION

This dissertation explores individuals' concepts of health and being healthy and how these are constituted in everyday life.

The theoretical and analytical perspective of this research draws on interactionism, phenomenology, and feminism. My intent in doing this research has been to contribute to the sociological social psychological understanding of health by applying a feminist theoretical perspective to the study of health.

I argue that health is a social, contextual, and historical phenomenon. Meanings of self, body, and health, while seeming to be universals, are constituted and materialized through interpretation and action by situated, embodied selves. Individuals construct notions of health and healthiness out of the conceptual raw materials of cultural discourses of health. These discourses serve as interpretive frameworks for organizing daily experience along socially and culturally acceptable lines. Thus, while health discourses organize meanings, actions, and relations, the organiz<u>ing</u> is done by acting individuals in everyday practical "health" activity. Healthiness is more than a simple effect of social and cultural discourses; it also

involves the continual creation and recreation, or "bringing to life," of symbol and meaning by interpreting, acting, and embodied persons.[1]

Considering health and healthiness from this constructionist perspective raises a number of theoretical and analytical issues pertaining to subjectivity, self, and body. First, it shifts analytical attention to the self as an acting subject (and not a simple by-product of discourse),[2] located within a network of social relations, interpreting both material and conceptual "health" phenomena and engaging in health activities. In the contemporary western world of the respondents of this study, these activities are often focussed on the body (e.g. body maintenance activities) and are conflated with other body-related notions such as gender and age. Second, it raises the lived body to a position of theoretical and analytical saliency because the body is explicitly problematic in health as both an object and a medium of health practices. Thus, the body as healthy is considered to be a concrete and particular lived experience

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[1]As I discuss in Chapters IV and V, there is a kind of constituting reflexivity to healthiness. That is, healthiness is both constituted by and constitutive of culture and can be seen as an enacted form of culture.

[2]This shift in analytical focus, away from the textual level and to the level of action in the world, is a characteristic of feminist postmodernism (as distinguished from postmodernism). See Smith 1989, Harding 1990, and Chapter V for discussion.

(and not a universal abstraction or experience) involving practical activities and interpretation in the everyday world. Also raised are phenomenological issues related to the significance of the body in the construction of self and health. My data suggests that the experience of being healthy involves a sense of self and a sense of body, which are emergent in what I have called "the selfsoma process." The selfsoma process is a private <u>intra</u>subjective selfsoma process which parallels the <u>inter</u>subjective self-as-social process in the construction of self.

The problematic of the body in the lived experience of health also introduces the concept of gender[3] to analyses of health because in the commonsense world, gender is a primary construct for organizing bodies and body-related phenomena. That is, bodies and the selves attached to them are generally considered to be either male and masculine or female and feminine. The body as problematic also poses the epistemological question of whether there is a "gendering"

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[3] Following West and Zimmerman (1987:126) and Butler (1990), this paper conceptualizes gender as "an emergent feature of social situations" and not as a stable property of individuals. In this sense, gender is "done." That is, it is continually constituted through practices in everyday contexts. See Chapter III discussion of the term "gender.

to knowing which is tied to the body as a ground of subjectivity and a condition for practical activity.[4]

In sum, health can be seen as more than a universal biological fact amenable only to scientific observation and explanation. Rather, it can be studied as a humanly constructed symbolic category, filled with culture-specific notions about the body and self, which serves as a framework for organizing one's daily experience and constructing self. Concepts of self, body, and health interlace; health is tied up with identity and awareness of self as being embodied and as being a body. Thus, the study of health provides a window on the interconnectedness of the social and the phenomenological.

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[4]Questions also are raised regarding the interconnectedness of gender and other constructions of the body which are integral to embodied lived experience, such as race and age. Gender, rather than race and age, was a primary focus for my research, so I focused on these linkages and not others. However, as I propose in the concluding chapter, the body can be considered as one more element in a "dynamic of interaction" (Dill 1987) in which race, class, age, and other aspects of self interact with each other, each influencing the other; resulting in lived experiences and self definitions of health and healthiness which are quite different from person to person.

In addition, as I argue in Chapter V, Implications, I am not arguing that all like-bodied knowers share a single epistemology and standpoint, nor am I arguing that the body is the sole epistemic ground. I am arguing that the body is a starting point, as object and subject, for all knowers in the world, and that it is a critical epistemic ground which exists in dynamic relation to other "grounds" such as race, age (both body-related) and culture.

This dissertation, then, is about health, but it is also about gender, subjectivity, and identity. My hope is that this research establishes the existence of linkages between these constructed aspects of self, and that these findings stimulate future research.

Organization of the Dissertation

The dissertation is organized into six chapters, of which this is the first. The second chapter discusses the contemporary context of health. The third chapter, the Theory Chapter, examines some of the ideas that have been put forth about self and body within the sociological social psychology of health and being healthy. The fourth chapter contains the Analysis and Findings while the fifth chapter outlines the implications of the findings. The concluding chapter identifies areas for future research.

Prefatory Comments

Throughout this research I use the term "postmodern." This term has many usages (Di Stephano 1990, Hawkesworth 1990, Flax 1989). I am using the term in the foucauldian sense that truth claims are contextual and historical rather than universalistic (Hekman 1990); however, I do not maintain Foucault's correlative view that, because of this, no Truths

exist or are valid and that the subject/self is unable to reflect on, analyze, and challenge the determinations of social discourse (Alcoff 1988). Nor do I believe, as does Foucault, that the bodily experiences of men and women in society are the same (Bartky 1988). Instead, my perspective is a feminist-informed postmodernist perspective which, as articulated by Fraser and Nicholson (1990:34-35), is:

> "...nonuniversalist.. It's mode of attention would be comparativist.. attuned to changes and contrasts instead of to covering laws.. It would replace unitary notions .. with plural and complexly constructed conceptions of social identity, treating gender as one relevant strand among others, attending also to class, race, ethnicity, age, and sexual orientation....In short, this theory would look more like a tapestry composed of many threads of many different hues than one woven in a single color."

This perspective recognizes and accepts the partiality of all views, and it does not expect theory to be a symmetry of oppositions and similarities (Harding 1987).[5] With respect to theorizing about health, this is not to suggest that we propagate a chaos of perspectives. Rather, it is to propose that, when considering health "truths," we make problematic the social relations and contexts (including that of the body) which underpin and frame these "truths." By doing so, we expose another filament of "the complex web" of relations through and within which the social experience of health is

[5]See Chapter III, Theory, and Chapter V, Implications, for a more in depth discussion of this perspective.

constituted and from which "truths" emerge (Baca Zinn et al, 1986).

CHAPTER I

THE CONTEMPORARY CONTEXT OF HEALTH

THE DISCOURSE OF HEALTH: SELF, BODY, AND HEALTH

Health discourse is an historically and culturally localized phenomenon. In western society, as Crawford (1985:63) has noted, "there exists .... an elaborate health discourse -- actually several discourses (professional-medical, political, literary, popular-reformist, everyday-personal)." The discourse of health encompasses ideas about the relationship between self, body, and society, including notions about what constitutes "well-being" and "being healthy"; what the nature, function, capacity, and utility of the physical body is; what "healthiness" can be expected now and in the future, and what actions ought to be taken and avoided for the sake of health. The discourse of health offers explanations of physiological phenomena and provides conceptual models which differentiate and explain them (Crawford, 1975; Young, 1980; Douglas, 1982; Currer and Stacey, 1986; Verbrugge,M., 1988; Glassner, 1989).

This chapter discusses the contemporary discourse of health in America from a constructionist perspective. Within this perspective, health is not considered to be a simple

biological fact, but rather is seen to be a constructed symbolic category filled with culture-specific notions about the body/self. Health is conceptualized as a socially- and culturally-sensitive interpretive framework for organizing daily experience.

The intent of this chapter is to provide a sociological analytic understanding of the milieu in which my respondents create, recreate and enact health for themselves in contemporary western daily life. The first section outlines the theoretical concepts of the social constructionist perspective and the units of analysis relevant to an examination of the discourse of health. The second section offers a comparative example of the temporality and historicity of health discourse by briefly reviewing the historical changes in concepts of "health" and "being healthy" since the nineteenth century. In the final section, the contemporary discourse of health is described and considered from the constructionist perspective.

SECTION I: THE SOCIAL CONSTRUCTION OF HEALTH

Sociologists, anthropologists, and philosophers have pointed out at length that conceptualizations of health are problematic and that different society's and cultures have different renditions of "health" (Zola, 1966; Idler, 1975;

Murcott, 1979; Fabrega, 1980; Taussig, 1980; Mischler, et al., 1981; Kleinman, 1980; Currer and Stacey, 1986; Herzlich and Pierret, 1987; Crawford, 1987). As Kelman (1980:133) put it, the meaning of health in any society is a social, cultural, and intellectual construction intended to "characterize the human organism in some general and useful way." Others have shown how the "particular configuration of health" in any society is a product of a "continuing and reciprocal interaction" between individuals as biological beings and their social and cultural environment (Susser, Hopper, and Richman 1984:23), as well as how the construction of definitions of health and the identification of health phenomena rests on values about what constitutes organic, functional, and social "normality" (Hannay 1988; Susser 1974).

The philosopher, Monroe Lerner, has enumerated the problems inherent to a positivist scientific approach which methodologically treats health as though it is a category of phenomena which can be observed and measured (Lerner 1973). Lerner points out that health is not unidimensional and amenable to observation and direct measurement as are weight, distance, or temperature, but is a multi-dimensional, qualitative characteristic of individuals and communities, similar to intelligence, social class, and authoritarianism. "Health" can only be inferred; its

dimensions and components derived from an understanding of the individuals and their relationship to and subjective interpretations of their social and cultural milieux (Lerner, 1973:6). As Nietzche argued

> "there is no health as such, and all attempts to define a thing that way have been wretched failures. Even the determination of what is healthy for your body depends on your goal, your horizon, your energies, your impulses, your errors, and above all on the ideals and phantasms of your soul. Thus there are innumerable healths ..." (Nietzche, 1974, quoted in Turner, 1986).

The Discourse of Health and the Body as Cultural Object

The discussion above has argued that health is a social phenomenon constructed out of the raw materials of category and meaning particular to a time and place. Health, as a symbolic category involving the body, is a framework for organizing daily experience along culturally normative lines -- not only physiological experience, but also abstract notions of "well-being," "dis-ease," and morality.[1] The discourse of health comprises these notions and their associated forms of conduct.

---

[1]One example of the morality/health linkage is the notion of health as a duty (Herzlich 1987) and a responsibility (Blaxter 1990; Crawford 1975,1987; Renaud 1975).

One of the primary symbolic and natural raw materials of health constructions is the body. As the anthropologist Mary Douglas (1982) elaborated in her classic analysis of "The Two Bodies," the body is a "natural symbol" and ideas circulating in the social body are articulated in the personal body.[2] The body is both natural and social, "a powerful medium" through which we express our individual and social experience (Crawford, 1985:60).

The body is a unique cultural object because it is more than conceptual social symbol and culturally inscribed object (text); it is also human "agency and potentiality" (Turner, 1986). The body and body-related doings involve interpretation and practical activity. As Haraway has so elegantly phrased it: "Bodies, then, are not born; they are made" (Haraway, 1989:10). With respect to health, the particular constructions of "health" in a society are practiced through the body as a medium and on the body as an object.

Concepts of "The Body" and "Self" as Constructed Categories

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[2]For example, the concept of ownership of the body which emerged frequently in my interviews can be interpreted as reflecting a capitalist conception of the healthy body. Featherstone (1982) has written on the "consumer" conception of the body in late capitalist society.

Before contiunuing, it should be noted that even though it is often assumed today that the concepts of "the body" and the individuated "self" attached to the body are universal and have always existed in the form that we know them today, they, too, like the concept of "health," are conceptualizations of culture. Mauss (1979:90) has argued that the notion of the person/self housed in one body is a "category," an Idea, and not an inherent and given reality. Hirst and Woolley (1982) point out that early Greek texts depict the human body as an assemblage of distinct parts (not a homogeneous unity) through and upon which supernatural forces act. The conscious, responsible, unitary "self" of later western thought is not apparent. Rather, the "individual" is a mortal agent whose actions are a consequence of Divine and irrefutable decision.

Foucault (1975:195) has argued that concepts of the "body", "health", and "disease" are not unprejudiced observations about facts, but are instead effects of discourse or "syntactical reorganizations" of newly perceived phenomena. He locates the emergence of the concept of the "body" as the envelope of the "subject" and as a discrete and individual entity in the revolution in scientific discourse and medical institutions at the end of the 18th Century. The "body," newly conceptualized as a discrete entity, provided a unit

of analysis amenable to clinical scrutiny and ultimately, to control by scientific, especially medical, discourse and technique.[3]

Analysis of the Social Constructions of Health Discourse

Thus far, I have argued that health is a social phenomenon, a symbolic category constructed out of culture-specific notions about the body/self, and that these social constructions of physical and metaphysical phenomena constitute a society's discourse on/of health, providing an interpretive framework for social members for organizing daily experience along culturally normative lines. I have also argued that abstract concepts as well as practical activities are fundamental constituents of body and health discourses because the body is both the object and the medium of health, the particular genre of health in a society being practiced on and through the body. In this constructionist perspective, health, body, and self are conceptualized as culturally and temporally located and circumscribed. The implication of this for social analysis

[3]"By acquiring the status of object, its (the body) particular quality, its impalpable color, its unique, transitory form took on weight and solidarity. No light could dissolve them in ideal truths; but the gaze directed upon them would make them stand out against a background of objectivity...And thus it becomes possible to organize a rational language around it. The object of discourse may equally be a subject..."(Foucault,1975:xiv).

is that the discourse of health in a society constitutes a site for exploring taken-for-granted notions of social and individual reality (Foucault, 1975; Idler, 1975; Douglas, 1982; Crawford, 1985).

With respect to analyzing discourse, Young (1980) has made the important point that analysts must be attentive to the "specificity" of a discourse. The "specificity" of a discourse refers to what is left out or denied, thus rendering certain objects and events apparent (and therefore, available to guide action and interpret experience) and others invisible (and therefore, unavailable). This is a necessary element of any discourse because it creates the "epistemological space which makes discourse possible in the first place" (1980:136), but it also demonstrates the constructed and political nature of discourse.[4] With respect to contemporary health discourse, Young's notion of specificity calls attention to the absent and excluded objects and events of contemporary health discourse and the implications of these exclusions.

For Foucault, analysis of discourse involves delineating power relations and their supporting technologies,

[4] For Young, the danger lies in being unaware of the existence of the specificity of knowledge, and therefore of being uncritical of the historical determinants of one's theoretical knowledge.

structures, and techniques. Foucault's post-structural explanation is that new discourses, or new ways of "seeing" old phenomena, are ultimately derivative of relations of power. This form of power guarantees its own production and reproduction through the establishing of institutional structures, technologies, and cultural techniques which come to be accepted as necessary and real. Foucault's concept of power differs from traditional definitions of the term.[5]
For Foucault,

> "power comes from below; it is induced in the body and produced in every social interaction. It is not exercised negatively from the outside, though negation and repression may be one of its effects" (Martin 1988).

Foucault argues that new discourses redefine the limits of objects and subjects, thus creating the space for the application of the social and cultural techniques which sustain and proliferate a particular way of seeing, and in the process make them appear indispensable (Bordo 1989).

Glassner (1989:180) has argued that structural explanations are insufficient analyses of discourse because they only explain why a a social trend occurs when it does; cultural

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[5]Traditional definitions conceive of power as the ability of a person or a group to carry out their wishes or policies, and to control, manipulate, or influence the behavior of others, whether they wish to cooperate or not. Generally, power is exercised through "thou shalt not" edicts (Duke 1976).

explanations are required in order to grasp why the trend takes the form that it does.

In sum, in studying health discourse, structural, cultural, and practical factors must be taken into account when exploring included and excluded categories of constructed meaning. The analysis of a society's health discourse necessarily involves analysis of the interpretation and construction of the body because the body is one of the main objects of health.[6] Moreover, because the body has the unique aspect of also being the medium of health and a locus of social control (Bourdieu, 1977; Foucault, 1979; Turner, 1986; Bordo, 1989), analyses of health discourse must attend to practical activities focussed on and carried out via the body as well as representations and conceptual images of the body.[7]

Some Theoretical Concepts for Analyzing Health Discourse

Following Foucault (1979), Bordo (1989:26-27) has suggested using the theoretical concepts of the "intelligible" (or conceptual) body and the "useful" (or practical) body for

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[6]As is discussed below, the body is <u>the</u> main object of contemporary health discourse.

[7]As Bordo (1989) points out, most critiques have focussed on representation and neglected the analysis of the practical aspects.

analyzing the body in society. The "intelligible" body refers to social representations of the body or "our cultural conceptions of the body, norms of beauty, models of health, and so forth." The "practical" body refers to the "set of practical rules and regulations" through which the living body is shaped to conform to existing conceptual forms, thus becoming a socially adapted and practical body. By delineating the conceptual aspects of health discourse (the cultural norms and ideas) and the practical elements (how we actually "do" health), the distinctive shape of health discourse at a particular time and place is illuminated.

These theoretical concepts are applied in the following section and in Chapter IV, Analysis and Findings.

SECTION II: A COMPARATIVE EXAMPLE: HEALTH AND THE BODY IN NINETEENTH CENTURY AMERICA

In order to highlight the previous points about the temporal and socially constructed nature of health and the "intelligible" or conceptual and "practical" dimensions of health discourse, a brief comparative example follows, focussing on the changes in the concepts of health and the body since the nineteenth century. This review also provides

a perspective on the historical underpinnings of contemporary health discourse.

During the nineteenth century, the formerly disparate concepts of health and the body became increasingly intertwined. "Health" began to be conceptualized as circumscribed within the borders of the personal body, while the body was increasingly perceived as an indivdual and independent entity, and the locus of health practices. As is discussed in the final section, by contemporary times, the discourses of health and the body are characterized by increasing ambiguous definitions of what constitutes "health" and the "body".

Historical Underpinnings of Contemporary Ideas about "Health"[8]

The idea of "health" as a phenomenon within human control was not prevalent in the United States until the early 1800's. Up to that time, Puritan and Calvinist ideas of limited election to salvation, of a vengeful God, and of humans as essentially depraved were dominant. Within this doctrine, health and disease were conceptualized as the

[8] Historical analyses of health and illness in 19th century America can be found in Burnham (1984); Whorton (1986); Mrozek (1987); and Green (1988).

outcome of Divine and intractable judgement. God determined whether or not an individual was to enjoy health on earth or be stricken with disease; individuals could do little to abrogate God's will. Health and physical well-being were not viewed as goals toward which an individual should deliberately strive. Diet and physical activity were mundane activities of daily existence, not conscious actions taken in pursuit of ideals of health (Burnham 1984; Whorton 1986; Verbrugge,M. 1988). In other words, at the level of human practice, health wasn't "done"; it was conferred by God.

During the late 18th century, these Calvinist and Puritanical notions were gradually supplanted by beliefs introduced from Europe of Christian perfectionism. In this view, God was seen as a loving father willing to grant salvation in heaven to those who performed good works while living on earth, and individual's had a duty and responsibility to seek salvation through good works (Whorton 1986; Mrozek 1987; Verbrugge,M. 1988). Allied with this idea of human responsibility for salvation was the notion of personal responsibility for health. An individual could influence his or her state of health or disease on earth through the exercise of reason, a God-given gift (Whorton 1986; Green 1988), and could achieve an original state of goodness through re-adoption of a natural mode of living

(Burnham 1984; Whorton 1986). In short, in practical terms, human activity began to take on new meaning with respect to health.

For some, nature was no longer viewed as chaotic and unintelligible, but rather as positive and good. Nature's laws were of divine origin; the human body as "natural" was believed to have an innate ability to regulate itself. As the house of the soul and "Nature's" construction, the body was a concrete representation of divine wisdom (Burnham 1984). The individual had a moral and religious obligation to understand and obey them (Whorton 1986). Within this conceptual framework, "health" became the Christian practical duty of each individual, knowledge of the body and its functioning became a moral obligation, and the presence or absence of bodily "disease" became an indicator of an individual's level of goodness and responsibleness (Fellman and Fellman 1981).

"Health," now conceptualized as a "natural" (not Divine) phenomenon, became subject to natural laws which could be understood. "Disease" became a product of humans and could be avoided by obeying newly understood natural laws, particularly the laws of miasmas from filth or "Environment," and the laws of the body or "Physiology" (Whorton 1986; Green 1988). Body structure and function

were understood afresh from a Newtonian perspective, post-Enlightenment, mechanistic perspective.[9]
In this "modern" view, the body was conceptualized as a machine, progressively devolving to a more degenerate state such that contemporary bodies were seen to be mere shadows of their former mechanical perfection (Whorton 1982). However, bodily health could be acheived through maintenance of bodily machinery.

At the practical level, the problems posed by these new conceptualizations of health and the body prompted the emergence of new fields of study in public health, physiology, bacteriology, and physical education (Burnham 1984; Whorton 1986; Verbrugge,M. 1988). "Discoveries" in nutrition science, physiology, and bacteriology linked diet, physical activity, and hygiene to bodily disease, resulting in a new practical focus on diet, activity, and hygiene as the means for delaying bodily degeneration and for keeping bodily machinery tuned and ready to perform God's work (Mrozek 1987; Verbrugge,M. 1988). People came to believe increasingly that through appropriate action, individuals could maintain a state of health conducive to the performance of good works and could protect themselves from

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[9]Feminists critiques have also pointed out the masculinist bias of such a perspective (Bleier, 1984; Bordo, 1986; Harding,1986; Farganis, 1989).

the increasing number of hazards to which they were exposed by the spread of urbanization and industrialization (Verbrugge,M. 1988).

In sum, at the conceptual level, a new belief in human (rather than divine) responsibility and moral obligation for health emerged from the confluence of Newtonian and perfectionist Christian thought and its associated beliefs of God, Nature, and natural law as positive and intelligible. At the practical level, this new perspective made the study of the body and its workings imperative. The concept of "being healthy" took on new social meaning, with respect to both individual public and private social action. In short, the transformation of the meanings of the terms body, self, and health moved with intellectual, structural, and cultural changes.

SECTION III: THE CONTEMPORARY CONTEXT OF HEALTH

The brief comparative example example above illustrates the historical and temporal nature of the conceptual and practical meanings of health.

Turning now to the present, we examine the conceptual[10] and the practical[11] elements of contemporary health discourse. These include the meanings given to health, self and body; notions of pathology and non-pathology; repertoires of conduct; and other phenomena included in and excluded from the category of "health" in a society. This is not intended to be an exhaustive critique of contemporary health discourse, but rather is meant to provide background for understanding the milieu in which my respondents experience and construct health for themselves in their daily lives.

Conceptual forms of contemporary health discourse are discussed first, followed by a discussion of the "practical" elements.

Contemporary Conceptual Forms of Health, Self, and Body

In contemporary western society, the rubrics "health," "healthy," and "healthful" have come to be applied to an enormous range of events, phenomena, and experiences. Several surveys of white, upper and middle class people have

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[10]This is the same as the previously referenced Foucault/Bordo concept of the "intelligible" aspects i.e. representation.

[11]Often referred to as praxis. I prefer Bordo's term of "practical" not only because I do not want to invoke the Marxist meaning of the term, but also because it has connotations of do-ing and do-able.

found a "diminishing gap" between concepts of "health" and "life" such that "health" has come to be associated with identity, attitude, body, work, family, and the environment. (Yankelovich and Gurin 1989:64; Gurin and Harris 1987; Caspersen, Christenson, and Pollard 1986).[12]

Even though a mulitplicity of phenomena have come to be perceived as within the boundaries of the conceptual category of "health," there remains a tendency to conceive of health predominantly in singular scientific (biological and biomedical) terms.[13] The specificity of this biomedical discourse excludes social and other nonscientific explanations of health matters. As Taussig (1980:5) has pointed out, this has repercussions at both the conceptual and practical levels in that it creates:

> "grotesque mystifications in which we all flounder, grasping ... for security in a man-made world which we see not as social, ...human, (nor) ... historical, but as a world of a priori objects beholden only to their own force and laws,

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[12]In a recent survey of white, middle class men and women, respondents' definitions of the "factors important to health"included everything from attitude ("being optimistic") to physical and emotional well-being ("feeling energetic," "feeling rested," "having somenone to love and being loved") to environmental and structural conditions ("living in a non-polluted area," "having time off from work to relax") (Yankelovich and Gurin 1989).

[13]The prevalence of the biomedical perspective has been attributed to the privileged explanatory position in ontological inquiry held by the natural sciences (including biomedicine) and their purportedly value-free empiricist methods (Starr 1982; Taussig 1980; Young 1980; Conrad and Schneider 1980; Fox 1979; Illich 1976).

> dutifully illuminated for us by professional experts such as doctors."

Taussig may sound a bit flamboyant, but his point is well taken that the conceptualizing of health and health matters in terms of a "science of physical things" constitutes a process of reification[14] in which the social, historical and temporal nature of "health" is obscured. Thus, "health" becomes an entity; defined as such, it can be sought after, acquired via medical means, achieved through practical action, and so forth.

Crawford (1985:62) does not directly refer to reification in his "cultural account of health," but does contend that health has become an end in itself and a substitute for salvation in contemporary, "disenchanted, secular, and materialist" western society. He also maintains that the implication of the biomedical discourse for individual self definition is that "in today's health discourse, there is a biomedical definition of the self, encoded as a cultural program with health as its personal, medical, and political objective" (Crawford 1985:63)

Calnan (1987) also notes the increasing priority placed on health as value in contemporary society. Rieff (1966:261)

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[14]See also Waitzkin 1989 and Lukacs 1971.

makes the same point, seeing it as exemplary of the contemporary cultural shift in emphasis from collective to individual ends:[15]

> "That a sense of well-being has become the end, rather than a by-product of striving after some superior communal end, announces a fundamental change of focus in the entire cast of our culture...."

The refocussing of human effort toward the well-being of the individual (and away from the collective) has been paralled by a rise in the perceived importance of "health" as an identifier of "who" a person is. "Health" has come to be synonymous with normality (Glassner 1989; Mishkind, et al. 1987; Crawford 1985; Williams 1983) such that it now has "moral overtones" (Hannay 1988; Crawford 1985:64; Blaxter and Paterson 1982), and is often equated with moral superiority (Kilwein 1989; Becker,M. 1986). Health has come to be seen as an admirable quality of an individual (Glassner 1988; Green 1986); an external reflection of an individual's internal self-discipline, determination (Mishkind, et al. 1987), and ability to work (Waitzkin 1989); and a socially recognized statement of status (Glassner 1989; Herzlich and Pierret 1987; Crawford 1985).

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[15] Reiff's analysis is part of a larger body of sociological work on the continuing modern shift toward narcissism and individualism.

As more and more human activities have come to be subsumed under the rubric "healthy" (and "not healthy"), the sense of self has come to be qualified more and more by a sense of self "as healthy". Health actions have become fundamental media for identity construction as increasingly large numbers of actions (e.g. dancing, walking) are newly defined as "health-related." As one mass market health journal states: "Taking control of your health --whether by doing aerobics, eating oat bran, or learning yoga --is the key to an overall sense of well-being" (Yankelovich and Gurin 1989:64). Another magazine author extols the virtues of D., "a woman who embodies, internally and externally, ...the New American Dream. That is, she's a person whose life is centered on a feeling of physical, spiritual and emotional health. That's what enables her to do anything she wants, be whomever she wants" (Britton 1989). In other words, health is now a means for defining one's Self.

The widening sphere of meaning of the concept of "health" and its effects upon the sense of self is especially evident with respect to "fitness" and the sense of self. Citing autobiographies by "fitness obsessed people," Glassner (1989:185) maintains that one "version of selfhood virtually equates the self with fitness activities." Glassner also notes the frequency with which fitness is presented in the

mass media as a resolution for an enormous range of personal problems.

One of the primary sites for the social construction of health in contemporary western society is the body, but as postmodernist critiques have shown, the body is an amorphous category (Butler 1990, Jacobus, et al. 1990, Haraway 1989). Indeed, the hallmark of contemporary discourse on the body is its lack of consensus about what the body is.[16]

Braidotti (1989:152) describes the body of contemporary discourse as a "mosaic of detachable pieces" and a "source of living material for bioscience" which is regarded as the center of instrumental intellectuality. Braidotti (1989:151) coins the term "empirical-transcendental double game" to refer to the ambiguity inherent in postmodern discourses about the subject/body in which the embodied subject is simultaneously merely a biological organism, "the sum of its organic parts," and more than the sum of its

[16]"Important divergences exist between the discourses of the biosciences, psychoanalysis, and the law - to name only three - as to what exactly "the body" is...The proliferation of discourses about the life, the living organism, and the body is coextensive with the dislocation of the very basis of the human subject's representation....That modernity should be the age of production of disourses and modes of capitalization of the organic human being indicates that no consensus exists as to what the embodied subject is" (Braidotti, 1989:151).

parts, "the threshold for the transcendence of the subject...."

Constructions of the body have not escaped the postmodernist conceptual shift from ordered hierarchy to fragmented network (Kellner 1988) and from sameness to difference. In her analysis of "postmodern bodies", Haraway (1989:14) contends that the body has ceased to be perceived as a "relatively unambiguous locus of identity, agency, labor, and hierarchicalized function" and is perceived instead as unstable and as "a highly mobile field of strategic differences."

Similarly, Featherstone (1982) maintains that the body in contemporary discourse is conceptualized as having differentiated "inner and outer" aspects. Inner aspects refer to optimal functioning, performance, and the ability to do things; outer aspects refer to appearance and movement within social space. Featherstone argues that the contemporary body is regarded as a plastic, visual surface which requires constant attention, and as an entity, is infinitely amenable to modification and improvement through the practical activity of "body maintenance."

The possibility of a resolution to postmodern fragmentation and polarization is precisely the appeal of the fitness

trend according to Glassner (1989). In Glassner's view (1989:183), the contemporary body is viewed as being potentially continuous with self through the medium of fitness; thus, the promise of fitness activities is the promise of "nullification" of the "fundamental polarity" between body and self.

The Practical Forms of Health, Self, and Body

The conceptual forms of health, self, and body are played out in practical activities such as body maintenance. As the conceptualization of "health" has swelled to encompass an ever increasing number of events, phenomena, and experiences of daily life, commerce in "health" products, facilities, sevices, equipment, and foods has burgeoned, producing jobs for workers and billions in revenues for employers (Business Week 1989; Brand 1988). Consumers are buying magazines, books, and home videos oriented to health and fitness in record amounts such that health and fitness mass market media have become the top sellers of all mass media consumer goods (Glassner 1989). Even the academy has been affected. The new "health" has become recognized as a legitimate and compelling subject for academic scientific and social scientific research work, even dissertations (Glassner 1988, 1989; Conrad 1987; Becker, M. 1986; Sabol 1986).

Use of leisure time has taken on a "health" focus for many individuals. Ironically, leisure time is now often spent on labor-making devices such as treadmills and stairs (Jacobs 1977, in Glassner 1989:187).[17] Results from the American Sports Data (ASD) study of participant sport[18] reveal that participation rates in "health activities" among most demographic groups has increased, with women and older adults showing the greatest increase. The ASD estimates that there were nearly 15 million new "health and fitness" participants in 1988, with weight training and mountain biking increasing among men, and walking, stationary cycling, and aerobics increasing among women (Sports Industry News 1989).

"Health" has come to define myriad existing practices (e.g. eating, walking, sleeping) in contemporary society and new forms of activity have been created in the name of and for the sake of health. Glassner (1989) notes the prevalence in the fitness field of "simulacra" or representations of representations, such as stationary bicycles which bear little resemblance in structure or utility (transport) to

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[17]As one of my dissertation committee members noted in reference to a paper she had heard presented, these labor making devices further fragment the body into biceps, triceps, thighs, and so forth, thus symbolically connecting the body to the late capitalist economy.

[18]Sixteen thousand interviews were conducted.

their road-ridden counterparts. For individuals, the use of these new products involves not only learning how to use them, but also going somewhere (e.g. health club) to use them since they are often too expensive to buy for home use. Food, too, is now increasingly identified as "healthful" or not; hence, eating and shopping for foods has become a health-related activity. Thus, daily activity for many is now infused with "health" meanings.

Attempts to enact the conceptual ideals of "healthiness" in practice is fraught with contradiction for individuals, especially women. Bordo (1988, 1989, 1990) has pointed out that numerous contradictions exist for women with respect to the practical and conceptual elements of health and the body. Many women starve themselves, thus making their bodies weak, in order to achieve the ideal of healthiness as "being strong," "in control," "not overweight" and visually akin to the lean male body, (the latter suggesting that the male body has become the norm). Morse (1987) notes that the new female ideal body portrayed in video merges the contradictory elements of strength/beauty, muscularity/slenderness, and hardness/curvaceousness. Faurschou (1987, quoted in Glassner 1989:185) cites the contradictory character of the contemporary era which is "no longer an age in which bodies produce commodities, but where

commodities produce bodies: bodies for aerobics, bodies for sports cars, bodies for vacations,...."

CONCLUSION

Structural analyses by several sociologists have argued that the "structural shifts" responsible for this "privileged position" of health and fitness in American public discourse include the aging of baby boomers and their desire to stave off chronic and degenerative diseases through diet and exercise, the effort on the part of hospitals to recoup decreasing revenures by marketing health promotion services, and the growth of in-house corporate "wellness" programs designed to reduce insurance costs and increase employee productivity (Glassner 1989:180; Conrad 1987; Becker, M. 1986). Waitzkin (1989:222) argues that, in practice, the biomedical definition results in an interpretation of health as "the ability to work."[19] In turn, this interpretation is

[19]Waitzkin's concept of "work" references productive, economic labor. In my view, this is too limited a definition. "Being able to work" has come to have a more general meaning: it signifies "capacity to do," but lacks a specific direct object (e.g. productive labor). In this sense, it's meaning is closer to the U.S. Marine Corps slogan of "semper paratus" (always prepared) in that it references the capacity to do anything and everything at any time. The concept of fitness exemplifies this, in that much effort is spent "getting fit" for the sake of "being fit." In other words, the question of "fit for what?" has no direct object except itself. See Chapter IV, Analysis and Findings, and Chapter V, Summary and Implications, for further discussion of this point.

reinforced and diffused by the making and implementing of public health policies which focus on the importance of a healthy work force[20]. Moreover, mass media practices focus on the production and dissemination of images of health which portray "health" as the capacity to do productive work and the "healthy person" as one who produces economically.[21]

While these structural explanations address the question of means or "how" health has come to be such an important conceptual category in contemporary discourse, cultural analyses have taken up the question of why. These analyses themselves exemplify the ambiguity and complexity of contemporary life in that they often must come up with new definitions and neologisms and/or borrow analytic terms from other disciplines for their analyses. (As I discuss below, this is not to suggest that this is "good" or "bad" in terms of analyzing social phenomena. Rather, it is to illustrate the feminist point that the traditional (Cartesian) symmetrical analytic categories of opposites and consistencies no longer adequately describe experienced social reality.) For example, Glassner spends much time

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[20]See also Brown (1979)

[21] Waitzkin also cites the fact that worker productivity is one of the most commonly used standards for judging the cost-effectiveness of medical practices (Waitzkin 1989:222; Weinstein and Stason 1977).

detailing why he uses the literary term "postmodern" to describe fitness even though it carries other connotations and denotations. He uses the term because it fits best, but has to deconstruct, then reconstruct it to conform to the meaning he is trying to convey concerning the aesthetic features of fitness products and practices.[22] Glassner uses a comparative approach to describe the contemporary fitness trend, saying that the trend is not modern, but is postmodern, but not entirely so, and therefore might be best referred to as "dismodern." (A term which lets us know what it is not, but not what it is).

Glassner's analytic dilemma is exemplary of contemporary life. But, as feminist theorists have suggested, theorists cannot expect analytic categories to be consistent and "stable" if they are to reflect adequately the complexity of the contemporary world (Harding 1987, 1990). Contemporary life is a jigsaw of contradiction and complexity which defies singular definitions. Exercise is used to relieve

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[22] "By using the term postmodern, I do not intend, however, to engage in what is coming to be called postmodern social theory... nor do I intend to engage in metatheory. Rather, my use of the term postmodern is a matter of convenience for crossing disciplinary boundaries. For better or worse, postmodern has become the currency in several scholarly literatures to refer to certain aesthetic practices and attendant ideological positions....(Glassner 1989:181)

stress, leisure time is spent "working" out, and so forth. Thus, in keeping with this "reality," explanations of social phenomena may include internal contradictions. (Such explanations would be anathema to positivist theorists.)

In sum, the contemporary context of health in which the respondents of this study create and recreate health for themselves is characterized by change, contradiction, and complexity.[23] Health is more than a universal biological fact amenable only to scientific observation and explanation. Rather, it can be studied as a constructed symbolic category, filled with culture-specific notions about the body and self, which serves as a framework for organizing daily experience. It is this perspective that informs this study.

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[23] The inclusion of an increasing number of activities, objects, and other matter within the boundaries of the category "health" appears to represent an expansion in our understanding and knowledge of everyday phenomena; I would argue, however, that it represents a narrowing of our "way of seeing" or conceptualizing events and phenomena in the daily world because it confines our understanding of these events and phenomena to the scientific (biological and biomedical) terms predominant in discourses of health. In other words, there has been a covert simplification of meaning. As activities, objects, and other phenomena have been recast and given new meaning as "health-related", health as a category of explanation has expanded, but in the process the breadth of possible alternative explanatory categories has been diminished. A seeming clarity has been achieved through obsfuscation.

CHAPTER II

METHODOLOGY

INTRODUCTION

The Relatedness of Theory and Methodology

Methodology usually echoes theory. Mine was no exception. My methodology reflects my feminist theoretical perspective in which the Cartesian concept of "objectivity" is rejected in favor of a concept of subjectivity as positionality.[1] That is, subjectivity is conceptualized as a kind of locatedness which is informed by indigenous discourses and is constituted in activities practiced by resourceful and imaginative agent/actors. With respect to the practice of research, this means that the researcher is not an objective "viewer" standing outside and looking into the universe of those being studied, but is herself an actor analyzing other actors.[2] It also includes the theoretical possibility

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[1]See Chapter, III, Theory, for explication of this perspective. Later, in this chapter, I address some of the recent debate on fieldwork and modes of interpretation and presentation of data.

[2]As Warren (1988:46) notes, one of the primary contributions of feminism to methodology has been the bringing back into focus the role of the researcher's emotions in fieldwork. See also Katz Rothman (1986) and Rubin (1976) for personal accounts of the effect of emotions on the fieldwork research process.

that, as in quantum physics, the universe studied in the research project is not a static phenomenon existing "out there", but is itself, in some strange sense, "brought into being" by the participation of those who participate (i.e. the researcher and the researched).[3]

In terms of my own research methodology, this had two important ramifications. First, it brought into the foreground an awareness of my own experiences, biases, and interests and their influence upon my framing of the research problem and my analysis and interpretation of the data. Second, it demanded that I use a methodology that recognized the involvement and influence of the researcher in the research process, and more importantly, harnessed this involvement for the benefit of the research process.

Choosing the Grounded Theory Approach

Given the above, and the fact that one of the strengths of my graduate department was qualitative analysis,[4] I chose to use grounded theory as my methodology (Glaser and Strauss

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[3]See Shalin (1989) for a discussion of quantum physics and its kinship with the interactionist preoccupation with "defining the situation."

[4] It was no accident that my "location" as a student was in a program heavily oriented to qualitative analysis, given my interests.

1967; Strauss 1987).[5] Grounded theory is more a structured strategy for analyzing data and generating theory, than it is a method for testing a priori theoretical ideas.[6] This approach appealed to me. It spoke to my above mentioned interests as well as to my interest in developing an understanding of health behavior which took into account new feminist and postmodernist perspectives. My own research suggested that existing theories of "health" behavior were partial perspectives, representative of their own time and place of origin.[7] These cognitively-oriented theories

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[5]I also relied on Schatzman and Strauss 1973, Lofland 1971, and discussions of theory in one of Anselm Strauss' seminars.

[6] Strauss (1987:5) states: "The methodological thrust of the grounded theory approach to qualitative data is toward the development of theory, without any particular commitment to specific kinds of data, lines of research, or theoretical interests. So it is not really a specific method or technique. Rather, it is a style of doing qualitative anlaysis that includes a number of distinct features, such as theoretical sampling, and certain methodological guidelines, such as the making of constant comparisons and the use of a coding paradigm, to ensure conceptual development and density."

[7]The health behavior literature is voluminous. I am referencing that part of the literature that addresses volitional health protective and health related behavior (as differentiated from illness behavior). This subsection of the literature is itself enormous. The development of theoretical and analytical distinctions between behavior related to "health" and behavior related to "illness" has been the substance of social scientific and epidemiological inquiry since the 1950's. Nonetheless, Becker's (1974) "health belief model" is the most renowned. Numerous studies as well as revisions by Becker and colleagues have been published since the publication of the original paper (Cummings, Becker, and Maile, 1980; Wallston and Wallston, 1982; Becker and Maiman, 1983; Janz and Becker, 1984; Leventhal, et al. 1985).

(continued...)

overlooked aspects of the experience of being healthy, especially those aspects related to being embodied male or female in a particular time and place.[8] Grounded theory offered a structured means for exploring "being healthy" and generating new theory.

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[7](...continued)

Cognitive models of health behavior such as Becker's Health Belief Model (Becker 1974) have predominated over sociological models such as Suchman's (1964, 1965, 1966, 1967). The prevalence of a cognitive orientation (rather than a sociological orientation) to understanding health behavior was largely the result of a confluence of historical and situational factors. In the early fifties, within the Public Health Service, interest was focused on prevention (not treatment) of disease; especially, the phenomenon of public reluctance to utilize the PHS's (low or no cost) preventive screening and testing measures for early detection of diseases such as TB, cervical cancer, rheumatic fever, polio, and dental disease (Rosenstock, 1974:328). Coincident with this phenomenon was the existence of a group of researchers within PHS who were trained in the Lewinian phenomenological tradition of social psychology and had a "strong philosophical commitment" to theory development (1974:329). This group, when confronted with PHS' practical problem of human behavior with respect to prevention, conceptualized it as a problem of individual perception and motivation within an ahistorical framework (i.e. prior experiences were not theoretically paramount). In addition, they wanted to develop theory which would be adaptable to more than the current practical problem. Thus, in Rosenstock's analysis, it was "almost foreordained" that health behavior would be conceptualized and explained in primarily cognitive terms with sociological factors playing only a supportive explanatory role (1974:329).

[8]It should be noted that there is a growing literature on health and being healthy which addresses lay perspectives and experiences. For example, see Stacey 1986, Calnan 1987, Kotarba and Bently 1988, and Blaxter 1990. Although these studies recognize sex differences in health behavior, they do not address the issue of health behavior from a phenomenological perspective which takes as problematic being embodied male or female.

DECIDING WHAT TO STUDY AND HOW TO RESEARCH IT

My decision to study the experience of "being healthy" was motivated by a number of things: my academic exposure to feminist critiques of traditional theory which prompted me to question the theoretical underpinnings of the research studies to which I was exposed; my dissatisfaction with the emphasis in "health" research on "illness"; my frustration with the comparative dearth theories and studies of health which moved beyond the "medical model" and explored lay experience; and finally, my own efforts at "being healthy."

In deciding how to study "being healthy," one particular experience triggered my decision to frame my research as I did. This occurred during a dissertation research and writing seminar in which I was presenting possible topics and approaches for my dissertation. Another student asked me to elaborate on a point I had made concerning published public health research on women's and men's morbidity and mortality rates and the assumption that human health/illness experiences and activities are generic (rather than distinct for men and women). In formulating my own response, which drew on feminist and sociology of health and illness research, I realized that my dissertation focus would not be to verify a question such as whether or not men and women

had different rates of health (and illness), but rather, would be to move one (theoretical) step back and tap men's and women's own interpretations of "being healthy" in order to generate theory directly related to the lived experience of health. In doing so, I'd alleviate my dissatisfaction that the theoretical assumptions of most existing research did not adequately reflect lived experience because they assumed a homogeneity of experience among and between men and women.[9]

The guiding questions that I came up with for my dissertation proposal were:

How, in what ways, and in what social and material circumstances do men and women define "health" for themselves and utilize resources to produce, promote, and maintain "health" for themselves?

What differences, if any, are there in the definitions of health emergent from awareness of self and body in men and women?

Is the doing of health a form of "doing gender" as conceptualized by West and Zimmerman (1987:126) such that health actions not only a) represent one of the "many socially guided perceptual, interactional, and micropolitical activities that cast particular pursuits as expressions of masculine and feminine 'natures'," but also b) constitute a form of situated social conduct of which gender is an "emergent feature ... both as an outcome of and a rationale for" existing social arrangements.

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[9]A number of studies have focussed on sex differences in health behavior. Most attribute these differences to either role-related risks and benefits or to differing illness/prevention orientations between men and women. See: Natanson 1975, 1977; Cleary, Mechanic, and Greenley, 1982; Gottlieb and Green 1984; Hibbard 1984; Verbrugge 1985, 1987.

The questions were guides, not commandments. As the research progressed, unanticipated nuances of these questions as well as linkages between the questions presented themselves through the data, prompting me to refocus my analysis.[10] For example, my data suggested that differentiating between men and women was not theoretically dense enough (question #1); if possible, I needed to differentiate between and among men and between and among women. With respect to question #2, I realized that I needed to bring topside the similarities, not just the differences, between men and women.[11]

THE RESEARCH PROCESS

Crafting an Interview Guide

Armed with my set of topical questions, I developed a preliminary questionnaire to use as a guide in the interviews. [See Appendix A for questionnaire.] The interviews were to be naturalistic, unstructured, and open-

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[10]As I discuss below, this process of reconceptualizing and re-theorizing is a fundamental aspect of the grounded theory approach.

[11]In some respects, these rephrasings of my original questions could be considered "findings" of the research, and as such, would be discussed in the chapter on Findings. I do discuss them there. The purpose of relating them here is to illustrate part of the methodological process that I went through in moving from my initial phrasing of the research problem to the final presentation of research findings.

ended; the purpose of the questionnaire was to ensure that certain topics were covered in the interviews. The questions were designed to probe respondents' definitions of health and healthiness in themselves and in others, their criteria for estimating health in themselves and others, and their strategies and actions taken for health. Questions included: Do you consider yourself a healthy person? How do you know you are healthy? How do you account for your healthiness? What kinds of things do you do for the sake of health? How do you know if someone else is healthy? and so forth.

Sample Selection

Determining who would be in my sample of respondents was not easy. To begin with, I had limited financial resources for travel so my immediate geographic area had to be my study area. I also had limited time (as do all graduate students) to conduct my research, so my sample size had to be small. With respect to choosing who would be part of my sample, one dissertation committee member wisely suggested that I streamline my sample as much as possible in order to minimize the number of confounding factors. This meant identifying a group of similarly situated persons. I chose a group to whom I had easy and ready access and who would agree to be interviewed, and re-interviewed if necessary. My

final sample comprised nine men and twelve women, ages 35-55, white, and of middle to high income. None had children and all had partners. The decision to interview couples without children came about as a result of a conversation with my dissertation committee in which we discussed the range of effects of parenthood and single-hood on health behavior. Selecting individuals for my research who were partnered and without children alleviated having to address this range of effects. I initially interviewed two people that I knew and then used a snowball sampling technique to find the remaining respondents (whom I did not know).

Timing Interviewing, Coding, and Memoing

Since grounded theory is based on an iterative process of collecting and coding data, dimensionalizing codes and developing categories from them, and returning to the data and comparing categories in search of linkages and possible new categories, my interviewing and my analytic coding process went on simultaneously.[12] I began by interviewing three people and "open coding"[13] their responses before

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[12]My methodological process closely follows that described by Strauss (1987). In my discussion I am using the technical terms of grounded theory as Strauss defines them (e.g "dimensionalize," "open code," and so forth).

[13]"Open coding" refers to the early stage analytic scan of the data for conceptual categories and relationships among ideas. It is "open" in the sense that the researcher has not (continued...)

conducting more interviews. After the initial coding, I wrote memos on the ideas suggested by the data. Each round of coding and memoing provided new or refined foci for subsequent interviews. (This process of coding and memoing is illustrated below). In two cases, I returned to previous interviewees and re-interviewed them in light of the new theoretical ideas which had evolved subsequent to their original interview.

Memos

The writing of memos was a vital part of my methodological process. The content of the memos ranged from inklings about connections between codes and categories to concrete comparisons of ideas, to notes to myself on things to be remembered. The collection of memos became a kind of bulletin board to which I could continually refer to re-ground myself in the ideas in my data. By the later stages of the analysis, I had so many pages of memos that I condensed the ideas in each into a statement or phrase which I then wrote (along with the computer file name of the memo) on a self-stick, two inch by two inch, "post-it" note. I

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[13](...continued)
yet defined and refined categories. Not only is the researcher "open" to all conceptual possibilities presented in the data, but also the data itself is "open" in that it is a mass of information whose conceptual content has yet to be sorted and refined.

tacked these post-it notes up on a wall in my study, thereby producing a map of the research. An unexpected benefit of using the self-stick notes was that they were easily rearranged on the wall. I grouped and regrouped the notes on the wall as the analysis progressed (and codes and categories emerged, collapsed into or separated from one another).

The Interviews

The interviews themselves were open-ended and unstructured. Respondents understood that the interview could be as long as was necessary or convenient for them. As mentioned earlier, I used a questionnaire as a reference to ensure that particular topics were covered. Since I wanted to tap men's and women's concepts of health and healthiness, I emphasized at the beginning that I was interested in the full spectrum of their ideas on health and healthiness. Often, I had to reiterate this point. In some interviews, a substantial amount of time passed before the interviewee mentioned ideas that he or she considered to be unorthodox. One woman said "Oh, you want that, too?" when I drew her out on a comment she had made about God and healthiness (Interview.03).

During the interviews, my own interest and familarity with many of the aspects of the contemporary cultural preoccupation with "health" was a resource for developing "on the spot" questions for drawing out interviewee responses. For example, my knowledge of nutrition and exercise provided a ready source of information for querying further those respondents who defined healthiness in terms of food and activity. At the same time, my lack of religious knowledge hampered my attempts to draw out those respondents who identified healthiness as God-given. (Which is not to say that I didn't try to draw them out, but rather that I felt less confident about my own interpretation of their responses. This is an example of the problems that can arise when the "locatedness" of the researcher and that of the interviewee differs.)

The interaction between the interviewee and myself eventually became an important source of data for my analysis. During the first interviews, I wondered if some of the respondents' reticence came from their desire to give me an answer that fit their impression of what I, as a doctoral student from a medical campus, would consider to be a "good" answer. However, after conducting and analyzing more interviews, I realized that interviewees tended to organize their responses such that medical, biological, body-oriented concepts preceded metaphysical, experience-based, more

speculative ideas. In other words, there was a pattern to the presentation of ideas about health such that biomedical definitions were usually presented first, followed by explanations based on personal experience.[14] Moreover, the experience-based explanations were often offered as counterpoints to biomedical definitions; thus suggesting that biomedical definitions were considered to be the norm from which other explanations deviated.[15] This "pattern of presentation" (as I referred to it in the analysis) directed my analytic attention toward "received" (i.e. ideas circulating in the public arena) and "derived-from-experience" (i.e. ideas grounded in the experiences of one's own and those of significant others) types of health knowledge. The data derived from coding for "received" and "derived" health knowledge was instrumental in developing the core category[16] of "knowing health."[17]

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[14]This was not surprising given the predominance of biomedical and "scientific" explanations of health in contemporary western society. For sociological analyses of this phenomenon, see Engel 1977, Crawford 1984, Glassner 1989.

[15]Interviewees often would preface their own, experience-based explanations with caveats such as "This may sound strange" (m.16) or "No doctor would agree with me" (f.07).

[16] A "core category" is a central category for the integration of theory. My core category of "knowing health" represented the coalescence of numerous related subcategories such as "derived health knowledge," "received health knowledge," "knowing the self as body," and "personal health history." See Strauss(1987).

Coding: An Illustration

One of the pleasures (and frustrations) of the grounded theory method is the discovery of themes and patterns in the data. One begins with a seemingly shapeless body of data, a pencil, possibly a computer and software program such The Ethnograph,[18] and time. Through the analytic honing processes of coding and memoing, theories are constucted from the data. The following illustrates this process for one code in my analysis.

My open coding of the first three interviews produced an overwhelming and unruly mass of health definitions, concepts, and practices. Comments ranged from "Healthiness is dis-ease... all things in moderation... no heavy duty, perverted obsessiveness" (f.07) to "Healthiness for me is no

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[17](...continued)

[17] I also discovered that people came to the interview with a personal health history. This history framed their understanding of themselves as healthy and it was this that organized their discussion. This eventually led to my exploring the process through which interviewees integrated and tested the validity of information from outside themselves with their own personal experiences which, in turn, led to my theoretical concept of an intrasubjective "selfsoma process."

For more on the personal health history, see Olesen, et al. 1990 and the concept of "health biography." Also see my discussion in Chapter IV, Analysis and Findings.

[18]A software program designed by sociologist, John Seidel, for doing qualitative analysis.

heartaches, headaches, or aches and pains"(m.06). Since I was interested in men's and women's concepts of health, I separated male and female responses and grouped them according to whether they were "abstract" or "practical." The decision to use the codes, "abstract" and "practical," was based on a previous lengthy round of coding which I had done on a number of journal articles, sections from books, and mass media articles and advertisements. The idea of coding this cross-section of material had come from my qualitative analysis seminar. The purpose was to sensitize myself to the concepts of health circulating in the public domain (and available to my respondents) and to provide a starting point for coding of my interview data. "Abstract" denoted universal, conceptual definitions while "practical" referred to being and doing by an individual. For example, the response, "health is the opposite of dis-ease," was considered to be "abstract." The response, "health is being able to do the things you want to do," was considered to be "practical."

As I went through the process of organizing the data in this way, I kept having difficulty deciding in which group particular responses should be put. Responses often fit into both; abstract and practical were often inextricable. When I divided up the response into its abstract and practical elements, the meaning of each seemed diminished in some way.

This sense of a loss of meaning was subliminal for me. I tried to write a memo and could't articulate precisely what I felt, but my own lived experience of health told me that something more was in the data. So, I went back to the data looking for an answer.

I coded for "abstract/concrete linkages" since this was the source of my puzzlement; I found responses such as: "Heathiness is like when I go for a run and you're physically working the body until the toxins are cleared out, and your whole body and mind is revitalized" (m.03) and "It's the way you see things and how you go about doing things, and whether you love your family and they love you" (f.011). The results of this coding corroborated what I had already found and brought to light two phenomena in the data that had gone unnoticed. Namely, that there were more similarities than differences between men's and women's abstract ideas about health and being healthy, but more differences than similarities with regard to how men and women actually went about being healthy in their daily lives (i.e. the actual actions that they described themselves doing).

In pondering this in a memo, I realized that the puzzle itself was the solution: one of the characteristics of the lived experience of health is that it has both abstract and

practical aspects, and it is through the relating of these two within a social and cultural context that the experience of "being healthy" is constituted for the individual. In other words, respondents, as socially-located men and women, had an inventory of abstract ideas about health, but they also "did" health in practical terms. Health actions were real-time, socially-located enactments of their abstract concepts of health, in turn, their experiences of enacting health influenced their abstract conceptions of health. Healthiness seemed to be an on-going spiral-like process made up of personal experience and received knowledge, each mediating the other. In some ways this seemed obvious, but from the point of view of theory and method, it raised the issue of the relationship between ideas and embodied (male and female) experience, and suggested that healthiness is not simply a biological phenomenon, but a socially and culturally informed experience and process. This meant that I needed to focus the analysis on process and relations as well as on explicit abstract and practical definitions.

I returned to the data and axial coded for "abstract" and "practical." The purpose of the axial coding was to discover imbedded relationships, conditions for these relationships, strategies related to them, and their

consequences.[19] The axial coding produced references and examples pertaining to "the body" (no self attached), "my body" (attached to self, including sense of physcial condition), "my self" (sense of personhood, including age, gender, occupation), "access to medical expertise," "being" (someone or something, is an on-going action), "doing" (activities), "capacity" (inherited and achieved), and "fitness" (for whatever goal the respondent designated). (The latter term was so frequent that it became an "in vivo code.")[20] These categories all had subcategories. For example, "the body" and "my body" had subcategories of "body maintenance" (a strategy related to healthiness), "body architecture" (a condition and a consequence of healthiness), and "body grammar" (a condition). Categories also related to each other; for example, "my body" was explained in terms of "capacity" (ability to do) and "being" (being female, being a certain age, etc.).

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[19] Axial coding "is an essential aspect of open coding. It consists of intense analysis done around one category at a time, in terms of the paradigm items (conditions, consequences, and so forth). This results in cumulative knowledge about relationships between that category and othe categories and subcategories" (Strauss 1987:32). That is, the researcher looks for "conditions," "strategies," and "consequences" in the data. "Dimensionalizing," a process developed by Schatzman [GET CITE FROM LS], refers to the process of making distinctions. Groupings of these distinctions make up a category.

[20] The term for a code adopted by the researcher which maintains the original language of the actora in the field.

Since I was interested in differences and similarities between men and women, I then grouped the categories and subcategories according to whether the respondent was male or female. In general, both men and women cited the same phenomena and used the same vocabulary ("the body," "my body," etc.) when defining health and healthiness; however, close analysis showed that the meanings of some of the terms were different. For example, men and women both mentioned "body maintenance," but their recommendations for what and how to "do" or practice it were different. Men defined body maintenance in terms of sports and strenuous exercise, while women defined it in terms of moderate exercise and grooming. Women usually also mentioned the setting as an important aspect of the activity (i.e. doing aerobics because it was indoors, and therefore, safe and private) while men rarely did. Both men and women voiced beliefs in the processual and mercurial nature of health; that is, the notion that health comes and goes based on what one does or is exposed to, that the body can be altered voluntarily, and so forth.

I counted the number of times men and women referenced particular categories. Men cited "capacity" and "fitness" more often than did women, while women referenced "my body" and "being" more frequently. In light of this, I recoded my male and female responses, looking for further nuances of

meaning of the various categories that figured prominently in their responses. For example, I recoded the men's responses for "capacity" and the women's responses for "my body." This recoding turned up more examples of what I already had found in previous codings, but no new revelations.

Given the fact that additional coding sessions were not producing any further refinements of the categories and subcategories of "abstract" and "practical," I considered them to be saturated categories. I then returned to the data to code for other categories. Ultimately, the product of the codings for "abstract" and "practical" were instrumental in deriving my core categories of "knowing health" ("knowing" grounded in received knowledge and comprising abstract ideas) and "body/self relationship" (an intrasubjective process related to the interaction of body and self) and "body/self/knowing process" (the relating of external ideas personal ideas and deriving one's own concept).

CONCLUSION

The above illustration is only a glimpse of the grounded theory process of coding, memoing, and generating theory. The illustration doesn't adequately convey the iterativeness

of the processes; one is continually searching for and revising categories, constructing and reconstructing them as additional codings and memos turn up new ideas and refinements of old ideas. The process continues until the researcher senses that the categories and the generated theories faithfully reflect the data.

To return for the moment to the point made at the beginning of this chapter, I would argue that this sense of authenticity and faithfulness reflects the locatedness of the researcher (i.e his/her perspective).[21] Accepting this, the researcher can be a resource for the analysis. In my own case, I often relied on my own lived experience of health as a comparative case for analyzing the data. This was not a foray into solipsism. Rather, it was a conscious application of feminist epistemological theory to methodology in which I made problematic my own "knowing" and defining of the situation (Roberts 1981; Stanley and Wise 1983). As Warren (1988:48-50) has pointed out, a feminist analysis prompts the researcher to recognize

> "the embeddness of all analysis within the observer's biography and historical location... (It is) an interpretive frame for interpretive frames."

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[21]If I were to conduct this study at another time, my findings would reflect that particular time and place and my "locatedness."

One of the implications of this view is that the "scientific, objective" perspective is itself a particular viewpoint of historically located persons.[22] From the point of view of my own research, to have chosen the "scientific, objective" perspective would have been to adopt a foreigner's viewpoint which obscured "the personal and emotional origins of (my) knowing" and its effect on the research product (Warren 1988:48). The "findings" of this qualitative study (or any study) must be interpreted as the product of an historically located person's theoretical and methodological process.

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[22]That these persons have been primarily white, middle class, and male has been eloquently argued by a number of feminists (Keller 1985, Hartsock 1985, Bleier 1984).

CHAPTER III

THEORY CHAPTER

INTRODUCTION: SELF, BODY, AND HEALTH

This dissertation explores individuals' concepts of health and being healthy and how these are constituted in everyday life. In my data, respondents invariably refer to self and body when they talk about health. References to being healthy prompt references to self which prompt references to body which prompt references to self. In other words, concepts of self, body, and health interlace; health is tied up with identity and awareness of self as being embodied and as being a body. From a theoretical point of view, this invokes social psychological theories about the substance, content, and processes related to self and body.

The theoretical and analytical perspective of this research is interactionist, phenomenological, and feminist. This chapter examines some of the ideas that have been put forth about self and body from the above perspectives. Given the large amount of work done in this area, consideration of all theories would be herculean, therefore, consideration is given to those that are most applicable to the larger theoretical concern of the research, namely, the sociological social psychology of health and being healthy.

The chapter is divided into three sections. **Section I** theorizes about theorizing. This section discusses briefly the limitations of the traditional Cartesian rationalist and positivist view[1] and reviews some of the feminist arguments for the establishment of new analytic categories such as gender, emotion, and body. In short, Section I is a statement about the importance of thinking about the categories that we think with when we theorize. In the sense that theory and methodology are linked, this section could fit into the chapter on methodology, but is included here in order to set the tone for the discussions of particular theoretical viewpoints in Section II of the chapter. **Section II**, reviews interactionist, phenomenological, existential, and feminist theories of self and body with an eye to pointing out how each conceptualizes self and body (and health, if applicable). **Section III** delineates my particular theoretical perspective based on a synthesis of the materials presented in Sections I and II.

Chapter V, Implications, addresses these theories in the context of my data i.e. where the theories enlighten, where

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[1]Namely, the idea that an objective and universal "Archimeadian standpoint" exists from which universal Truth can be discerned. This idea has been a theoretical cornerstone of the Cartesian and positivist style of thought which has dominated western theoretical discourse since the "Enlightenment."

they fail in light of my research, and what my research suggests regarding modifications to theory and theorizing.

SECTION I: THINKING ABOUT WHAT WE THINK WITH -- THEORY AND THEORIZING AS PROBLEMATIC

Contemporary western mainstream analytic thinking about the self has been dominated by conceptual categories which were formulated by Descartes in 1619. The source of these conceptual categories was a series of dreams, "which most readers would surely regard as nightmares" (Bordo 1987:247). Descartes interpreted his dreams as revelations of the essential nature of the universe as mathematical and objectively knowable through formal mathematical reasoning, and of self and world (nature) as fundamentally and radically separated (Stern 1965). Descartes' "revelations," which he wrote down in his Meditations, represented a significant shift away from previous beliefs about the relationship between self and nature.[2] The epistemological standpoint (male, separate, objective) and the conceptual categories (subject/object, male/female, mind/body)

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[2] a) Bordo and concept of birth of new rationalist ideas which represented separation of the male self/knower from the mother, of separation from Middle Age ideas
b) art as perpective grows implying separation of object and subject

articulated by Descartes in the Meditations have served as the theoretical foundation upon which contemporary positivist, scientific belief has been built.

In the positivist, Cartesian view, "self" is cast as a duality of mind and body. "Mind" is unitary, rational, conscious, and masculine while "Body" is natural, generative, irrational, and feminine. Rationality, located in the mind, alone is considered to be the source of genuine and reliable knowledge.[3] Bodily experience, fantasy and emotion, being of the natural domain, are considered to be sources of illegitimate and unreliable knowledge (Seidler 1989:94), and even the source of madness (Foucault 1967). Things natural are to be distrusted and dominated via self-control. The rational, masculine mind-self is separate from and controls the body, desire and emotion.

> "A new theory of knowledge, thus, (was) born, one which regards all sense experience as illusory and insists that the object can only truly be known by the perceiver who is willing to purge the mind of all obscurity, all irrelevancy, all free imaginative associations, and all passionate attachments... For Plato and Aristotle, and throughout the Middle Ages, the natural world has been "mother" -- passive, receptive, natura naturata to be sure, but living and breathing nonetheless. Now, ...the formerly female earth

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[3]See Genevieve Lloyd (1984) on the association of reason with specifically "non-female" traits. This idea of maleness in relation to femaleness is explicitly evident in Kessler and McKenna's (1978) work on gender in which they show that "masculine" gender is often defined in terms of "not feminine."

> becomes inert res extensa: dead, mechanically interacting matter.
>
> "She" becomes "it" -- and "it" can be understood. Not through sympathy, of course, but by virtue of the very <u>object</u>-ivity of the "it." ... for the mechanists, ..the world <u>is</u> dead.... empathic, associational, or emotional response obscures objectivity, feeling for nature muddies the clear lake of the mind. The otherness of nature is now what allows it to be known" (Bordo 1987::260).

The revisioning of the world and human experience as a dichotomy of subjects and objects required a concomitant reconstructing of beliefs about the nature of identity. In the Cartesian view, individual "identity" is envisioned as a product of reasoning and consciousness.[4] "The specific consciousness we call scientific, western and modern is the long sharpened tool of the masculine mind that has discarded parts of its own substance, calling it 'Eve,' 'female,' and 'inferior'" (Hillman (1972:250).

THE LIMITATIONS OF THE CARTESIAN VIEW

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[4]As Seidler (1989:94) has pointed out, the Cartesian definition of identity as solely "a matter of consciousness ... reiterates a Christian tradition which often denigrated the body as a source of spiritual knowledge." However, [unlike the Christian tradition of the Middle Ages which ascribed to the body an important and legitimate function as embodied nature and the house of God and did not separate the person from the body] Descartes moved beyond denigration and redefined the body as object, as fundamentally separate from and inferior to the reasoning and intelligent mind.

As feminist theorists have pointed out, this association of self (the Subject), identity, and epistemological authenticity with male objectivity and autonomy and its corollary association of the Other with the female and Nature leaves us with an incomplete means for theorizing and understanding human experience (Code 1988, Bordo 1987, Grimshaw 1986, Merchant 1986, Lloyd 1984, Gilligan 1982). Put differently, the Cartesian view offers only partial truths about human experience (those of male experience) and limits theory to conceptualizing phenomena in terms of oppositions, dualities and polarities, such as masculine/feminine and subject/object. Indeed, it limits us to "consciousness" as a primary analytic category.

The Non-conscious

Numerous critics have called attention to the inadequacy of this perspective. Feminist critiques of epistemological theory have pointed out that the Cartesian view not only ignores aspects of subjectivity which have "deep roots" in the self and are "not easily accessible to consciousness" (e.g. desire, emotion, and fantasy), but also overlooks instances of consciousness (e.g. understanding intellectually the sexism of an image, yet being attracted by it) in which reason and desire are experienced as simultaneously conflicting and compelling and which are "not

necessarily amenable in a simple way to (Cartesian) processes of conscious rational argument" (Grimshaw 1988:101; Griffiths 1988; Jaggar 1988; Daly 1984).

Jaggar (1989:159), in her discussion of the lack of challenges to the accepted theoretical idea that emotion is not a "genuine" source of knowledge, has coined the term "emotional constitution" to describe that piece of the self constituted from emotion, desire, and fantasy. She suggests that different emotional constitutions may be epistemologically significant "in so far as they both presuppose and facilitate different ways of perceiving the world" (1989:169). In other words, emotions may be "helpful" and even necessary rather than inimical to the construction of knowledge.

In short, one of the criticisms of traditional theories of subjectivity is that they need to expand beyond Cartesian analytic limits and acknowledge the importance and genuineness of emotions, desire, and fantasy in constituting the self. A more adequate theory will include these new ways of conceptualizing and new categories of analysis.

Being in the World: Locatedness and Embodiment within a Network of Relations

Other feminists critiques have argued that subjectivity is not the universal and static entity that Cartesian theory would have it be, but rather is an experience or "positionality" (Alcoff 1988) which arises out of situated experience and is enacted in practice by embodied persons (Butler 1989; Alcoff 1988; Haraway 1988; de Laurentis 1986). This conception of subjectivity as position rejects inherently hierarchical theories of self, identity and autonomy which assume an underlying unitary and "real" self beneath a"false" self. That is, they assume that more and less "authentic" self exists and that the "lesser" self has only to rid itself of its false ontology in order to return to its more original state (Grimshaw 1986:94). The conceptualization of subjectivity as positionality is more than a simple remodeling of old theory; it requires the development of new analytic constructs which recognize

> "That there is no 'original' wholeness or unity in the self, nor a 'real self' which can be thought of as underlying the self of everyday life. The self is <u>always</u> a more or less precarious and conflictual construction out of, and compromise between, conflicting and not always conscious desires and experiences, which are born out of the ambivalences and contradictions in human experience and relationships with others" (Grimshaw 1988:104).

As I discuss in more detail in Section III of this chapter, in this conception, subjectivity is elastic. It is "an on-going process of construction" grounded in experience and "not a fixed point of departure or arrival from which one interacts with the world" (Modleski 1986). Conceptualizing subjectivity as an historical and contextual process highlights the political dimensions of subjectivity because it introduces the idea of the active (not overdetermined) subject interpreting and constructing multiple and shifting contexts from a particular position within those contexts. In this sense, subjectivity carries both meanings of the term "subject;" that is, subjects are both subjected to social discourses and subjects who engage in social construction (Alcoff 1988:431; DeLaurentis 1986). Identity, then, must be understood as "a re-writing of self in relation to shifting interpersonal and political contexts" (De Laurentis 1986:9).

One of the most important implications of the notion of subjectivity as positionality is that it raises gender[5] as a salient category in theories of subjectivity and identity

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[5]The discussion below outlines some definitions of the term "gender." Following West and Zimmerman (1987:126) and Butler (1990), this paper conceptualizes gender as "an emergent feature of social situations" and not as a stable property of individuals. In this sense, gender is "done." That is, it is continually constituted through practices in everyday contexts.

because it recognizes practice and location (embodiedness and one's place in a network of relations) as constitutive of subjectivity. The Cartesian notion of a "generic human" (Alcoff 1988) gives way to a notion of possible multiple, different, and contradictory human "beings."

Gender

Even though many agree that gender needs to be raised to a primary analytic category when theorizing about social life (Jaggar and Bordo 1989; Connell 1987; Flax 1987; Smith 1987; Fraser 1986; Kessler and McKenna 1978), many perspectives exist on what constitutes "gender" and how to treat it theoretically. This section gives a brief synopsis of some of these views in order to provide background for the subsequent analysis of gender as a relevant category when theorizing about "being healthy."

Most perspectives coalesce around the ideas that gender is a social construction crafted out of the particulars of time and place and that it is an on-going process, and not an "objective" attribute of persons. In this sense, gender is conceptualized as a classificatory scheme. Linda Alcoff (quoted in O'Barr 1988:399), in her comments about a seminar on the cultural construction of gender, notes that:

> "Most of us in the seminar were committed to the idea that gender is a social construct of some

> sort (though there were various beliefs about how the construction of gender occurs), but we were also committed to the idea that the construction of gender should also be thought of as a fluid, on-going process. To think of one's gender as a stable property and an objectively determinable property is to be the victim of ideology. Gender should not be thought of as an object with clear boundaries and properties at all."

Conceptualized as a social construction and on-going process, gender becomes an analytic category which is location-sensitive. The construction of gender is not universal and essential, but is historically and culturally located, "formalizable in a non-arbitrary way through a matrix of habits, practices, and discourses" (Alcoff 1989:431). This conceptualization has lead a number of theorists to treat gender theoretically in terms of relations. For example, Flax (1987:624-628) states:

> "The experience of gender relations for any person and the structure of gender as a social category are shaped by the interactions of gender relations and other social relations such as class and race. Gender relations thus have no fixed essence; they vay both within and over time... Gender, both as an analytic category and a social process, is relational...

In these perspectives, the analytic emphasis turns to delineating relations of power and domination (Connell 1987; Flax 1987; McKinnon 1982).

> "Through gender relations two types of persons are created: man and woman. Man and woman are posited as exclusionary categories. One can be only one gender ... The actual content of being a man or woman and the rigidity of the categories themselves are highly variable across cultures and

> time. Nevertheless, gender relations so far as we have been able to understand them have been (more or less) relations of domination. That is, gender relations have been (more) defined and (imperfectly) controlled by one of their interrelated aspects -- the man" (Flax 1987:628).

Similarly, MacKinnon (1982:19) states that:

> "Sexuality, then, is a form of power. Gender, as socially constructed, embodies it, no the reverse. Women and men are divided by gender, made into sexes as we know them, by the social requirements of heterosexuality, which institutionalizes male sexual dominance and female sexual submission. If this is true, sexuality is the linchpin of gender inequality."

McKinnon touches on one of the primary points raised by theorists; namely, the idea that gender has been inextricably confounded with sex/reproduction/biology in the world of everyday life. This is problematic for theorists. Flax (1987:634-7) notes that the concept of gender relations is a "useful" analytic category for understanding social relations, but that theorists "need to deconstruct further the meanings we attach to biology/sex/gender/nature" because both men's and women's understanding of "biology, embodiedness, sexuality, and reproduction" is tied up with ideas about gender and gender relations to such an extent that gender and biology have become metaphors for one another.

Pulling together the ideas that gender is a social process and that it is entangled with sex/reproduction/biology,

Connell (1987:140) has suggested conceptualizing gender as a "linking" concept which ties social practices in general to "nodal practices" around reproduction and parenting. In this sense,

> " 'Gender' means practice organized in terms of, or in relation to, the reproductive division of people into male and female... Gender practice might be organized in terms of three, or twenty, social categories. Indeed, our society recognizes a fair variety -- girls, old men, lesbians, husbands, and so on...(The definition of gender as a linking concept) leaves wholly open the question of how extensive and how tight those links are, and what their social geometry is....
>
> Gender in this conception is a process rather than a thing...If we could use gender as a verb ...it would be better for our understanding..." (Connell 1987:140).

Connell sees gender as a " process of organizing social life in a particular way" (1987:140). In western societies, the particular organization of social life is characterized by a hierarchical "gender order" of "hegemonic masculinity" (Connell 1987:183). This gender order is sustained by the linking of everyday practices to reproduction. These practices are organized so as to maintain existing heirarchical social relations not only between and among men and women, but also among men themselves and women themselves. Moreover, Connell argues, these social relations are relations of power which remain "stabilized" in their existing form to the extent that "the groups constituted in the network have interests in the conditions for cyclical

(i.e. conforming) rather than divergent practice" (Connell 1987:141).[6]

The foregoing analyses attest to the salience of gender as an analytic category. Their delineation of the socially constructed and processual qualities of gender, its temporality and historicity, and its use as organizing framework for identity within sociality delimits the "what" of gender, but does not address the "how" of gender. That is, how it is constituted in the everyday world, how it is socially constructed, and how it serves to organize social reality.

Theorists who have grappled with the question of how gender is constituted in everyday life, have conceptualized "gender" as a form of social classification of the individual; both as an attribute and an accomplishment of the individual (Garfinkel 1967; Kessler and McKenna 1978; Connell 1983). This follows the common-sense notion of gender as a property of individual people. The concepts of gender attribution and accomplishment are supported by corollary theoretical concepts of role enactment,

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[6] Related to this idea is Smith's (1987) argument that already existing social relations inform present-time enactments of gender in social interaction.

interaction, and display.[7] Bleier (1984:80), for example, characterizes gender as

> "...different sets of social attributions -- characteristics, behavior, appearance, dress, expectations, roles, etc. -- made to individuals, according to their gender assignment at birth."

Building on Garfinkel's (1967) ethnographic work, Kessler and McKenna (1978) argue that gender is a constituent of self which is formed through an attribution process engaged in by one's self and others in interaction in the everyday world. Kessler and McKenna make the important point that the real work of the gender attribution process is not the initial assigning of a gender category, but rather the sustaining of the sense of "naturalness" of an assigned gender category (1978:159).

Goffman (1977) coins the term "genderisms" to refer to sex-linked individual behavioral practices. Goffman argues that gender is a "social complex" which not only provides grounds for identifying individuals, but also is a source of "accounts" for excusing, justifying, and explaining individual behavior. Goffman also refers to "institutional reflexivity" or the social phenomenon in which particular institutionalized practices (e.g. segregated and different toilets for males and females) are "presented as a natural

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[7]Connell 1987, Chafetz 1988, and Butler 1990 offer good reviews of these theories.

consequence of the difference between the sex classes, when in fact it is rather a means for honoring, if not producing, this difference" (1977:65). In other words, institutionalized practices of everyday life are part of the repertoire of interactional skills which, when invoked, work to maintain differences between masculine and feminine human beings.

For Goffman, gender is enacted and produced by individuals in particular interactions and not others, but, as West and Zimmerman point out (1987:130), Goffman trivializes the importance of gender in all interactions by relegating it to "something that happens in the nooks and crannies of interaction, fitted in here and there and not interfering with the serious business of life." They propose a conceptualization of gender that does justice to "what is involved in doing gender as an ongoing activity embedded in everyday life" (1987:130).

West and Zimnmerman (1988:126) suggest conceptualizing gender as "an achieved property of situated social conduct." Their alternative view shifts the theoretical focus away from individual attributes, a focus which they argue lacks

explanatory power,[8] and toward the places, protocols, and processes of interaction.

> "Rather than as a property of individuals, we conceive of gender as an emergent feature of social situations: both as an outcome and a rationale for various social arrangements and as a means of legitimating one of the most fundamental divisions of society...Gender is the activity of managing situated conduct in light of normative conceptions of attitudes and activities appropriate for one's sex category. Gender activities emerge from and bolster claims to membership in a sex category" (West and Zimmerman 1988:126-127).

In their view, "doing gender is unavoidable" in a society in which the existence of differences between men and women is an essential part of the cultural fabric (1988:137).

Connell (1987:141) also proposes consideration of gender as a property not of individuals, but of institutions, in the sociological sense of institutions as arenas of routine, custom, and repetition. Connell argues that institutions organize the practices of social life in particular repetitive patterns which serve to maintain existing relations. Connell conceptualizes gender as an attribute of institutionalized practice which organizes social life in a particular way (1987:140).

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[8]"... We contend that the notion of gender as role obscures the work that is involved in producing gender in everyday activities, while the notion of gender as display relegates it to the periphery of interaction" (West and Zimmerman 1988:127).

Summing up, most theorists agree that gender is engaged in the processes of interaction, even though explanations vary as to the "how" of that engagement. Most conceptualize gender as a social constructing process through which a particular identity as gendered is conferred upon and assumed by an individual. In and through social interaction, individuals produce gender. Gender is something that is attributed, accomplished, enacted, and continually done.

The attributing, accomplishing, enacting, and "doing" of gender are forms of "practice" in the material world. This practice occurs in interaction (with self and with others). Butler (1990:139) suggests thinking of gender as a "corporeal style" which is both "intentional and performative, where 'performative' suggests a dramatic and contingent construction of meaning."

> "Gender ought not to be construed as a stable identity or locus of agency from which various acts follow; rather, gender is an identity tenuously constituted in time, instituted in an exterior space through a stylized repetition of acts (Butler 1990:140).

Butler also makes the important point that the material focus of gender is the human body, but that the meaning of gender extends beyond the borders of the material body. That is, gender is constructed and located on the surface of the body, but gender signifies more than the exterior body ; it

also signifies the interior self of the body (Butler 1990:134-141).

> "The effect of gender is produced through the stylization of the body and hence, must be understood as the mundane way in which bodily gestures, movements, and styles of various kinds constitute the illusion of an abiding gendered self. This formulation moves the conception of gender off the ground of a substantial model of identity to one that requires a conception of gender as a constituted social temporality" (Butler 1990:140).

The recasting of gender as a "constituted social temporality" moves theory away from a concept of gender as an inherent and stable attribute of individuals and toward a conceptualization of gender as actively "done" in interaction (with self as well as others). This reconceptualization requires new analytic categories for theorizing about the self which not only can account for the variations in gender-constituting in different contexts and historical moments, but also can account for the variations among women and men as well as between them. It also requires recognizing that "gender intersects with race, class, ethnic, sexual, and regional modalities of discursively constituted identities...(such that) it becomes impossible to separate out "gender" from the political and cultural intersections in which it is invariably produced and maintained" (Butler 1990:3).

CARTESIANISM, FEMINISM AND THE STUDY OF HEALTH

The prevalence of the Cartesian perspective and the proposed reconceptualizations for a more adequate theory have significant repercussions for theorizing about the experience of being healthy, an experience in which the body plays a principal role. I cite a few examples here. They are addressed in more depth in the chapter on implications.

In studying healthiness, I heard the effects of Cartesian thinking in respondents' narratives when they discounted their health-related intuitions and bodily sensations as "irrational" and therefore, illegitimate. In many cases, this lead to a continual search for outside sources of opinion about the healthiness of their body. Their seeking of "outside" explanation and validation for their "irrational" bodily feelings seemed to be driven by a tacit belief that bodily-derived knowledge required "reasoned" explanation. Those who "trusted" their body-derived knowledge and acted on it expressed frustration at being told to "check it out with a professional."[9]

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[9]A female respondent who developed her own regimen for "being healthy" was repeatedly urged by her friends to have what she was doing "checked out" by a doctor. The respondent felt, however, that her own bodily-derived information was more reliable than doctor-derived information. See also: Jordan 1977.

The holistic health tenets that emphasize "listening to the body" are also saturated with Cartesian ways of thinking about the self and body. Mind and body are experienced as sharply dichotomized and hierarchically related.

As I have stated previously, the experience of health is inextricable from (but not limited to) the experience of the body. In terms of the body and identity, the Cartesian suppression of the feminine aspect, the division into subject and object, and the association of self to rational mind, disparages the experience of the body in constituting the self. Seidler (1989:94) argues that the Cartesian perspective does more than disparage bodily experience; rather, it insists on the denial of bodily experience and ties this denial to the constituting of identity. For males, control of the male body through disembodied reason is seen as essential to identity as male because the female and the feminine represent (natural and untrustworthy) emotion and irrationality.

> "The male body in the Cartesian tradition was to be used as an instrument, rather than as something through which individuality could be expressed. Men were to be estranged from their bodies as they were from the natural world they had learned to fear and distrust. Men copuld only assert their humanity through mastery over the physical world, and by learning to dominate their passions and desires. It is this inherited notion of self-control as dominance that has been so closely identified with modern forms of masculinity" (Seidler 1989:94).

For female-bodies persons, this same perspective defines their very mode of being (their embodiment) as inferior (because "natural" and "non-cognitive") and renders male body and experience as the preferred and "real" mode of being.

The upshot of Cartesianism for theory is that it cannot adequately address the range of human experiences of being-in-the-body, of which healthiness is one, because female experience is made invisible and male experience is cast as the "generic" human experience. A more adequate theory will include new conceptualizations and categories that reinstate feelings and emotions and recognize the gendered aspects of human experience (Grimshaw 1988:137).

With respect to the study of health and healthiness, if feminist challenges to Cartesianism are accurate, and gender is a constructed aspect of social situations and of body, then gender is always being "done" (as are other identities of race, class, and so forth). Health and healthiness, as body-grounded experiences, thus become intertwined with other socially constituted identities. In terms of theory construction, this moves the conceptualizations of health and healthiness away from universal, ahistorical, and essential categories and considers them instead as socially

constructed, particular to time and place, and related to other discursively constituted identities.

SECTION II: INTERACTIONIST, PHENOMENOLOGICAL, EXISTENTIAL, AND FEMINIST THEORIES OF SELF AND BODY

This section presents brief reviews of interactionist, phenomenological, existential, and feminist theories of self (and body where applicable). The purpose of this section is to lay the theoretical groundwork for the analysis of data in Chapter IV. The symbolic interactionist viewpoint of G.H. Mead is reviewed first; summaries of social constructionist, phenomenological, existential, and feminist perspectives follow.

G.H. MEAD AND SYMBOLIC INTERACTIONISM[10]

Mead's conceptualizes the self as social process. As such, his theory of self is fundamentally a theory of self development.

> "The self has a character which is different from that of the physiological organism proper. The self is something which has a development; it is not initially there at birth, but arises in the process of social experience and activity, that is, develops in the given individual as a result of his relations to that process as a whole and to other individuals within that process" (Mead 1934/1962:135).

In Mead's view, the self is not static; rather, the self changes because of its basic characteristic of being able to

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[10]My main sources for this section were Baldwin 1988, Weigert et al. 1986, Ferguson 1980, and Natanson 1956.

act upon itself and respond to itself. That is, it is characterized by reflexivity. Mead's concept of self differs from psychoanalytic theories in that he conceives of self as having no structure per se, such as an ego, id, or superego, instead, he conceives of the self as fundamentally social and processual.

> "It is the social process of influencing others in a social act and then taking the attitude of the others aroused by the stimulus and then reacting in turn to this response, which constitutes a self" (Mead 1934/1962:171).

Mead also conceives of mind as process and equates it with the cognitive process of reflexiveness. Mind is not bound up in the individual organism because, as socially constituted, it is co-extensive with sociality.

> "In defending a social theory of mind, ... we are opposing all intracranial or intra-epidermal views as to its character and locus...If mind is socially constituted, then the field or locus of any given individual mind must extend as far as the social activity or apparatus of social relations which constitutes it extends; and hence that field cannot be bounded by the skin of the individual organism to which it belongs" (Mead 1934/1962:223).

Mead's concept of mind as socially constituted assumes that sociality is a priori to mind. Unlike the essentialist view, Mead claimed that mind and self could not exist as objects prior to society because social process is the means of self development. The reflexiveness associated with mind is the modus operandi of self as social process. Mead's

processual self is conscious, cognitive and creative. Through the selective process of perception, the individual self chooses to interpret certain objects and not others, and constructs an interpretation of and a response to them. Mead claims that objects are given meaning and value by individuals; individuals "bestow" meaning on objects in their environment. Mental processes are active, interpretive processes and not simple responses to external stimuli. These mental processes constitute the self-as-social development process. In short, self is cognitive; consciousness is social.

> "Emphasis should be laid on the central position of thinking when considering the nature of the self. Self-consciousness, rather than affective experience within its motor accompaniments, provides the core and primary structure of the self, which is thus essentially a cognitive rather than an emotional phenomenon...The essence of the self, as we have said, is cognitive; it lies in the internalized conversation of gestures which constitutes thinking, or in terms of which thought or reflection proceed" (Mead 1934/1962:173).

As Ferguson (1980:55) says, "the relationship between self and society is purely an intellectual one." Mead devises the analytic concept of the "generalized other" to refer to the mechanism through which the individual and community are connected. The generalized other

> "gives to the individual his sense of unity. The attitude of the generalized other is the attitude of the whole comnmunity... It is in the form of the generalized other that the social process influences the behavior of the individuals involved in it and carrying it on...; it in this form that the social process or community enters

> as a determining factor into the individual's thinking" (Mead 1934/1962:154).

Mead believed that "a complete self," "a self in the fullest sense," could only be realized through taking the attitudes of others both toward oneself and toward the community and its activities.[11] In this way, norms of behavior are established and internalized, and the inndividual self comes to reflect the larger social group. Thus, for Mead, the generalized other represents a means of social control.

But, Mead (1934/1962:168) argues, it is through the same mechanism which provides for social control, namely, the generalized other, that individual choice is provided.

> "...we must not forget this other capacity, that of replying to the community and insisting on the gesture of the community changing. We can reform the order of things;... we are not simply bound by the community. The process of conversation is one in which the individual has not only the right but the duty of talking to the community of which he is part, and bringing about those changes which take place through the interaction of individuals...We are continually changing our social system in some respects, and we are able to do that intelligently because we can think" (Mead 1934/1962:168).

In Mead's view, the standards of the community are not only the basis of social cohesion, but also are the raw materials of conflict and social change. That is, individuals,

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[11]Mead (1934/1962:155) refers to the community's "social projects," "institutional functionings," and "various larger phases of the general social process."

through their cognitive faculties, can disagree with accepted standards and propose new ideas and initiate new actions. Ferguson (1980:33) clarifies this point: "There is no reason to assume that in complex societies the generalized other will be homogeneous or consistent. The existence of different, and perhaps conflicting standards of conduct within the generalized other broadens the grounds that are available for a critical response."

Mead's concept of the generalized other rests on his analytic separation of the "I" and the "me" aspects of the self. Even though the "I" and the "me" are empirically separate, Mead separates them analytically in order to elucidate his conception of self as "a social process of interaction between two dialectically complementary elements of self" (Ferguson 1980:33). The "I" is the source of individual freedom and social change because it is spontaneous, creative, and unpredictable. The "me" is the link between the individual and the community because it encompasses the generalized other, the internalized norms and ideas of the community. As Ferguson (1980:34) and Natanson (1956:15) point out, Mead presents two different and conflicting perspectives on the nature of the "I/me" relationship.[12] At one time, he posits this relationship as

[12]Ferguson quote on I/me; p34-37.

one in which the "me" judges the actions of the "I," thus limiting the creative potential of the "I" to the range of standards established by the "me." In another instance, he claims that the the "I" both acts and judges while the "me" provides the context (norms) within which the "I" judges its actions. Mead never resolved this conceptual conflict; however, what is important for our purposes here, is the concept of two separate and dialectically related aspects of self which interact in an ongoing process.

Summary and Critique of Mead

Summing up, one of the strengths of Mead's view of the self as social process is that it allows for both agency and social order. It also provides a conceptualization of self as an on-going process rather than a universal and static phenomenon. There are some problems with Mead's viewpoint, however, which arise out of his emphasis on cognition and his acceptance of the Cartesian idea of dichotomous subjects and objects. Both the strengths and weaknesses of Mead's theory have important implications for the study of healthiness.

With respect to Mead's concept of the generalized other, Ferguson (1980:155) makes the point that: " a purely conceptual theory of self is not sufficient because

knowledge does not necessarily lead to action." In other words, people do not just follow the generalized other because they have internalized it. There must be something which impels people to follow certain standards and not others (Ferguson 1980:55). Moreover, if there are numerous sets of standards or attitudes possible within the generalized other, how does one set come to be sanctioned over another? Through exercise of power? Through deferral? It seems quite possible that the generalized other could have a subtext of gender, race, class, and so forth[13]. That is, the generalized other may be constituted out of the dominant group perspective (e.g. western white males) and may not be the generic collective viewpoint driven by morality and the natural good, as Mead suggested it was. If so, with respect to gender, this helps explain theoretically the sense of self-as-inferior experienced by women and other out-group people; in other words, they have internalized a generalized other which casts them as inferior. From a theoretical standpoint, this means that Mead's generalized other may function prominently in the acquisition and continuance of a sense of self as gendered (or as of a certain age). In turn, this effects the sense of healthiness because the experience of healthiness is tied to a sense of

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[13]Nancy Fraser's (1987) coined the term "gender subtext" in her discussion of the "unthematized gender subtext" of Habermas' work.

self and a sense of body. [See Chapters IV and V for discussions of healthiness as comprising a sense of self and a sense of body.]

Mead's cognitive emphasis also precludes his theory from addressing the non-conscious aspects of experience; aspects which are quite salient when the body and health are at issue.

Casting the self development process as cognitively driven and the individual as a conscious, rational, moral actor ignores aspects of the self and self development such as emotions and non-conscious actions (habits). It also relegates the body to a position of "object" in the world and thereby overlooks the contribution of bodily experience to self development.

One of Mead's basic assumptions is that body and physiological experience do not involve the self. Body is separate from self, another object in the world. There is an implicit Cartesian denigration of feeling and elevation of cognition which defines corporality (nature) as separate and

independently alive.[14] Body and self are theorized as polarized subject and object:

> "...it takes a moment's abstraction to realize that pain and pleasure can be there without being the experience of the self...I think it is obvious when one comes to consider it that the self is not necessarily involved in the life of the organism, nor involved in what we term our sensuous experience, that is, experience in a world about us for which we have habitual reactions.
> "We can distinguish very definitely between the self and the body. The body can be there and can operate in a very intelligent fashion without there being a self involved in the experience... The self has the characteristic that it is an object to itself, and that characteristic distinguishes it from other objects and from the body. It is perfectly true that the eye can see the foot but it does not see the body as a whole...we cannot get an experience of our whole body." (Mead 1934/1962:135-6)).

The problem for Mead with respect to theoretically encompassing the body is that he is caught in Cartesian thoughtways. By theorizing the body as object, as something outside the self which is observed by self, he disregards the possibility that body may "get an experience" of itself through feeling or some other means than (Cartesian) seeing. (Feeling, of course, is rejected by Cartesianism as not a genuine source of knowledge.) It may be that self "sees" and body "feels," but the possibilities could not be explored theoretically as long as reason and rationality remained the only acceptable and "real" definitions of what constitutes

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[14]This is contrary to the phenomenological experience of being in the body in which self and body are not experienced as separate; each breathes the same breath.

"experience." In short, Mead's view of self development needs to be expanded to include the body as subject and the role of non-cognitive experience in constituting self.[15]

In his work on the fitness movement in America, Glassner (1989:183) suggests that the promise of the "fitness" experience and the pursuit of the "fit body" in contemporary society is a nullification of Mead's concepts of the polarized self and body, of the body "as object in the world," and of body as "object to which there is no social response which calls out again a social response in the individual" (Mead 1938:292).

Glassner argues that in fitness activities the body becomes a focal point of interaction, more than an object, and "hence, a key constituent of the 'me' -- that experience of self in which the vision of the community is vitally present" (Glassner 1989:183). Glassner adds that even in the private pursuit of fitness, the body is experienced "by way of conceptual looking glasses" -- in other words by how it is interpreted by both institutions (e.g. medicine) and significant others, and by comparison with images presented in the media. "...Through fitness, selves are truly

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[15]A related question is whether the eye can see without an "I" to name what's seen or whether we can have a self without a body.

embodied. The physique has become a cardinal sign of the self...The information a person gives off by being fit is meant to be both economical and globally favorable for the self, ..."(Glassner 1989:184).

Goffman

In some ways, this is reminiscent of Goffman's theory of body idiom (1963), although Goffman's theory is undergirded more by the idea of the body as medium (in the "object" sense) of the self/subject. Nonetheless, Goffman's point is that individual's each have a "body idiom" or specialized vocabulary of self made up of gestures. Gestures, of course, presuppose the existence of a body.

> "There is, then, a body symbolism, an idiom of individual appearances and gestures that tends to call forth in the actor what it calls forth in the others, the others drawn from those, and only those, who are immediately present."
>
> "Now these embodied expressive signs ... seem well designed to convey information about the actor's social attributes and about his conception of himself, of the others present, and of the setting. These signs, then, form the basis of unfocused interaction,..."
>
> "Body idiom, then, is a conventionalized discourse....(and) a normative one.... There tends to be agreement not only about the meaning of the behaviors that are seen but also about the behaviors that ought to be shown" (Goffman 1963:35).

Goffman's concept also recalls Mead's concept of the generalized other and points the way for a theoretical understanding of how gender (and other discursively constituted identities) come to be sustained through the generalized other.[16]

> An individual ... cannot stop communicating through body idiom ...He must either say the right thing or the wrong thing. He cannot say nothing... Finally, it should be noted that while no one in a society is likely to be in a position to employ the whole expressive idiom, or even a major part of it, nevertheless everyone will possess some knowledge of the same vocabulary of body symbols. Indeed, the understanding of a common body idiom is one reason for calling an aggregate of individuals a society" (Goffman 1963:35)

By expanding this idea of a shared symbolism enacted through body idiom to include gender, a theoretical space is opened up through which it is possible to see how self is communicated as gendered through particular body gestures which are understood to be different (and differentiating) for females and males. In other words, body idiom communicates gender to others and also provides a means for learning gender. (See Cahill 1989 for further discussion of the latter point.)

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[16]Although it's doubtful that at the time of writing Behavior in Public Places Goffman explicitly intended his concept of body idiom to offer such an explanation. His later work (1977), "The arrangement Between the Sexes," explicity addresses the gendered nature of gestures.

Additional implications of the sybmbolic interactionist perspective are included in Chapter V, Implications. I turn now to a discussion of the phenomenological sociological perspective.

SELF AND BODY IN PHENOMENOLOGICAL SOCIOLOGY

Phenomenological sociology is a social science perspective grounded in the philosophy of phenomenology.[17] As Lester (1984) points out, even though phenomenological sociology does not offer an explicit theory of the self (as do the symbolic interactionist and dramatalurgical perspectives), it does have significant implications for theorizing about self because it examines how individuals experience their social worlds (Lester 1984:36).

The discussion in this section focusses on the work of Alfred Schutz (1967, 1970), one of the key theorists of phenomenological sociology. An abstract of some of Schutz's basic terms and tenets precedes the discussion of the implications of phenomenological sociology for theorizing about the self.

Schutz was concerned with explaining how meanings are derived and acted upon by actors in the everyday world (Wagner 1975). Schutz's work builds on the tenet of philosophical phenomenology that knowledge is the product of

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[17]Phenomenology takes as it focus the study of consciousness or "the way in which appearances of objects (whether they are physical, social, or merely imaginable) are constituted by an <u>active</u> subject" (Lester 1984:37). See Husserl (1962), Merleau-Ponty (1962, 1964), Zaner (1970).

active, conscious subjects interpreting phenomena (objects) of their everyday world (Altheide 1977). One of these "objects" is the self.

> "Self is one social and imaginable object available to consciousness. Like other objects, the appearance of self-as-object progressively unfolds through an interlocking set of conscious acts. Thus, the phenomenologist's interest in self would be in how "it" is intended and appears through intentional, conscious acts" (Lester 1984:38).

Schutz uses the terms "natural attitude"[18] to refer to the taken-for-granted assumptions held by individuals and used by them to interpret and act in the lifeworld. Wagner (1970:15) defines the natural attitude as an individual's

> "stance taken in recognition of the hard facts, the conditions for his actions as encountered in the objects around him, the will and intentions of others with whom he has to cooperate or otherwise deal with, the impositions of customs and the prohibitions of law, and so on. This stance is essentially pragmatic, prevalently utilitarian, and meant to be 'realistic'."

The natural attitude assumes a "thereness" to the world and a shared sense of this thereness among those who share a lifeworld.[19] This lifeworld world is "intersubjective,"

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[18]The natural attitude is "the mental stance a person takes in the spontaneous and routine pursuits of his daily affairs, and the basis of his interpretation of the lifeworld as a whole and in its various aspects. The lifeworld is the world of the natural attitude. In it, things are taken for granted" (Wagner 1970:320).

[19]This is Schutz's theory of the "alter ego": "No motive exists for the naive person to raise the transcendental question concerning the actuality of the world or concerning

(continued...)

> "...common to all of us, in which we have not a theoretical but an eminently practical interest. In this sense it may be said that a pragmatic motive governs our natural attitude toward the world of daily life...."(Schutz 1962:73).

Influenced by this practical interest in the world, the natural attitude consists of a "stock of knowledge" about the social reality of the everyday world within which an individual lives. The stock of knowledge is the "means by which an individual orients himself in life situations" (Wagner 1970:15). In Schutz's words, it is a "scheme of interpretation" for "typifying" or categorizing phenomena (1962:74).

These interpretive schemes are "continually in flux" (Schutz 1962:74), impelled by each individual's practical interest in the situation at hand and his/her "biographically determined situation" or unique life history which is comprised of that individual's singular set of experiences (Schutz 1962:73). This biographically determined situation precludes any two individuals from having the same

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[19](...continued)
the reality of the alter ego ... I assume everything which has meaning for the Other or Others with whom I share this, my lifeworld" (Schutz 1962:135). The alter ago assumes a "reciprocity of perspectives" that is, the taken for granted belief that self and other are similarly situated such that if places werre exchanged, the perspective would remain the same (Schutz 1962:12).

subjective experience of the situation (Schutz 1962:73; Wagner 1970:15).[20]

Even though individuals' stocks of knowledge are differently constituted, Schutz claimed that they provided the basis for social order:

> "The sharing of a stock of knowledge is essential for day to day routines...It provides "recipes" for all varieties of activities...Society is possible because all members share this commonsense awareness of order...it is their taken-for-granted acceptance of this perspective that actually promotes order, as reality is recreated everyday. To the extent recipes are held in common, much social experience is routinized, normalized, taken-for-granted, or "typified" (Altheide 1977:136).

But the potential for disorder always exists because stocks of knowledge are not coherent within the individual, nor are they consistent among individuals. Thus, shared meanings can become problematic, necessitating a reconsideration of typifications and a reconfiguring of stocks of knowledge.

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[20]"Man finds himself at any moment of his daily life in a biographically determined situation, that is, in a physical and sociocultural environment as defined by him, within which he has his position, not merely his position in terms of physical space and outer time or of his status and role within the social system but also his moral and ideological position. To say that this definition of the situation is biographically determined means to say that it has its histry; it is the sedimentation of all of man's previous experiences...and as such his unique possession, given to him and him alone. This biographically determined situation includes certain possibilities of future practical or theoretical activities which shall briefly be called the "purpose at hand" (Schutz 1962:73).

From Schutz's perspective, the lifeworld both constrains individuals (in the form of social and cultural beliefs, meanings, and so forth which precede the individual and are taken for granted) and provides the basis for individual freedom (by providing guidelines for interpretation and conduct).[21] That is, individuals can rely on "typifications" and "recipes" for conduct for negotiating mundane and familiar situations; they are thus freed from having to negotiate every situation, but are still able to modify their knowledge or conduct if a problematic situation arises (Ritzer 1983:210).

The Self in Phenomenological Sociology

Phenomenological sociology is primarily concerned with the conscious self as subject, "the originator of experience within a biographically determined situation" (Lester 1984:42). As noted above, this subject self is an active, intending self whose interpreting of the lifeworld is motivated by practical interest and informed and constrained by social and cultural "schemes of value order" (Martindale 1981:583).

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[21]"World ... is something that we have to modify by our actions or that modifies our actions" (Schutz 1962:73).

Schutz was more concerned with elucidating how shared meanings are derived than with developing a theory of self. However, he does address the self as object in his concept of "self-typification" (Schutz 1962:60). Self-typification is part of the process of typifying others; that is, when one individual typifies another, s/he must also typify himself/herself. According to Schutz, this reciprocity exists because individuals are motivated by practical interest, and as such, must have a motivation to typify an object (person, place, et al) one way and not another. Thus, in simple terms, the salesman typifies the person in the store as "buyer" (and not someone else) and in the process typifies himself as "seller" (and not someone else).

Self-typification, like all typifications, is subject to appraisal and modification. It is reconfigured in the process of everyday life in order to meet the practical demands of the situation at hand. Thus, in the above example, the salesman who has typified himself as "seller" approaches the "buyer" and discovers that the individual is an old friend who he hasn't seen for many years. The "buyer" now becomes typified as "friend" by the salesman who, in turn, typifies himself anew as "friend."

Lester (1984:44) points out that self-typifications involve "the retrospective glance." The creation of meaning of self

occurs retropectively because individuals have to move outside their activity in order to interpret what's going on and who they are; they can't simultaneously endow the actor and the act with meaning. (In other words, the salesman steps momentarily outside his activity of selling and "sees himself" as a salesman.) Even though self-typifications are modified in everday situations, the individuals derives a coherent sense of self from the consistent application of particular typifications (e.g.salesman, Caucasian, etc.) (Lester 1984:44).

In sum, explaining the substance of "self" was not a high priority for Schutz. Rather, he was concerned with explaining the derivation of shared meanings by interacting selves. Nonetheless, implicit in this formulation is a concept of self which is conscious, intentional, socially and culturally derived, and pragmatic.

Critique of Phenomenological Sociology

As Altheide(1977:150-152) points out, self is more than intentional, rational, and cognitive, and individuals are motivated not only by a practical interest in the situation at hand, but also by feelings and emotion. Schutz offers only a partial view of the self. Moreover, as Altheide (1977:152) contends, there is more to understanding the

social world of the individual than simply delineating the "how" of cognitive processes; the "sentimental and motivational sources" which precede congitive processes must also be understood. "To understand the cognitive rationality out of its sentimental context is to misapprehend most of what is important to us in our daily lives" (Altheide 1977:152).

In this latter respect, Schutz seems ironically to have shied away from a theoretical area of human motivation which seemingly would be of paramount importance to his study of everyday life. Ritzer (1983:215) accounts for these omissions by citing Schutz's concern with "scientific sociology" such that he skirted areas which he considered to be part of deep consciousness (i.e. too individualistic and subjective and thus not amenable to scientific study). This may also be why Schutz does not deal with the body except as an object available to self and others for typification.

Finally, questions need to be raised concerning Schutz's theory of the availability of typifications for appraisal and modification. Ritzer points out that Schutz maintained that certain typifications may be reconfigured, but "the large structure" of typifications (i.e. deep cultural beliefs, norms, etc.) are not generally questioned (Ritzer 1983:209). It may be that deep structure typifications such

as man or woman, Jew or Catholic, white or black are not as available for appraisal and modification as are other [more surface] typifications, but the premise needs to be expanded to include the questions of whether and why particular deep structure typifications are more or less amenable to modification at different times and by different people, depending upon the who, what, where of a particular situation. The fact that the anatomical body is often the ground of these deep structure typifications also needs to be considered.

SELF AND BODY IN BERGER AND LUCKMANN'S THEORY OF THE SOCIAL CONSTRUCTION OF REALITY

Building on the Meadian perspective of self-as-social-process and on the phenomenological perspective of shared meanings, Berger and Luckmann, in The Social Construction of Reality (1967), lay out their phenomenologically-grounded theory of the etiology of knowledge. Berger and Luckmann maintain that no one Reality exists for all individuals; rather, through a dialectical process, individuals construct seemingly "objective" realities for themselves out of the raw materials of their subjective experiences of everyday life. In a paradoxical way,

> ".... man is capable of producing a world that he then experiences as something other than a human product ... It is important to realize that the relationship between man, the producer, and the social world, his product, is, and remains a dialectical one. That is, man ... and his social world interact with each other. The product acts back upon the producer...Society is a human product. Society is an objective reality. Man is a social product" (Berger and Luckmann 1967:60).

For Berger and Luckmann, the individual's particular social world comprises roles, identities, and institutions -- which the individual believes to be objectively "real," but are actually the products of human subjective processes -- and which are "legitimated" and maintained by the routines and

interactions of everday life (1967:149).[22] "What remains sociologically essential is the recognition that all symbolic universes and all legitimations are human products; their existence has its base in the lives of concrete individuals, and has no empirical status apart from these lives" (Berger and Luckmann 1967:128). As was true for Mead, language plays a primary role in Berger and Luckmann's theory. It is seen as the primary mechanism through which the individual derives a sense of the objectiveness and a priori-ness of everyday phenomena.[23]

The individual who inhabits these social worlds is conceptualized as a dichotomy of consciousness and organism. This conceptualization follows from their classical view of "nature" and "hu-man" as objectifiable and separate and of

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[22]"Legitimation as a process is best described as a "secon-order" objectivation of meaning. Legitimation produces new meanings that serve to integrate the meanings already attached to disparate institutional processes. The function of legitimation is to make objectively available and subjectively plausible the "first-order" objectivations that have been institutionalized...Legitimation "explains" the institutional order by ascribing cognitive validity to its objectivated meanings" (Bergerand Luckmann 1967:92-93).

[23]"The reality of everyday life appears already objectified, that is, constituted by an order of objects designated _as_ objects before my appearance on the scene. The language used in everyday life continuously provides me with the necessary objectifications and posits the order within which these make sense and within which everyday life has meaning for me....language marks the coordinates of my life in society and fills that life with meaningful objects" (Berger and Luckmann 1967:22).

"animality" and "socialty" as co-existing in tension with one another (1967:180). Nature and society, "organism" and "social self," are seen as existing in dialectical relationship to one another.[24] In keeping with this view, the "body" is variously referred to as "the organism," "the individual animal," and "the individual biological substratum" (1967:180) and is equated with the need for nutrition and "functioning sexually" (1967:181) while consciousness is equated with cognition and intentionality (1967:20).

The dialectical relationship of organism and self has both "external" and "internal" aspects.

> "Externally, it is a dialectic between the individual animal and the social world. Internally, it is a dialectic between the individual's biological substratum and his socially produced identity" (1967:180).

The external aspects refer to the concept that social reality "determines" not only consciousness and activity, but also "to a considerable degree, organismic functioning ... society sets limits to the organism ..." (1967:182). The

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[24] Berger and Luckmann explicitly point out (1967:204, note 44) that their "dialectic" is different than "the dialectic of nature" proposed by Marxism which "theoretically dehumanizes man" by making him the object of natural forces. Their dialectic, on the other hand, "underlines that man's relationship to his own body (as to nature in general) is itself specifically a human one." They do not explicity define what "human" means, but presumably it equates with consciousness, socialty, and non-naturalness.

internal aspects relate to the "peculiarly human" relationship between organism and consciousness grounded in "the eccentricity of man's experience" of being and having a body (1967:50). Berger and Luckmann describe the relationship as one in which "man experiences himself as an entity that is not identical with his body, but that, on the contrary, has that body at his disposal" (1967:50). As is discussed below in the critique subsection, this characterization casts self and body in the classical subject/object manner and implicitly posits a hierarchical relationship (within the dialectic) in which conscious self is of a "higher order" and has power over (must subjugate) the "lower order" natural body (1967:182).[25]

In Berger and Luckmann's view, the triad of consciousness, body, and sociality, produces and maintains an identifiable self. The identity of the self constitutes a social and subjective reality. Self, as a social production, must always be understood within its particular formative social context (1967:50). Identity transforms the embodied self

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[25]Definition of "dialectic" in American Heritage Dictionary: "The contradiction between two opposing forces viewed as the determining factor in their continuing interaction;" also, "The Marxian process of change through the conflict of opposing forces, whereby any given contradiction is characterized by a primary and secondary aspect, the secondary succumbing to the primary, which is then transformed into an aspect of a new contradiction."

into a meaningful object.[26] "Identity is formed by social processes. Once crystallized, it is maintained, modified, or even reshaped by social relations. The social processes involved in both the formation and the maintenance of identity are determined by the social structure. Conversely, the identities produced by the interplay of organism, individual consciousness and social structure react upon the given social structure, maintaining it, modifying it, or even reshaping it"(1967:173).

Thus, the ontology of human-ness is seen as variable from social context to social context. As Berger and Luckmann describe it: "man produces himself" (1967:49). This social production, however, is always tempered by the natural or "biological substratum" of the body, which in turn, is constrained through the human subjective and social process of "reality" construction.

> "Man is biologically predestined to construct and to inhabit a world with others. This world becomes for him the dominant and definitive reality. Its limits are set by nature, but once constructed, this world acts back upon nature. In the dialectic between nature and the socially constructed world the human organism is transformed. In this same dialectic man produces reality and thereby produces himself" (1967:183).

The implicit meaning of "himself" in the last sentence above is the cognitive self sans body. The body exists, but is

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[26]"As a totally social production, identity is a humanly constructed, defined , and sustained meaningful object. To be recognizably human, an organism must be interpreted as a meaningful identity; that is, as an object. An "object" is any reality toward which humans symbolically organize their responses and thus give it meaning (Mead, 1934). The object is socially meaningful to the extent that responses by others and by self fit together to reach the goals and embody the intentions of interacting individuals, as well as to represent the group's collective action" (Weigert, et al. 1986:31).

Other than the cognitive Subject self. The body, as Other, is "subjected to" interpretation by conscious self. Self, in other words, is conceptualized as a cognitive production.

Critique of Berger and Luckmann

Berger and Luckmann's concept of the social construction of reality has much value with respect to understanding the cognitive aspects of self construction; however, self is more than cognitive production. Their view, premised upon the classical perspective of subject/object dichotomies, assigns to cognitive faculties the primary role in self construction; consequently, the powerful role played by the body in self construction remains unproblematic.

This is not to say that Berger and Luckmann theoretically ignore the body. As noted above, Berger and Luckmann conceptualize the body as a biological substratum which is "overcome" and "continually subjugated" by the cognitive self such that "organismic functioning" is seen as being "determined" by social reality (1967:182). In addition, the conceptualization of organismic functioning is limited to the "basic" needs of food, reproduction, and so forth. This is satisfactory, in that it expresses the idea of the sense of the "objective" world as being constructed in day to day interaction, but it neglects to consider explicitly the

experience of the body-as-lived and the scope of that experience beyond the basic physiological need for food, warmth, and the like.

Berger and Luckmann's view that "man experiences himself as an entity that is not identical with his body, but that, on the contrary, has that body at his disposal" (1967:50) overlooks (and therefore fails to explain theoretically) experiences in which self is experienced as constructed by the body -- experiences such as being pregnant (Levesque-Lopman 1988), having a chronic disease (Kotarba 1977), or being "fit" (Glassner 1989). Moreover, Berger and Luckmann fail to address the point that, in the case of gender identity, the self is experienced as identical[27] with body (Kessler and MckKenna 1978; Weigert, Teige, and Teige 1986). That is, in the common-sense daily world, the body is usually experienced as dichotomous, as either male or female, and self is experienced as being attached to one of two bodies. Feminist theorists have argued that, for women especially, self is often experienced as continuous with the

[27]Berger and Luckmann do not define their meaning of the word "identical." I am using it here in its sense of "analogous."

body (Gross 1987; Hodge 1988; Riley 1988; Jacobus, et al. 1990).[28]

Berger and Luckmann continually use the metaphor of control and "power over" to describe the relationship between the natural body and the cognitive self.[29] By adopting this perspective, Berger and Luckmann limit the theoretical understanding of self, body, and society to a hierarchical and coercive model, thus overlooking the aspects of "agency and potentiality" inherent to the body (Turner 1986). In other words, they miss out on the "power to" aspects of the body and the contribution of body to self knowledge. Feminists have argued that the "power over" perspective is as a predominantly masculine view (Hartsock 1985). With respect to Berger and Luckmann's theory, this suggests that their theory is grounded in male-bodied experience (subjectivity) and needs to be expanded to include other bodied experiences.

Body and self are hardly equals in Berger and Luckmann's conceptualization of the self and body dialectic. This

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[28] In her discussion of the temporality of the category "woman", Riley (1988:96) argues that we are "hit by the intrusions of bodily being" as when we become a "woman-thing" as a consequence of some male remark.

[29] They variously use the terms "control," "conflict," " opposition," "overcome," "victories," " and "subjugation."

concept of a hierarchical relationship stems from their belief that "human existence takes place in a context of order, direction, and stability" (1967:51). Berger and Luckmann claim that this essential equilibrium cannot be provided by "organismic resources" alone.

> "The inherent instability of the human organism makes it imperative that man himself provide a stable environment for his conduct...biological facts serve as a necessary presupposition for the production of social order" (1967:52).

Whether this assumption of equilibrium adequately reflects the lifeworld is being challenged by physics as well as postmodernism. Moreover, the category, "biological facts," is a shaky one. It has been argued that some phenomena that have been considered biological facts are actually themselves social constructions. Gender is an example. Kessler and McKenna (1978) argue that gender has been and is an "incorrigible assumption" which guides social construction, yet is itself a social contruction.

In addition, by conceiving of the body as being of a "lower" order than "higher order" cognition (again a hierarchical model), and as needing to be be tamed by sociality, the body and non-cognitive processes are implicitly degraded and rendered less valuable, trustworthy, and genuine than conscious processes in reality construction processes (self

or otherwise). Theory is deprived of a constructive and beneficial view of body/nature.

Finally, Berger and Luckmann's theory of the socially constructed nature of reality seems to imply that no reality is fact or essence. This causes problems when trying to conceptualize oppression, pain, and so forth. Are these illusions? Subjective constructions? The theory as stated cannot encompass such concrete experiences of "reality."

In short, Berger and Luckmann's theory offers a partial perspective on the "reality" of the body and its role in the process of self construction. Their theory only considers the body in terms of its subjugation by consciousness; but the body-as-lived is more than a conceptual construction. Moreover, by neglecting to consider more fully the role of the body, they never reach the point of conceptually treating the <u>intra</u>subjective interaction of self and body.

Despite the above limitations, Berger and Luckmann's concept of the social construction of reality is a valuable theoretical tool for understanding self and identity construction as social processes. Like Mead's social psychology, Berger and Luckmann's sociology of knowledge underscores the importance of subjective <u>process</u> and

on-goingness in the construction of reality in everyday life.

This concept of on-goingness and process is a cornerstone of the existential sociological perspective of self and body; the perspective which is discussed in the next section.

SELF AND BODY IN EXISTENTIAL SOCIOLOGY

Existential sociology takes as its focal point the total experience of the individual in a situation. This focus on all the aspects of an experience, rather than on particular aspects such as the derivation of meanings (phenomenology) or the definition of the situation (symbolic interactionism), differentiates existential sociology both theoretically and methodologically from other sociological perspectives. As Lester (1984:57) points out, existential sociology shares certain tenets with both symbolic interactionism and phenomenology, but what makes existential sociology unique is its particular "combination of subject matter and methodological principles." That is,

> "Existential sociology does not begin with a definition of its subject matter, theoretical paradigm, or set of assumptions about proper scientific methods...We take the complete man- and woman-of-flesh-and-bone in the concrete social situations in which we find them...We do not stand outside experience and impose prejudged criteria of scientific methods upon that experience. We create truth from within by finding what works, what enables us to understand, explain, piece together, and partially predict our social world" (Douglas 1977:5).

Existential sociologists argue that other sociological perspectives give theoretical primacy to reason and cognition while neglecting the role of emotion and physical being in human experience (Douglas and Johnson 1977). In doing this, they advance a false fragmentation in theory

which does not correspond to actual lived human experience (Lester 1984:54).

With respect to theories of self, existential sociologists argue that traditional views cast self as "isolated," "choiceless," and coerced by the past (Tiryakian 1968:76). The existential sociological view, on the other hand, views the self as both free and constrained (Ritzer 1983:421; Douglas 1977; Lester 1984).[30] Self is conceptualized as a fusion of rationality, feelings, and emotion, with embodiment playing an essential and key role in self experience (Douglas 1977; Lester 1984).[31] Fontana (1984:7) says: "The self is not a reified entity but an incarnate one ... self is enmeshed in the reality that surrounds it and is inseparable from its physical body." The existentialists raise feelings to a position of theoretical salience in

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[30]Douglas (1977:14): "Man is necessarily both situational and free. Yet to be situational is to be constrained by, at least indirectly determined by, the situation; to be free is to be the opposite, to be unconstrained and transituational. Man is both. Man is in basic conflict with himself and his world - determined and free, situational and transituational."

[31]Douglas (1977:15) states: "We begin with what Merleau-Ponty called "brute being" ... and see how necessary and valuable reason is to all human life, how reason guides feeling to expression, gratification, fulfillment, and growth. We must then see that reason can do this only by becoming fused with feeling, ... Reason becomes a force, rather than merely a symbolic shadow or memory device, by being invested with feeling. It becomes fused with feeling by <u>succeeding</u> as a guide to the expression, gratification, fulfillment, and growth of those feelings we have and crave."

studies of human experience. Feelings are seen as preceding reason and pervading thought, but as being "guided" by thought (reason) whose task it is to find ways to express and gratify feelings (Douglas 1977:14). For existentialists, self is always in process, or "becoming," such that it is always creative, situational, and problematic. As Douglas (1977:14) says:

> "Man's existence is fundamentally problematic, both for man as actor and for anyone who would understand his existence. Man is varied, changeable, uncertain, conflictful, and partially free to choose what he will do and what he will become, ... The only way man has been able to survive, both in the physical and social world, has been by adapting himself to it...Man is fundamentally grounded, situational - existential. His worldly existence is fundamentally changeable and emergent,...; so man is also fundamentally changeable and emergent."

Existential sociologists posit that amidst all the experiential impermanence, there lies within each individual a "real" self, a "brute being" that constitutes the Self (Kotarba 1984). External to the self is the "identity" (or identities) that are bestowed by others upon the self. In these conceptualizations, they differ from interactionist theorists who maintain that the bestowed self, or social self, constitutes the Self.

This concept of a "real self" or "brute being" which exists alongside the social self is a pivotal point for existential sociology. The concept provides the theoretical footing for

explorations of the role of the body and intrasubjective processes in constituting the self.

For example, Kotarba (1977:272), in his study of chronic pain, has pointed out that the symbolic interactionist concept of "the definition of the situation" does not encompass experiences such as having chronic pain.

> "The person with chronic pain adopts the definitions of others when they are meaningful to the management of the pain. But this is frontwork, not reality. The primary definition of being sick comes from the person's body. Even the social definition, "it's all in your head" that refers directly to the self is disregarded. One cannot reasonably deny bodily feelings because the body the fundamental experience of life... the person with chronic pain ...adjusts his everyday life in response to the dictates of his body, whether or not the dictates of others correspond."

Kotarba (1977:261) also notes in his discussion of the secrecy of chronic pain that it is "an experiencing of oneself that is not generally visible to others" and that each individual decides whether or not to communicate "the sense of his pain" to others. This phenomenon of secrecy calls into question the adequacy of interactionist theories of self because it suggests that there are dimensions of self-experience which occur outside interaction with the Other (and even are withheld from interaction).

Kotarba (1977:261) suggests that Others are not the only audience for self, and that the "experiencing of oneself is also an audience to the self, ..." Indeed, one is a private audience to oneself.

> "There is another level of secrecy that necessarily applies to all experiences of self, for feelings and emotions can be objectified through conversation and body language, but the uniqueness of one's body and self cannot be shared, even if so desired" (Kotarba 1977:262).

For Kotarba, the experience of chronicity is the ground of interaction between self and body. In this sense, there is a private experience of self, an internal interaction or intrasubjective process which is implicated in the "becoming-ness" of the self. The body plays a key role in this process.

Existential sociology posits the body as theoretically problematic for theorizing about the self. The problematic of the body is expanded upon and developed by feminist theory. The next section briefly summarizes some of these suppositions.

SELF AND BODY IN FEMINIST THEORY

Much feminist theory has concerned itself with the relevance of the material body to epistemology.[32] The idea of the specificity of men's and women's bodies, of sexual difference as lived and the distinct reality of the materiality of the body, are the basis of several critiques of traditional perspectives of self and subjectivity (Gross, 1986; Balsamo,1988; Hodge, 1988; Riley, 1988). These theories take as there starting point the lay, common-sense notion that there are two different kinds of bodies in the world, a male and female, and that the experience of being bodied male or female has different dimensions. Gross (1986) argues that the traditional liberal perspective of generic "man" (read: "human") is just that: a perspective grounded in male-bodied experience and constituted in opposition to a female "nature". As such, it provides no phenomenological grounds for a subjectivity grounded in female-bodied experience; in fact, it denies a female subjectivity and relegates it to an inferior status because it is underpinned by the Cartesian concept of opposition of (desirable) reason (associated with the masculine) and (undesirable) nature (associated with the feminine). For the

[32]There is a large literature on essentialism, the body, and french feminism. I do not discuss these here. Good discussions are available in Marks and de Courtivron 1981, Nye 1988, Fuss 1989, and Allen and Young 1989.

same reason, this perspective is seen as less than adequate for theorizing about the experience of being female (or anything other than western, white, and male) in the world.

Feminism, Postmodernism, and Deconstructionism

In attempting to develop a more adequate theory, feminist theories of subjectivity and the body often cite poststructuralist and deconstructionist thought as their source of inspiration.[33] The work of Foucault has been a primary stimulus for many feminist theorists because it converges with many feminist concerns. Diamond and Quinby (1988:x) have pointed to four "especially striking" convergences of Foucault and feminism:

> "Both identify the body as the site of power, that is, as the locus of domination through which docility is accomplished and subjectivity constituted. Both point to the local and intimate operations of power rather than focusing exclusively on the supreme power of the state. Both bring to the fore the crucial role of discourse in its capacity to produce and sustain hegemonic power and emphasize the challenges contained within marginalized and/or unrecognized discourses. And both criticize the ways in which Western humanism has privileged the experience of the Western masculine elite as it proclaims universals about truth, freedom, and human nature."

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[33]There is much debate among feminists about the usefulness and applicability of poststructuralist and deconstructionist theory to feminism. I do not cover this debate here. Good discussions can be found in Benhabib and Cornell 1987, Strathern 1987, Weedon 1987, Christian 1987, Diamond and Quinby 1988, Mascia-Lees, et al. 1989, Di Stephano 1990, and Nicholson 1990.

As Diamond and Quinby go on to point out, this is not to suggest that Foucauldian and feminist analyses "mirror one another," but rather that they complement each other, each raising issues which the other "has ignored or missed."[34]

Feminist theorists of the body and subjectivity have employed postmodernist concepts of discourse, representation, and praxis, to analyze the body in society. In this view, "the body" is theorized as being the site of cultural inscriptions and the medium of social praxis.[35] It is seen not as a biological fact. Rather, it is considered to be rendered into a specific shape and meaning through normative representations (of health, beauty, and so forth) and socially-designated practices (brushing teeth, wearing certain forms and types of clothes, etc.).

By conceptualizing the body as a concept and a construction, the body becomes an explicitly problematic category for

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[34]As noted in the previous footnote, there is much debate about the alliance of feminism with postmodernism and deconstruction. Diamond and Quinby (1988:ix) refer to it as a "friendship" marked with tension.

[35]See Chapter III of this dissertation, The Contemporary Context of Health, for an example of discourse, the body, and feminist adaptions of postmodernist theory.

epistemology for its raises questions of location, history, and temporality in constituting the self (Riley 1988; Butler 1990).

> "The body is not for all its corporeality, an originating point nor yet a terminus; it is a result or an effect.... The impress of history as well as of individual temporality is to establish the body itself as lightly or heavily gendered, or as indifferent, and for that to run in and out of the eye of the social"(Riley 102-103).

By proposing that there is no one generic woman's (or man's body), that there are only temporal constructions, new categories of analysis, such as gender, are created. This has implications not only for theories of self and subjectivity, but also for theorists themselves as located, embodied beings engaged in the activity of theorizing. Rich (quoted in Fuss 1989:52) captures this idea when she says:

> "...When I write 'the body,' I see nothing in particular. To write 'my body' plunges me into lived experience, particularity: I see scars, disfigurements, discolorations, damages, losses, as well as what pleases me.... To say 'the body' lifts me away from what has given me a primary perspective. To say 'my body' reduces the temptation to grandiose assertions."

Constructionist theory is often considered to be in opposition to essentialist theory, but as Butler (1990) has pointed out, both schools of thought take as a starting point the raw material of the anatomical body. Constructionist theory presupposes an anatomical body which is shaped by cultural constructions. In short, it is

difficult for theory to escape the importance of the body in constructing the self. As Haraway (1989:10) summarizes it: "Bodies, then, are not born; they are made."

This has important implications for studying health and healthiness because it raises the questions about the relationship between body, constructions of self, and the experience of being healthy. If bodies bear different cultural inscriptions and are integral to experiences of healthiness, and if selves are socially constructed, then theoretically, healthiness becomes a social phenomenon. That is, there may not be a physiological difference between male and female body healthiness, but because of social and cultural interpretations of male and female bodies, the phenomenological experience of healthiness may be quite different.

Feminist theory has raised important questions concerning traditional theories of self, subjectivity, and the body. The following section pulls together strands of the theories into my own perspective.

SECTION III: APPLYING THEORY TO THE STUDY OF SELF, BODY, AND HEALTH; MY THEORETICAL PERSPECTIVE

Each of the theoretical perspectives reviewed in the previous section has important implications for the study of self and healthiness. In this section I tie together the concepts of self-as-social-process (interactionism), of intersubjectivity (phenomenology), of social constructionism, and of the body as influential in the constituting of self (existential sociology and feminism) into my theoretical approach for studying health and healthiness.

I've tried to point out in the above reviews that, until the advent of existential sociology and feminist theory, the body was often relegated to an inferior theoretical status relative to consciousness in theories of self. Most of the theoretical work focussed on the development and refinement of categories of analysis related to consciousness and subjectivity. It is not that the body has been entirely ignored by theory, but that it has been invisible as an explicitly problematic category of analysis. If one reviews theory, one sees that the body has been talked about implicitly for many years; for example, Goffman's (1959) "face-work" is about bodily being. My perspective tries to

retain the body as explicitly problematic in the study of health and healthiness.

My perspective is grounded in the feminist notion of all perspectives as partial perspectives because of the locatedness of the theorist herself. In this sense, the conception, the collection, and the analysis of data are a reflection of the particular historical moment in which the study is done. (One can study the study much as one would study a film from another period as an example of a particular cultural moment). I do not make this point to undermine the findings of the study nor to suggest that theorizing be considered as meaningless. Rather, I want to underscore two ideas. First, that to theorize is to take a stand and that the analysis of this stand may itself contribute to theory; and second, that the partialness of this stand does not diminish its importance, but acts as a reminder of the need to continually question the adequacy of the perspective.

MY THEORETICAL PERSPECTIVE

My theoretical perspective builds on a feminist postmodernist vision. This feminist postmodernist perspective takes aspects of different postmodernist philosophies and ties them together into a specifically

feminist approach to epistemology and practice. This feminist perspective is by no means a consistent and coherent philosophy to which one can point and say "aha, there it is." It is itself in process, as the proliferation of theoretical discussions concerning feminism and postmodernism attests (Flax 1987; Mascia-Lees, et al. 1989; Nicholson 1990). Following Harding (1987) and her notion that analytical categories are unstable, and should be so, if they are to faithfully reflect the complex and sometimes incoherent daily world, the feminist postmodern "view" is not only in process, but is itself a process. In this sense, the perspective exemplifies one of its tenets; namely, that there is no one transcendent Reality, nor one "correct" viewpoint, the former being able to be "known" through adoption of the latter. Rather, this perspective recognizes the locatedness of the perceiver/knower and the variability of "knowing" and "truth" (Collins 1989; Hawkesworth 1989).[36] Haraway (1988:583) has redefined "objectivity" in feminist terms to denote "situated knowing" or a partial perspective grounded in location, embodiment, and practice. From this perspective, Truth and Knowing are not universals, but are emergent from one's situation.

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[36]Hawkesworth (1989:549) argues that knowledge is a form of located human practice: "Knowledge, then, is a convention rooted in the practical judgements of a community of fallible inquirers who struggle to rescue theory-dependent problems under specific historical conditions."

My theoretical approach adopts the feminist perspective of subjectivity as position (De Laurentis 1986; Alcoff 1988; Haraway 1989), which is to say that there is a positionality to subjectivity which emerges from subjects being both active- subjects-who-construct while simultaneously being themselves "subjected to" social construction. This approach changes the theoretical boundaries of subjectivity by amending the (deconstructionist) notion of identity and subjectivity as solely the product of cultural inscription (text or "language") to include the practice and production of meaning by active self-analyzing subjects.[37] In this revised conception, the relations involved in practice and production become an explicit focus for theoretical and methodological scrutiny.

> "The positional definition ... makes ...identity relative to a constantly shifting context, to a situation that includes a network of elements involving others, the objective economic conditions, cultural and political institutions and ideologies and so on" (Alcoff 1988:433).

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[37]Feminist theory has had to come to terms with the postmodernist tendency to get lost in a meaningless relativism in which all views are equally valid and every perspective is no perspective (Diamond and Qiunby 1988; Alcoff 1988; Haraway 1988). Haraway (1988) notes that many feminists have unthinkingly accepted the positivist idea of the existence and opposition of relativism and objectivism. Haraway points out that both are "malestream totalizations" (1988:584) and must be rejected in favor of a politics and epistemology of partial perspective.

In sum, there is no one "subject" and singular subjectivity which all persons share. Rather, there are multiple and variable subjects whose subjectivities are made possible through continual interpretation of the world and are delimited by the historical moment in which they are realized.[38] These historical contexts themselves are continually in flux, however, and as such, individual subjects are continually interpret and reinterpret their selves (their identities). In this sense, the concept of subjectivity as position frees the subject from total determination by history and discourse because it reconceptualizes consciousness as "a strategy" (Alcoff 1988) and an on-going process grounded in experience (de Larentis 1984, 1986). In short, this conceptualization of subjectivity "gives agency to the individual while at the same time placing her within particular discursive formations" (Alcoff 1988:425).

In terms of studying health and self from this perspective, the experience of healthiness can be conceptualized as a social phenomenon involving self as social process, intr<u>a</u>subjective processes of self and body, and practical activities informed by historically specific discourses.

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[38]Kintz (1989:115) has called these historical moments the "symbolic systems there waiting for us and into which we are born."

Healthiness can be considered as an interpretive framework[39] for interpreting and organizing bodily experience and identity along culturally acceptable lines.
The concept of interpreting and organizing retains the idea of the active subject and focusses theoretical attention on the dialectic between the acting, creative subject "doing health" and the meanings of health available through discourses of health.[40] Activities and discourses related to the lived body are explicitly implicated because the body is basic to the experience of healthiness.

By introducing the problematic of the body, the issue of gender is raised with respect to studying the lived experience of healthiness. This is because in the lay, common sense world, the body is seen as dichotomous, as either male or female, and self is usually perceived to be attached to one of these two bodies and is assigned a gender of masculine or feminine accordingly (Kessler and McKenna 1978).

In terms of my own perspective, I retain the possibility that that the problematic of the body in health (and in illness) may not be limited to only two bodies -- to two

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[39]Kotarba's (1984) phrase.

[40]Smith (1988) refers to the dialectic between praxis and discourse as "textually-mediated discourse."

discrete, abstract and universal male and female bodies. Turner has pointed out that even though the interpretations of difference and sameness of the body are textual (an effect of discourse), embodiment itself is more than a conceptual construct; it is also agency and potentiality (Turner, 1986). So there may be gross categories of male and female bodies, just as there are race and class categories, but the body-as-lived is as varied as the living, and theory must take this into account. In addition, the body can be seen as another part of the dynamic of interaction in which race, class, age, and body interact with each other, each influencing the other, and resulting in lived experiences and self definitions of health and healthiness which are quite different from person to person (Dill, 1987).

Within this theoretical framework, health actions or the "doing of health" can be analyzed as instances of social interaction in which social order is negotiated, produced, and reproduced by socially situated selves. The doing of health constitutes a kind of situated social conduct grounded in the materiality of the body, in the body as "lived" within a social and cultural context (Gross, 1986; Balsamo,1988; Hodge, 1988; Riley, 1988). The doing of health also represents a kind of doing of gender (West and Zimmerman, 1988), not because there is essential difference between male and female body healthiness, but because of

social and cultural interpretations of masculine and feminine selves -- selves which are attached to male and female bodies. In other words, ideas about the healthy body are intertwined with notions of gender and self. Decisions about what actions to take to be healthy or "health doings" are colored by ideas about appropriate masculine and feminine behavior. In short, gender must be considered when theorizing about "being healthy."

Summing up, my perspective builds on interactionism and feminist adaptions of postmodernism, expanding them to include explicitly the problematic of the body. The perspective can be grasped more fully through example, as in Chapter IV, Analysis and Findings. In that chapter, the perspective is applied to data.

CHAPTER IV

ANALYSIS AND FINDINGS

INTRODUCTION

The focus of this research is the conceptualizing and the "doing" of health by men and women in the everyday world. Using the grounded theory method,[1] interview data was analyzed for men's and women's definitions of health and being healthy and how these were rendered and produced as health actions in the lifeworld. The analysis of the data presented in this chapter explores the linkages between men's and women's definitions of "health" and "being healthy," awareness of self and body, and gender.

The chapter is divided into two sections. The first section describes the analysis of the data and is divided into Part A, the Conceptual Level of Health, and Part B, the Practical Level of Health. The conceptual level refers to how men and women define (and think about) health and being healthy. The practical aspects of health and being healthy refer to the how, where, and when or actual "doing" of health in everyday life. The section is organized in this way in order to

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[1]See Chapter II, Methodology for a description of the grounded theory method.

reflect the lived experience of health which has both conceptual and practical aspects. The second section synthesizes the data presented in the preceding section and raises it to a conceptual level. As the analysis in Section I shows, men and women had similar ideas in the abstract about "what health is," but their practical activities or health "doings" were quite different. Put differently, abstractions tended to be alike between men and women, but practices were distinctive. Gender was an underlying theme of health practices. The second section of the chapter offers some tentative sociological explanations of how and why the concretizing of similar abstractions of health in daily life involved distinctive practices of health for men and women.

SECTION I: ANALYSIS OF THE CONCEPTUAL AND PRACTICAL LEVELS OF HEALTH

The first part of this section presents the data on abstract concepts of health; that is, how my sample of respondents thought about and decribed "health" and "healthiness" in the abstract. The second part deals with the practical aspects, or the doing of health.

PART A. THE CONCEPTUAL LEVEL OF HEALTH

DEFINITIONS OF HEALTH

In general, men and women shared similar ideas about what constitutes health. The only striking variation was that women (and not men) often referenced other people, such as family or friends, in their definitions. The cosmos of health depicted in respondents' definitions included most aspects of being human: physicality, consciousness, emotions, spirituality, and social situation (family, work, income level, etc). The idea of health was closely associated with the idea of "well being," that is, of "being alive," but with the positive qualifier "well" attached. In other words, abstract notions of health and healthiness were identified with the positive aspects of "being" in the world and were grounded in lived experience. Some definitions were so encompassing that they approached amorphousness, but their grandness indicated the degree to which the idea of "health" in contemporary minds has become synonymous with a particular condition or state of "life" itself.[2]

Health as a Condition of Being: Capacity, Function, Fitness

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[2]The last section of this chapter proposes some theories for why the concept of "health" has taken on the grand proportions that is has in contemporary westen society.

Turning now to the data, most respondents defined "health" as a state or condition of being. Comprehensive definitions, such as the following, were numerous:

> "My definition of health would be physical, mental and emotional well being" (m.10).

Some definitions related this state of being to capacity, performance, and function:

> "(Health is) being balanced in the things you do" (F.05).

> "(Health is) being pysically fit and able to do what I need to do"(m.12).

Health as Friendship and Family

Women, not men, frequently alluded to friends or family in their definitions of health:

> "A really healthy person is a well person, they take care of themselves and their family and friends,..."(f.05).

> "It's also being loved and being able to love, ..." (f.17).

The Body as the Site of Health

The actuality of being bodied was almost always referenced in abstract concepts of health. The body was understood to

be the site of health. Sometimes references to the body were explicit, as in:

> "...(Health is) when I'm in shape, I feel energetic, I've got good color in my cheeks" (f.05).
>
> "I'm a healthy person because I'm in shape physically, I'm not overweight, ...I have good muscle tone,.."(m.02).

Often they were implicit and referenced feelings or the ability to do something:

> "I can do my work better, I enjoy things more"(m.14).
>
> "...The bottom line is that I am able to go through my day and accomplish what I have to do without any physical or mental encumbrances"(m.18).

The idea that the body is the site of health served as the conceptual underpinning for many of the protocols identified by respondents as necessary for maintaining health such as eating well, getting sleep, and so forth. (These are discussed in more depth in the next section on practical activities related to health.)

The Flickering Nature of Health: Temporality and Process

The idea that the body is the site of health was also the probable conceptual basis for the frequent references to the flickering nature of health. Both men and women

conceptualized health as a transitory state and a process. As one man phrased it:

> "Health is living. You're alive and you're healthy or you're not healthy as you go along. It's like a living through." (m.02)

The temporal[3] aspects of health were seen to be influenced by external factors such as the existence or absence of job or family pressures as well as by hereditary factors.[4]

> "...I guess health is a relative term anyway. I don't exercise that much, mainly because of work, I want to but it's a time problem, ..., and I have allergies. They're only slightly debilitating, but I have them..." (m.06).

> "I was sick all the time when I worked in a daycare center..."(f.19).

Intentionality and Health

Another factor considered to be important to health was intentionality. Deliberate, intentional action was often referred to in definitions of health. Both men and women mentioned avoiding smoking, abstaining from drinking, eating "good" foods, getting sleep, and exercising as essential to health. These references to consciously taken actions

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[3]"Temporal" in both its meanings of "transitory" and "pertaining to the body."

[4]Other studies have found references to the idea of a "reserve of health," as Herzlich (1973) has termed it. See also Pill and Stott 1982, Blaxter 1983, Herzlich and Pierret 1987, and Blaxter 1990.

indicated that health was conceptualized as an accomplishment of a thinking individual.[5]

Health as Accomplishment

Respondents' characterizations of health as an accomplishment suggested that health was conceived of as a creation. Each person was seen as having a biological base, a body, and what one did with that body resulted in various states of health.[6]

Health as Private and Discretionary

Health conceived of as accomplishment also implied that health was regarded as a private matter and as dependent on one's discretion. As such, health sometimes took on a moral

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[5]The idea of health as an accomplishment leads to the notions that the responsibility for health resides with the individual and that the etiology of both health and illness can be traced to the habits and practices of the individual. This point is discussed in more depth in Chapters II and V. See also Crawford (1978, 1980) and Featherstone (1982).

[6] Turner (1986:236) has suggested that each disease has an organic grammar, but the speech of the sick patient is highly variable, creative, and idiosyncratic."

Sacks (1981:224) has noted a similar phenomenon with migraines:"If the foundations of migraine are based on universal adaptive reations, its superstructure my be constructed differently by every patient, in accordance with his needs and symbols. Migraine ... starts as a reflex, but can become a creation."

dimension, in that health actions were seen as being consciously chosen or not chosen, and therefore, were considered to be reflections of one's own (or another's) inner being.[7] This notion of morality was evident not only in respondents' verbal intonations in the interviews, but also in their use of words implying obligation or duty, such as "should" and "ought," and phrases such as "drinking <u>pollutes</u> your mind" (m.02) and "when I go on a <u>binge</u> of <u>junk food</u> ... I feel <u>rotten</u> as a person" (m.04).

The Multidimensionality of Health Concepts: Ideal-typical Concepts and Personal/experiential Concepts

Many respondents had difficulty capturing their idea of health in words and would qualify their abstract definitions with references to the experiential dimension of health, as in statements such as "it's a feeling"(m.10) or "sometimes it's there and sometimes it's not" (f.13). These comments exemplified the multidimensionality of concepts of health. Respondents simultaneously maintained abstract, ideal

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[7]This is reminiscent of contemporary arguments that people who have AIDS are being punished for their (sexual) sins. Sontag (1978) also has made the point that persons with cancer are often regarded as having brought the illness onto themselves. Blaxter (1983, 1990) found that some believed that healthiness was a person's duty. A belief which implied that unhealthiness was indicative of personal failure.

typical,[8] concepts of health (e.g. health as a state, a process, and so forth) as well as specific and concrete concepts ("my" or someone else's particular state or condition, or health-related "quirk.") While the former were abstractions, the latter were particularized and personalized versions of health which were grounded in experience.

One male respondent (m.02) specifically mentioned having both an "ideal" and an actual concept of health, stating that he always "strived" to have his actual health reach the ideal. He agreed that the ideal could never be reached by virtue of it being an ideal. The importance of the ideal was as a goal and as a comparative case for assessing his actual state of health. In this case, an ideal typical concept of health served as a guide for interpreting and defining "health" in the present.

Respondents' general, ideal typical and concrete, personal concepts were interrelated in an on-going spiral of reflection and experience: abstract, general concepts of

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[8]"Ideal type" is a Weberian term for a conceptualization or "thought-model which combines ideas and evidence into an analytical construct" (Martindale 1981:54).The ideal type does not correspond directly to one specific instance, but is a compilation of a number of instances. It serves as a comparative model for evaluating phenomena. An important characteristic of the ideal type is that it is tentative and is examined and refined continually.

health were continually tempered by respondents' own particular lived experiences,[9] yielding new abstract, ideal typical concepts regarding health; in turn, lived experiences were (re)interpreted in keeping with these new concepts. This interrelatedness was especially evident when respondents were asked to reflect on their concepts of health over their lifespans. Almost all respondents talked about the changes they had made in their basic eating and hygiene beliefs and habits as they grew up (e.g. changing ideas about having eggs for breakfast, or the frequency and vigorousness with which teeth should be brushed, and so forth). A number of respondents cited "lifestyle"[10] changes that they had made as an adult (e.g. changing their smoking and drinking habits) as a result of acquiring "new" information on the health implications of these activities. Other respondents referred to personal body-related experiences which had prompted them to revise their concepts of health. As one man said:

> "I used to think that I had to workout everyday in order to be healthy, but I know now that I can workout five times a week and still be healthy. I

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[9]This included "new" information derived from internal, bodied experience as well as information received from external sources in the social environment, such as the public media or significant others.

[10] The term, "lifestyle," was frequently used by respondents. Generally, it referred to smoking, drinking, exercise and other specific habits. This meaning was in line with contemporary public media depictions of the category, "lifestyle." Sometimes, respondents used the term to denote the more comprehensive idea of "a way of life."

> might be more healthy working out more, but who's to say? I feel pretty good and that's good enough for me" (m.14).

Or, as one woman put it:

> "I never exercised as a child...I wasn't expected to, ... I guess because I was a girl. I rode horses but that's not exercise ..." (f.17).

The Plasticity of Health Concepts

Both of the preceding comments reflect the plasticity of concepts of health (e.g. beliefs about what is required to be healthy and what the meanings are of terms such as "exercise" and "healthy.") Health concepts were not static or fixed, but were stretched and contracted in accordance with lived experience.

Summary: Definitions of Health

Summing up, definitions of health referenced notions of states of being, temporality, embodiment, capacity, fitness, social situation, and heredity. The content and meaning of the two terms "health" and "healthiness" were variable, changing over time with experience and exposure to social and cultural phenomena. In addition, respondents maintained simultaneously two types of health concepts, ideal typical and personal/experiential, the two interacting with each other in an on-going spiral of reflection and refinement.

SELF AND BODY IN CONCEPTS OF HEALTH

Implicit in both types of concepts of health was the concept of a self, either as the intentional actor making decisions, or as the consciousness attached to the [material] body, or as the being performing an action. The self of ideal typical health concepts was a model self, detached from local experience, while the self of personal/experiential health concepts was a self attached to a specific body in a particular time and place, a self bearing the signifier "my".

"My" Self as Healthy: The Health Inventory and the Sense of Self and Sense of Body

The latter, personal and particular self as healthy had both physical and metaphysical dimensions. When asked to describe health and being healthy, respondents moved back and forth between references to themselves as physical bodies and as sentient beings.

> "I'm in good shape", "I have good muscle tone", "I've got good color", and "I feel energetic", "I feel good", "I feel challenged."

These responses catalogued a kind of "health inventory" which encompassed internal and external, visible and

invisible, physical and metaphysical dimensions of themselves.

Further analysis of the responses showed that these dimensions could be grouped into inventories of things one's self was believed to "have" and things one's self was expected "to do." The former included one's own particular stock of corporeal and incorporeal health-related items such as body size and shape, strength, capacity to do, genetic endowment, and friends. The latter included one's "health"-related activities and practices such as eating "well" and exercising.[11] These "have's" and "doings," were often intermixed in responses:

> "Health to me is the food you eat, how you carry yourself, from the clothes you wear, to the size you are, body fat, skin tone, and whether you're sick. I feel if you take care of yourself by working out and eating right, ... you will be stronger and healthier" (m.06).

> "I know I'm healthy. I'm in good shape. I exercise regularly, I eat a very good diet. I know how to avoid getting colds and flus. I get enough sleep. I don't party and abuse my body. I guess, in a nutshell, I take care of myself" (f.05).

As these respondents' remarks suggest, judging one's self as healthy involved a taking stock of one's health inventory, that is, of one's self as both material body and conscious actor. Put differently, the sense of being healthy

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[11]For example,"I get enough sleep", "I don't overexercise and I dont starve myself."

implicated both a sense of self and a sense of body (a body self)[12], both of which were tied to a conception of past and future actions.

The Development of the Concept of the Selfsoma Process

The concept of the health inventory led to the development of another analytic concept related to the self/body relationship,[13] that of the "selfsoma process." The selfsoma process refers to the intrasubjective process related to self, body, and action-in-the-world. The health inventory concept captured the idea of both being and having a body; however, it did not capture analytically the process-ness related to self, body, and practice, namely, the active engagement of individuals in self-analysis and action-taking.

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[12]The concept of a sense of body is akin to the concept of "the physical self" proposed by Olesen, et al. (1990) in their work on the mundane ailment. The physical self is similar in substance and process to other selves and identities, but is

> "grounded in self's assessment of body experiences.... (The physical self is) one among many selves, which evolves and is transformed not only in interaction with others, but in the processes between self as knower and the body which draw draw upon subjective and cultural resources (Olesen, et al. 1990:451).

[13]"Self/body relationship" was one of my analytic categories.

Implicit in the data on the health inventory was a conception of self as physical being and conscious actor, engaged in a continuous process of self-reflection and action in which self assessed physical and metaphysical states, derived a sense of current "health", and took action based on these assessments.[14] The data suggested that individuals maintained a sense of self and a sense of body (bodyself) which made up the health inventory at any one moment; it also showed that they regarded the balance of items in the health inventory as fluctuating with time and action. For example, individuals would refer to themselves as having been healthier at a former time, or as becoming healthier through certain activities.[15] Moreover, the elements of temporality, on-goingness, and action were

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[14]The idea of on-going self assessments related specifically to the body undergirds the concept of the "health biography" developed by Olesen, et al. (1990) in their social psychological work on mundane ailments. The health biography is

> "a conception of the body and its parts having a history of susceptibilities, potentialities, and immunities or vulnerabilities to affliction... This long history ... provided a rich resource of definitions, symbols and baselines for further evaluation of new and familiar mundane ailments, as well as memories of the physical self in the past and an anticipated self in the future."

[15] This harked back to the concepts of the ideal typical and the personal/experiential abstract concepts of health in that individuals conceived of themselves as more or less close to their ideal at any time.

repeatedly manifest in respondents diction. Verbs were often transformed into nouns when desribing healthiness, as in eating well, exercising, having friends.

Given these elements in the data, my analytic category of "self/body relationship" needed to be broadened to encompass these other related, but distinct process-related properties of the self/body relationship. This called for an analytic concept sensitive to the dimensions of time, mutability, intentionality, continuousness, and possibly pattern.[16] (All of these were dimensions which had been referenced by respondents in their abstract definitions of health). The self/body relationship involved more than a static accounting of a physical and metaphysical "health inventory;" it encompassed a process-related triad of self, body, and action (self-defined "health" practices) through which individuals arrived at a sense of themselves as healthy, to whatever degree, at any one time.

At the time that I was working on this part of the analysis trying to integrate all of these elements in the data, I was reading Porter and Porter's (1989) study of the experience

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[16]The possibility of a pattern existing within process was an idea borrowed from chaos theory in theoretical physics. In this perspective, temporal and spatial processes are considered to be patterned, although their very orderliness may be derived from disorderliness in either time or space dimensions. See Gleick 1987.

of illness in Georgian England. Porter and Porter use the terminology of "synergy" to describe the experience of self and body in illness. In medicine, "synergy" refers to the combined or correlated action of two different agents, organisms, or parts of the body. The notion of synergy seemed as though it would capture the idea of action and relatedness implicit in the data on the sense of self and the sense of body. Reviewing my data with this concept in mind, I found that respondents' alluded to "my body" and "my self" using phrases such as "a back and forth experience"(m.06) and "a relationship with myself"(f.07). This language corroborated the idea that self and body are experienced as synergistic with respect to health; however, it also pointed out the analytic insufficiency of the concept of synergy. Synergy was overly suggestive of unproblematic collaboration and missed the interactive, "back and forth," negotiated elements to which respondents referred. Thus, in the process of testing the concept of synergy for analytic relevance (and finding it inadequate), another dimension of the self/body relationship related to being healthy became clearer, that of the continuous transaction between self and soma.

I tied this dimension of intrasubjective interaction together with the dimensions of the sense of self, sense of

body, temporality, and process and referred to them as the "selfsoma process."

The Selfsoma Process

The selfsoma process encompasses awareness of self as protean body (sense of body) and as social person (sense of self). It is an intrasubjective and developmental process through which individuals derive a sense of themselves as healthy at any particular time. Continuous transactions between self and body constitute the selfsoma process. One can imagine the selfsoma process as a cycle of intrasubjective interactions in which conscious self analyzes physical and metaphysical signs and signals (e.g muscle soreness, body size, energetic feelings) in light of self's exisitng definition of health, takes actions related to these in order to move closer to or maintain health (ices muscles, changes eating habits, practices hobby), analyzes the effects of such actions, and comes to a new conceptualization of self as healthy (to whatever degree). In short, the selfsoma process is an on-going intrasubjective dialogue between the asomatic and somatic self. This dialogue uses a vocabulary of physical sensation and emotion and involves action in the world (i.e. "health" practices), interpretation of the effects of these

practices, and a consequent reconceptualization of self (as healthy or otherwise).

The Reflexivity of Self and Soma within the Selfsoma Process

Within the selfsoma process, body and self are not experienced as divided into two parts; that is, as dichotomous "mind" and "body" in the Cartesian positivist sense. Nor, as in the Cartesian fashion, is the body simply a vacuum which has been filled up with a mind (and a soul).[17] Rather, body and self are experienced as reflexive aspects of one wholeness, one "being"; neither complete without the other. The material, or somatic, and immaterial, or asomatic, represent different dimensions of the same self engaged in action in the world.

The reflexivity of self and soma could be heard in the alternating grammatical referents used by respondents to describe the experience of health. Due to the linearity of language, when talking about being healthy, respondents had to separate references to body and self grammatically into subject and direct object. Lived experience is quite different, however, for in lived experience the somatic and

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[17]Butler 1990:135 notes that in Cartesian, positivist thinking "The soul is what the body lacks; hence, the body presents itself as a signifying lack. That lack which is the body signifies the soul as that which it cannot show."

asomatic selves are always related to and contingent on one another. Given this disjuncture between lived experience and linguistic rules, the referent of the "I" continually vacillated such that in one sentence the subject would be the asomatic self, and in the next sentence, the subject would be the somatic self.[18] For example:

> "when I wake up I reflect immediately on how I feel -- whether I'm tight from the workout the day before and whether I feel like getting up at all .. and whether I can't face the day and what I have to do.." [f.03]

> "I guess the bottom line for me is being physically fit, being resistant to disease, and being happy... so I can go through my day and accomplish what I like to do without any physical or mental encumbrances" (m.02)

The reflexive relationship of self and soma also had elements of contingency. That is, the state of one was seen as having the potential to affect the state of the other. The interplay of soma and self was described as having repercussions for both.[19] This contingent and reflexive

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[18]If one were to consider healthiness as a verb, it would be a true grammatical "reflexive," that is, it's subject and direct object would be identical.

[19]The idea that self and soma are reflexively and contingently related is exemplary of the contemporary discourse on healthy lifestyles which suggests that this reciprocity can be harnessed in the interest of creating or maintaining health for oneself. The following is a typical example drawn from a popular health magazine:

> "Lifestyle changes are funny. They leak. They hop over boundaries. Quit smoking and you may find yourself exercising more; exercise more and you may want to eat better" (American Health, 1989).

relationship between body and self was evident in responses such as the following:

> "I know I'm healthy by the way I feel... when I go on a binge of junk food...I feel rotten as a person.."(m.04)

> "... I am buoyed by the knowledge that I'm physically stronger than I've ever been in my life, ...Other "forty-somethings" are experiencing depression ... (but) I can cope with other more critical demands of my life because of my physical training"(f.09)

> "It's (being healthy) all those things I said. It's really a body feeling, but it's also my head. I can take on the world if my body feels good"(f.05).[20]

Finally, an individual's selfsoma process was seen as yielding a personal and particular healthiness. Healthiness was considered to be a product of a personal and particular self and body. In other words, the experience of being bodied, of the intrasubjective pattern of interplay and

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[20]Note the language in the above. The respondent uses a somatic metaphor (the head) to describe the asomatic aspect of herself. Johnson (1989), has suggested in his book, The Body in the Mind, that the body provides the metaphors for mental activity; that how we experience mental activity is through our physical experiences e.g. "hitting a brick wall" is used to describe the a mental block. I think that this may also be an artifact of language and intersubjectivity; in other words, it is a necessary translation into concreteness of an intangible for the purpose of communicating the experience and making it "real."

interaction between self and soma, was regarded as unique to the individual.[21]

> "I'd say it's a feeling. Either you feel it or you don't on any given day....for me it's how I feel and for someone else how they feel. (f.07)

> "If a person feels that he or she has physical, mental and emotional well-being, then I would say that that person is healthy from that person's point of view. ...I would say that its almost impossible to say that there's one measure of health. I think that that's very individual and perhaps if a person smokes cigarettes and is over weight, but is happy, physically, mental and emotionally, its not my place to suggest to that person that he or she is unhealthy" (m.02).

Nuances of Difference in Women's and Men's Perspectives on the Relationship Between Self and Body

While both women and men referred to the reflexiveness, contingentness, and uniqueness of self and body in the selfsoma process, there were nuances of difference between men and women in their descriptions of the interactive relationship between self and body and being healthy. Men

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[21]The notion that the intrasubjective selfsoma process is unique to the individual is reminiscent of Mead's theory of the self and social interaction, that each self is individual because of its unique sociality and complement of interactions.Self is not static, predetermined, or invariant; each self

> "has its own peculiar individuality, its own unique pattern. Because each individual self within that (social) process reflects in its organized structure the behavior pattern of that process as a whole from its own particular and unique standpoint within that process...(Mead, 1977:234).

frequently referred to healthiness as "keeping" or "being in control" and "minding" one's body. Men seemed to imagine themselves as having "power over" relationship to their bodies.

> "Taking control of your health ... is the key to an overall sense of well-being"(m.10)

> "I have different routines that I go through to stay healthy -- various things that I know I have to do like watching what I eat and getting enough sleep"(m.02)

My male respondents spoke about their bodies as though they "belonged" to them (in the same way that an object belongs to one). Women, on the other hand, generally did not use the language of ownership when talking about their bodies, but rather referred to their bodies as though their bodies had a momentum of their own.

> "A lot of times I keep on eating even though I know it's not good for me and even though I'm eating something good like rice cakes. It's like my body just wants those things right then..." (f.07).

> "Sometimes when I'm running along, I feel like I'm not there. It's just my body moving on its own, knowing what to do and how to do it. I've read sports psychology stuff that says that you have to have confidence in your ability to perform. I take that to mean that I have to have faith in my body to pull out a six minute mile...(f.15).

This was not an experience of the body as object, but was an experience in which their bodies took on a subjectness.[22] These gender differences became even more apparent when respondents talked about their health practices. These health practices are discussed in Part B.

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[22] The concept of control and mastery which was prevalent in men's references to their bodies was less evident in the language of my female respondents. Women seemed to grant a "beingness" or subjectness to their bodies. The relationship between self and body was experienced as more lateral than hierarchical. This mirrors some of the feminist theories that women's relationships are characterized more by affiliation and cooperation than are men's (Gilligan, 1982; Dinnerstein, 1976).

Diamond and Quinby (1984) have noted the prevalence of the language of "control over one's body" in contemporary discourse, arguing that such language blinds us to other more nurturant and aesthetic conceptions of bodies.

PART B: THE PRACTICAL LEVEL OF HEALTH: DOING HEALTH IN EVERYDAY LIFE

THE DOING OF HEALTH[23]

Symbolic interactionists view the self as situated in everyday life (Mead 1964; Blumer 1969; Douglas and Johnson 1977; Kotarba and Fontana 1984). With respect to health and being healthy, this implies that abstract ideas about "health" and self as "healthy" will be derived, interpreted, and acted upon in daily life in accordance with socially and culturally defined meanings.[24] This experience of being situated in a particular social and cultural circumstance (or in postmodernist terms, of being "discursively located") became analytically conspicuous when comparing respondents' descriptions of their everyday health practices with their abstract definitions of heath and being healthy, for the homogeneity between men's and women's abstract conceptions of health dissipated into gender specific forms when translated into action in the everyday world.

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[23]This analysis of health practices focusses on the phenomenological dimensions of doing health. It does not explicitly consider the influence of social contexts on health practices, although these have been shown to play a role in health doings. Blaxter (1990) provides a thorough review of this literature.

[24]These derivations, interpretations, actions and related phenomena constitute what postmodernists would refer to as the health "discourse" of a particular time and place.

Men's and Women's Health Practices

Men and women unanimously cited biological and physiological "needs of the human body" for rest, exercise, and food in their responses. The prevalence of references to food, rest, and exercise as being essential to being healthy suggested that these have become staples in the commonsense understanding of healthiness.[25] Many of the women and some of the men also referenced friendship.[26] There were degrees of difference, however, in ideas about how much and what type of exercise, food, and rest men and women "needed." In these cases, the ideas of the "healthy" body as a social phenomenon infused with social meaning and of health practices as instances of the social construction of bodies as gendered, began to be evident in the data.

In my interviews, women usually listed food first in response to the question, "What kinds of things do you do to

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[25]In several places in my fieldnotes, I noted to myself that respondents references to food, exercise, and rest were spoken in an "of course" or "obviously" tone of voice.

[26]This may have been partly a reflection of the well-publicized research on the positive relationship between health and social support. The idea of connectedness to others as integral to being healthy is also reminiscent of feminist theories of care and affiliation as being an important moral value, especially for women. See Gilligan (1982), Rose (1983), Kittay and Meyers (1987).

be healthy?" They then mentioned exercise and rest. All of my male respondents mentioned exercise first, then sleep, and food usually tagged along as the last item of importance. When men did mention food, the nutrient quality was what was important. For women, the caloric value was also, if not equally, as important as the nutrient value. When I asked women about what men should do to be healthy, they still listed food as most important, sleep as next in importance, and exercise as least important (but not to be ignored by any means). When I asked men about what women should do to be healthy, most deferred, saying they didn't know or that the woman would have to decide for herself. One man responded with "the same thing (as I do), I guess, but less."

These responses exemplified an emerging theme in the data, namely, that men considered being healthy primarily in terms of activity and performance while women usually conceptualized being healthy in terms of a state of being, such as being nourished or being rested.[27] These responses also referenced cultural notions of there being two kinds of

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[27]To a certain degree, these responses also seemed to reflect social norms and roles related to men as actors-in-the-public-sphere and women as food preparers/nurturers-in-the-private-sphere. Since my anlysis was focussed on phenomenological aspects, I did not pursue the implications of these responses for role theory. This would be a fruitful area of inquiry for future research.

human bodies, male and female. Human bodies (one's own and other's) were seen as having similar needs, but different combinations and degrees of these needs depending upon whether they were male or female. These lay ideas about the healthy body are at odds with medical notions of a universal human body which only varies in its reproductive aspects.[28] In the commonsense world of my respondents, the body was far more dichotomized; a phenomenon which theorists of gender and the body have long argued (Dinnerstein, 1976; Kessler and McKenna, 1978; Gross, 1988).[29]

Health as Mechanics and the Body as Machine

In the process of categorizing interviewees' references to health practices, I was struck by the plethora of mechanistic metaphors. For example, "food" was referred to as "fuel;" exercise concerned "biomechanics" and "improving the oxygen uptake" of the heart, the body's "pump;" and being healthy was a matter of routinized "workouts" designed to produce "fitness." All of these references reflected a

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[28] For example, male subjects often used in medical research as representative of both male and female bodies, the implication being that researchers can extrapolate findings to females; also diseases are usually described without reference to maleness or femaleness.

[29] See the discussion below on gender.

mechanistic, almost industrial, work-oriented approach to being healthy.

The frequent allusions to the concept of "fitness" begged the question, "Fit-ness for what?" When asked this question, respondents usually stated "so I can do what I want or have to do." One man answered in an isn't-it-obvious tone, "fitness for living." The notion of "fit"-ness of the body highlighted the conception of the body as the medium or mechanism through which one reaches the condition of "healthy"-ness.

While analyzing this section of the data I was also searching the literature on the body and came upon Featherstone's (1982) analysis of the body in consumer culture. Featherstone argues that late captialist culture assures its continuation by fostering an interpretation of the body as a machine requiring constant servicing and repair (i.e consumption of goods).[30] Featherstone coins the term "body maintenance" to refer to the contemporary notion that the body is machine-like and must be maintained because it is believed to be subject to aging, deterioration,

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[30]In a similar vein, O'Neill (1985:100) has written on the "productive body." This concept refers to the body as an extension of the consumptive/productive economy in that the body is reified into "productive sectors" related to production and consumption (e.g. cosmetics for the skin, medicine for the internal organs, and so forth).

disease, and abuse by oneself and others. He also argues that the body in consumer culture is conceptualized as having "inner" and "outer" aspects (Featherstone 1982:18). Inner aspects refer to optimal functioning, performance, capacity to do things, and the potential for breakdown (lack of capacity). Outer aspects refer to appearance, movement within social space, and the potential to be touched and heard. Featherstone's concepts of "body maintenance" and the "inner and outer body" analytically captured several elements in my data.

Body Maintenance

My respondents often cited "body maintenance" activities as essential to producing health for one's self. Body maintenance conceptions were undergirded by a notion of the body as protean, potentially vulnerable, and alterable:[31]

> "I exercise regularly. I eat a very good diet. I know how to avoid getting colds and flus. I get enough sleep. I dont party and abuse my body. I guess, in a nutshell, I take care of myself."

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[31] Featherstone(1982:22) suggests that body maintenance is tied to a concept of plasticity of the body, such that, if we work hard enough we can alter our bodies. This was blatantly evident in an ad in a popular health magazine which stated: "The fact is, you can choose your own body. The proper diet, the right amount of exercise, and you can have, pretty much, any body you desire" (American Health, March, 1989: 49).

Both men and women mentioned the need for specific, purposeful, and regular "body maintenance" in order to be healthy. Their approaches to body maintenance were different, however.[32] Men emphasized sports and outdoor activities -- one specifically excluded aerobics because it was womanish, "for girls," as he put it. Eating well was also considered to be important, but was usually mentioned as a corollary to being able to do well in sports. Curiously, most men also mentioned tooth-brushing and flossing.

> "..A lot of days I don't feel like working out, but I do anyway. I push a little harder because I know that when I get through my workout, I'll feel better" (m.08)

Women also mentioned physical activities, but the emphasis was not on sport activities but on exercise activities (many mentioned aerobics). Food consumption was important for women, but interestingly, they often referred to it using the verb "to diet" rather than, as did men, the verb "to eat well." (I read this as a linguistic reflection of men's and women's different relationship to food and the body.) Unlike men, most women mentioned caring for their skin, shaving their legs, getting their hair cut, and other

[32] Extrapolating on Featherstone's concept: one could ask if these different ideas were grounded in different ideas about male and female machines and their servicing requirements.

appearance-related items as being basic to body maintenance.

> "(To stay healthy) I try to keep things balanced. I don't over workout, I don't slug it; I try not to overeat, and I take care of all my personal needs...I use sunblock, shave my legs, keep my hair looking nice... (f.07).

These differences in emphasis and approach to body maintenance practices reinforced the emerging theme in the data regarding men's performance orientation to healthiness and women's state-of-being orientation. Men were concerned with the body as the medium of action; function and capacity of the body were of paramount importance. Implicit in men's orientation was a concern with potentiality, with being able to act in the world. Women were also concerned with maintaining function and capacity, but they were equally concerned with the appearance of their bodies. Implicit in this emphasis was a concern with keeping the body in a presentable state or condition.

The Inner and Outer Aspects of the Body

Considering the above comments and analysis in light of Featherstone's concept of the inner and outer body, men and women differed in their emphasis on inner and outer aspects

of the body.[33] Men tended to emphasize the inner body phenomena of function and capacity more than the outer body phenomena of appearance, while women focussed more or less equally on both inner and outer phenomena.[34]

Subject Bodies and Object Bodies

Featherstone's primary analytic perspective is materialist, therefore he does not concern himself with the phenomenological ramifications of his concepts; however, his concept of the inner and outer body is relevant to a phenomenological understanding of self and body.

Inner and outer body concepts reference conceptualizations of the body as a "subject" (or "agent" body) and as "object" body. In her analysis of the effects on body identity of Cartesian dualism which divides the world into dichotomies of active/passive, subject/object, mind/body, and so forth,

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[33]Related to outer body aspects was the concept of body architecture; a concept which was recurrent when people described healthiness. The body was considered to be the "space" of healthiness and, as is discussed below, the "shape" and "size" of the body was an indicator of healthiness. One man used a traditional religious metaphor of the body as a sacred building: the body as "the temple of your soul."

[34]Returning for a moment to the previously mentioned concept of subject (or agent) and object bodies, this suggests that women have a sense of body as simultaneously subject-body and object-body while men tend to have a sense of body as primarily subject (or agent) body.

Young (1979) points out that body identities have been dichotomized into woman-body-as-passive/man-body-as-active.[35] Thus, subject body comments would include:

> "being able to go through my day and accomplish things","being in shape physically so I can do things", and "having good muscle tone."

References to the "object" body would include:

> "having good color," "having good skin tone", "not having eyes that are glazed over", "looking agile."

When men's and women's references to body maintenance and to the inner and outer body are considered in light of the concept of subject and object bodies, one finds that men's comments more frequently reference the subject body while women more frequently reference the object body. This suggested that men and women each maintained a unique phenomenological stance toward their bodies.

<u>SELF AND BODY IN SOCIETY: OTHER SELVES AND BODIES</u>

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[35]Young notes that this is most obvious in sporting activities because sports activities require acting body subjects. Young theorizes that women have traditionally been excluded from sports activities and have self-selected themselves out of sporting activities precisely because they are seen as object bodies and have accepted this cultural viewpoint themselves. In other words, their body-objectness precludes them from participating in activities which demand a bodysubject. Also see Duquin (1989) and Rintala (1989) for discussions of women as body objects in the context of sport.

Up to this point the analysis has dealt with the intrasubjective selfsoma process and constructions of self and body in health and being healthy. The analysis now turns to the intersubjective processes related to health, self, and body; namely, the issue of the embodied individual as situated individual. As social person, the somatic self(body)/subject is not solely a subject, but is also "subject to" observation and interpretation by others.[36]

The Healthiness of Other Selves and Bodies

With respect to being healthy and making judgements about healthiness in others, this accounting includes (but isn't limited to) judgements about others' bodies and body practices. My respondents used the body as an indicator of the presence or absence of healthiness in both the asomatic and somatic selves of others. For example, asomatic self references included:

> "Well, I'll tell ya, if they have a cigarette in their mouth, then they must be stupid.."(f.07)

> "If they have good skin color and glow, then I know they must know what they're doing with their life"(f.10)

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[36]Lauretis (1986) uses the concept of "subject/subject to" in her analysis of subjectivity as grounded in experience and praxis. She does not explicitly raise the issue of the body as that which is "subjected." Building on her idea, I argue that the body is the site and instrument of subjectedness precisely because it is the "precondition for practice," as Turner (1986) has pointed out.

Examples of somatic self references were:

> "Well, it's pretty easy. I just look at them, if they're not in shape, I say, "Those people are not healthy" (m.02)
>
> "I think even as a general rule, we tend to judge people by whether or not they have physical manifestations of illness and whether or not they complain about being ill. Yes, sometimes a person's pallor or look will betray whether or not they are healthy ...I mean, if somebody is looking down and they are flushed and the way that they are moving" (m.06).

Body Insignia

In short, in many instances, aspects of the body and body practices were used as a kind of insignia by which asomatic non-biological, non-physical "healthiness" could be "read" in an other. These cues, which I call "body insignia," served as indicators of dimensions of the other person asomatic self, including gender. In other words, they referenced an ontological healthiness. In terms of gender, this referred to the health of one's state of womanhood or manhood, to what degree one was "correctly" gendered and followed gender norms.

> "My mother always said you're a lazy person if you don't take care of your face and wear make-up..."(f.07) face insignia=laziness in women, moral failure
>
> "We have some guys in our (aerobics) class. Their good and all, but I know most of them are gay" (f.12).

> "I can't do aerobics with all those girls. Come on..." (m.12).
>
> "I see a lot of girls in the weight room these days and it's too much. I mean I like how some of them look, but the real bulked up ones.. that's not right" (m.12).

Healthiness is not necessarily a point of observation --like hair color or height -- for most people. At least, not for my respondents when I asked them whether it came to mind when they met someone. However, certain body insignia can bring healthiness to the fore as an observation point. A person's skin color -- either "paleness" or "glow" was referenced frequently as provoking questions about another's health.

We also seem to associate certain body insignia with individuals, and if there are changes, then the question of healthiness comes to the fore. For example:

> (In response to how you judge healthiness in a friend:)
> "B. always looks healthy, if she doesn't, I know something is wrong" (f.03).
>
> "I can tell when J. (a dancer). has cramps -- she doesn't move her usual way" (f.09).

Age confuses people when they are trying to estimate the healthiness of others. There is an uncertainty about different age bodies and whether or not the individual is "healthy" or not. This is especially the case when

estimating the healthiness of someone of a different age than oneself. People usually said that they'd have to talk to a person in order to determine whether the person was "really" healthy or not.

> "I mean, when you get older, in many cases, people tend to be bent over, their shoulders tend to round out a bit more, but they may still be healthy ... You'd have to talk to that person" (m.06).

> "....But to see him physically and at his age, its difficult to look at a person at that age and know if he's healthy or not. I think just by looking in his eyes and the way he carries himself, I believe that he would be healthy, but I'd have to talk to him to really know" (m.05).

So, in the case of age, the body and body insignia are necessary but not sufficient for estimating the healthiness of others.

Another example of the body insignia as being insufficient for estimating the healthiness of another is in the case of people with disabilities. One male (m.02) and one female (f.07) respondent mentioned that when they see a person with a disability they do not consider that person to be unhealthy. The man referred to the disability as "a debt" that one worked with in life.[37]

GENDER

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[37] People with disabilities have long argued that "having a disability" and "unhealthiness" are not synonymous and that alternative definitions of "being fit" and "abled" are needed.

As noted previuosly, in the lay, common sense world, most people subscribe to the idea that there are two bodies, a male and female. There is a lived gendered specificity to bodies which is grounded in the materiality of the body. The problematic of the lived body has been a central issue for feminist social analysts who have argued that the body is a concept and that there is no one generic woman's or man's body, there are only temporal constructions (Gross 1986; Hodge 1986; Balsamo 1988; Jaggar and Bordo 1989).

> "The body is not for all its corporeality, an originating point nor yet a terminus; it is a result or an effect ...."The impress of history as well as of individual temporality is to establish the body itself as lightly or heavily gendered, or as indifferent, and for that to run in and out of the eye of the social"(Riley 1988:102-103).

The concept of the body as a temporal and gendered social construction was evident in interviewees' comments about their health practices. Even though men and women made similar general recommendations for themselves regarding what was required in order to be healthy (exercise, rest, "good" food, and so forth), when they came to act on their recommendations in the everyday world, they were guided and constrained by social norms and situations. Some constraints

related to "appropriate" sites for health activities.[38] As one man said regarding where he could exercise:

> "I can't do aerobics with all those girls" (m.12).

Or, as one woman remarked:

> "I can't run at night anymore now that we live in the city.."(f.05)

The issue of public safety (and danger) and being femaled-bodied was a recurrent topic in women's narratives. Women often cited concern about being safe while exercising. Men did not cite public safety as a health-related issue for themselves personally or for men in general. When men and women who identified themselves as runners and cyclists were asked directly about safety and exercise, most responded that women risked bodily harm if they went out in the dark (unless accompanied by a man), and that men, too, were taking risks by exercising at night; however, the "risks" for men referred to "tripping and falling down" and/or "hitting something" and not to personal bodily harm. In short, there were particular structural conditions related to female and male bodies; moreover, male and female bodies were each seen as having their own specific set of concerns regarding public safety and danger.

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[38]Goffman's (1997) essay, "The Arrangement Between the Sexes," especially the section on "Toilet Segragation," is a delightful and insightful essay on gender-based social codes and their effects on structural forms and social action.

Others constraints related to norms of behavior for men and women. One man said:

> "I'd do more (to be healthy), but I can't with my job hours. My boss at the lab would kill me"(m.06).

The conflict between work and health activities was a common theme for men. Many mentioned time conflicts (between work and health activities) while others cited the "unhealthiness" of "normal" work-related practices such as frequent traveling, eating restaurant foods, and spending hours sitting in planes and meetings.[39] A few men mentioned routines they followed in order to minimize the unhealthy aspects of their jobs, such as "walking around the building at least three times a day" (m.02) or taking vitamins and sticking to their home time zone sleep and eating times when traveling (m..08). Despite acknowledgments of the "unhealthiness" of occupational practices, work demands usually took precedence over health demands when making decisions about allocating one's time and efforts.[40] For these respondents, the social norms of making a living and

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[39]The particular "unhealthy" instances cited by these respondents reflects their executive professional status. It would be interesting to study a group of men of another income and occupation level in order to see if the same themes with different content emerged.

[40]This was also true for the two women executives in the sample of respondents.

using one's body for economically productive (economic) labor were paramount, even if such activities meant not "being healthy."[41]

One woman referenced norms of behavior for women when she said:

> "My mother always said that women who eat small meals are more feminine" (f.07).

Female respondents regularly linked healthiness, eating, exercise, and being thin in their responses. Three women[42] stated directly that their exercise and eating activities were motivated as much by a desire to "not be fat" as by a desire to be healthy.[43] Another respondent, expressing a common view among women about health and "not being fat," fortified her response with a comment that "being thin really is healthier for you" (f.11). There were a number of references to ideas about amounts of food required by men and women; amounts required by women were generally

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[41]Two male respondents mentioned friends who had had heart attacks and, as a result, had moved to other, less stressful occupations. These references to others who had "fallen by the wayside" seemed to be offerred as indirect comments on the degree of danger inherent in respondents' own occupational situations.

[42] f.03,f.19,f.09

[43]Interestingly, most women referred to "not being or getting fat" rather than to "being thin." Their language suggested that social norms of body size for women are based on notions of degrees of fatness rather than thinness.

considered to be smaller than those required by men, irrespective of what the man or the women did.[44] Two women respondents said that they often ate less (for weight control purposes) even when they knew it might be healthier to eat more.[45] In these cases, activities related to "being healthy" were influenced by social norms related to gender and the body.

Some of my respondents were acutely aware of the relationship between healthiness, the body, and gender and regarded their health actions as challenges to existing gender norms:

> "Masters (swimmer) women are special because they have instituted change into their lives and have been willing to be somewhat unconventional in doing it. Athleticism was discouraged in women of my generation. "Tomboy" was a perjorative term to keep us from expressing the physical aspects of ourselves. "Ladylike" was the standard to which we were held. Masters women have had to unlearn that early socialization and grow comfortable with thier physical selves... and as they are recognized, they open the door for other women" (f.09).

As this respondent's comments indicate, gender is emergent in health doings in that specific ideas about what male and female healthy bodies "do" are legitimated and reinforced at

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[44]Respondents usually cited difference in body siz as the determining factor.

[45]f.09,f.19

the social level through the taking of certain actions and not others by either men or women.

SECTION I: SUMMARY

The cosmos of health depicted in respondents' definitions included most aspects of being human: physicality, consciousness, emotions, spirituality, and social situation (family, work, income level, etc). The idea of health was closely associated with the idea of "well being;" in other words, abstract notions of health and healthiness were identified with the positive aspects of "being" in the world and were grounded in lived experience. Self and body were ever-present in concepts of health. Respondents maintained two types of health concepts, one ideal typical and the other personal/experiential, the two interacting with each other in an on-going spiral of reflection and refinement. Health concepts were not static, but were stretched and contracted in accordance with lived experience. The content and meaning of the terms "health" and "healthiness" were variable, changing over time with experience and exposure to social and cultural phenomena.

Underlying concepts of health was a concept of self as both physical being and sentient actor. In everyday life, the sense of self and sense of body(self) were experienced as different, but essential aspects of the same self as healthy. The sense of self and sense of body together

constituted a personal health inventory. This inventory was experienced as changing over time.

The notion of a fluctuating health inventory led to the development of the concept of the selfsoma process. The selfsoma process is an intrasubjective developmental process involving self, body, and action in the world through which individuals derive a sense of healthiness. Continuous transactions between self and body constitute the selfsoma process. In the selfsoma process, the self is continually taking account of the personal and particular body and its processes.[46] The relationship of self and body in the selfsoma process is experienced as reflexive and contingent and is regarded as unique to the individual.

The body in the selfsoma process was explicitly problematic. It was not a taken-for-granted presence or vacuous entity which enveloped consciousness, but was experienced as the vital and protean aspect of self. There were nuances of difference between men's and women's relatedness to their bodies. Men tended to maintain a "power over" or controlling relationship to their bodies, while women tended to maintain a more lateral relationship in which their bodies were perceived to have a subjectness of their own. For both men and women, the body was understood to be

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[46]The next section discusses the sources of meanings for these accountings and interpretations.

integral to health as both an object and a medium of health and health doings. Thus, the body in health played multiple roles. It was at once the object upon which health was practiced, the medium of such practices, and the material subject/self who experienced health.

The health inventory and the selfsoma process were tied to action in the everyday world. Deriving a sense of self and sense of body as healthy involved a repetoire of practices and "doings" in the everyday world. Health practices were undergirded by a mechanistic conception of the body in which the body was seen to be machine-like, potentially vulnerable, but alterable and maintainable if certain physiological "needs" for rest, nutrition, and exercise were met. Thus, being healthy was closely tied to "body maintenance" activities.

Despite the homogeneity of abstract conceptions of "health" and "healthiness," there were degrees of difference in ideas about how much and what type of health practices were appropriate for men and for women. Women emphasized practices related to states or conditions of being (e.g. being nourished or being rested) and phenomena related to their "outer" bodies. Men tended to emphasize performance, the capacity-to-do, and phenomena related to their "inner" bodies. These differences in emphasis seemed to reflect a

difference in men's and women's phenomenological, self/body stances. That is, men were seen to hold a "subject body" conception of themselves while women were seen to hold an "object body" as well as a "subject body" conception of themselves. Thus, with respect to theory, health practices provided a window on the phenomenological experience of self and body.

These differences between men and women insinuated that there is a lived gendered specificity to healthiness which is grounded in the materiality of the body. Despite making similar general recommendations for themselves regarding what was required in order to be healthy, when men and women came to act on their recommendations in the everyday world, they were guided and constrained by social norms and situations.

Gender was emergent in health doings in that specific ideas about what male and female healthy bodies "do" were legitimated and reinforced through the taking of certain actions and not others by either men or women. Gender was also an aspect of intersubjectivity. Body features and practices were used as a kind of insignia by which asomatic non-biological, non-physical "healthiness" could be "read" in an other. These cues, or "body insignia," were indicators of another person's ontological healthiness. In

terms of gender, this referred to the health of one's state of womanhood or manhood, to what degree one was "correctly" gendered and followed gender norms.

In this sense, the doing of health was a form of situated social conduct grounded in the materiality of the body, in the body as "lived" within a social and cultural context. "Doing" health represented a kind of doing of gender (West and Zimmerman, 1988). Ideas about the healthy body were intertwined with notions of gender and self. Decisions about what actions to take to be healthy or "health doings" were colored by ideas about appropriate masculine and feminine behavior. This was not because there was an essential difference between male and female body healthiness, but because of social and cultural interpretations of masculine and feminine selves -- selves which were attached to male and female bodies. Thus, gender was part of the interpretive framework for organizing bodily experience as healthy.

The next section picks up these analytical threads and ties them to a more theoretical and conceptual explanation of health and being healthy.

SECTION II: SYNTHESIS AND CONCLUSION

THE INTERCONNECTION OF SELF, BODY, AND DISCOURSE

My data suggests that healthiness is not a biological fact or universal essence, but is a social phenomenon emergent in the complex interplay between the intersubjective self-as-social process,[47] and the intrasubjective "self/soma process." The lived experience of health entails interpretion and practice by self, using the tools of symbol and meaning available in local discourse. From a postmodernist theoretical perspective,[48] how we "know" health (and other social phenomena) is through particular social and cultural discourses. There is not a healthiness that exists prior to culture or historical locatedness. Culture mediates the experience of healthiness (Douglas 1969; Foucault 1979; Jaggar and Bordo 1989; Butler 1990; Jacobus, et al. 1990).

My data suggests that this perspective needs to be expanded in order to understand more fully the experience of healthiness. More specifically, my data suggests that the

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[47]In the symbolic interactionist sense, as defined by G.H. Mead (1977) and refined later by Blumer (1966) and existential sociologists (Kotarba, 1984).

[48] A perspective grounded in insights drawn from sociology, anthropology, and philosophy.

experience of being healthy is not simply an effect of social and cultural discourses; being healthy also relies on conscious agency and strategic practice, on the continual creation and recreation of symbol and meaning by self-analytical persons. In this way, healthiness also mediates culture. In other words, notions of health and healthiness are discursively-formed, intepretive frameworks for organizing bodily experience along socially and culturally acceptable lines, but, as _interpretive_ frameworks, require clarification and rendering by self-analytical subjects. The variety of interpretations of self-analytical subjects makes up the particular spectrum of representations and practices of "being healthy" at any particular historical moment. Thus, there is kind of constituting reflexivity to healthiness That is, healthiness is both constituted by and constitutive of culture; it is an _active_ modality of culture.

This expanded perspective, which is grounded in feminist reconceptualizations of postmodern theory, (re)introduces to social analyses the analytic concept of the acting subject.[49] It also focusses theoretical attention on

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[49]Feminist postmodern theorists have argued that the traditional postmodernist notion of the subject as simply a effect of external structural processes is inadequate because it overlooks the analytical and creative processes engaged in by subjects, processes which are central to the producing of discursively-formed phenomena (DeLauretis 1986; Alcoff 1988;

(continued...)

healthiness as both mediating and mediated by culture. The producing of health by persons in their everyday activities literally "brings to life" social symbol and meaning through the medium of the lived body. The lived experience of health emerges from the interplay between the realms of the material and discursive, primarily because of the unique position of the body in health, as both an object and medium of health.

If one were to think of an individual's healthiness as a prism whose sides represented body, self, and social meanings (discourse), one would find that the refraction through any one side is simultaneously a refraction through the other sides such that the spectrum of health produced is always a refraction of all three. Being healthy thus is an historically located and known experience in which self, body, and discourse are interconnected and mutually transforming. The interconnectness of the three was evident in the data in that men and women held similar abstract ideas about what constituted health, but their concrete practices for realizing these abstractions in everyday life were different.

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[49](...continued)
Smith 1988; Nicholson 1990) . This feminist point of view is discussed in more depth in the Theory and them Implications chapters.

Gender

The idea that the body is lived (as "healthy or otherwise") within a context of social and cultural symbol and meaning raises issues related to the body as problematic, especially the issue of the body as gendered. What I found in studying healthiness was that gender was an underlying and recurrent theme. This was not surprising given the primacy of the body in concepts of health and healthiness and the fact that gender, like race, is one of the primary constructions of the body grounded in physical difference.[50] Contemporary common sense beliefs organize bodies as one of two types, male or female, and map onto these bodies one of two genders, masculine or feminine (Petras, 1978; Kessler and McKenna, 1978).[51] The experience of being healthy for my respondents, as residents of a commonsense world, was saturated with social meanings attached to the female and male body (e.g.gender, race, age, and so forth). In turn, health practices involving the body were instances in which self and body as gendered were constructed.

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[50] See Spellman 1988:127 for a discussion of the role of physical features in the construction of cultural identity.

[51]The "challenging problem" of the problematic body, as theorists of gender difference have put it, is the problem of there being "a differential relation between men and the body, and women and the body....of their being two different kinds of body, with different meanings, and cultural inscriptions ... (Hodge, 1988:162).

In this sense, the doing of health can be seen as a kind of situated social conduct, a social production grounded in the materiality of the body, in the body as "lived" within a social and cultural context. The doing of health represents a kind of doing of gender (West and Zimmerman, 1988). This is not because there is essential difference between male and female body healthiness, but because of social and cultural interpretations of masculine and feminine selves -- selves which are attached to male and female bodies.

Ideas about the healthy body are intertwined with notions of gender and self. Decisions about what actions to take to be healthy or "health doings" are colored by ideas about appropriate masculine and feminine behavior. In short, gender is part of the interpretive framework for organizing our bodily experience as healthy. We negotiate, produce, and reproduce social order through interpretation and construction of our selves as healthy and as bodies.

The Construction of the Self

In this sense, health activities can be seen as a form of practice which constructs the subject (the "person") in the same way that other social and cultural activities do.

Health is one classificatory system for mapping self and others. Healthiness is an interpretive framework for organizing everyday life. In short, what, when, and how we do health are indicators of who we are, our Selves.

Paralleling these intersubjective processes of self construction is an intrasubjective process, "the selfsoma process." As the data showed, being healthy was grounded in a sense of self and a sense of body[52] which were emergent in the intrasubjective self/soma process. I suggest that within the self/soma process, the self -- as one interactant in the self/soma process, and as "social process" in the interactionist sense -- brings social meanings to the self/soma interaction. Society is "in" the self/soma interaction via the self and language. In this way, social classifications, interpretations, constructions, and meanings of self and body, such as gender, enter the self/soma process. Gender and healthiness, as constructions, overlap and influence one another.

In addition, within the selfsoma process, the body is experienced as a ground of being and a source of subjectivity (Kintz 1989). My respondents referred to healthiness as though it were an experience which was known

[52]"Sense of body" referred to the "being" side of the existential phenomenon of both "having" and "being" a body.

through reflection upon self and body. The body presents signs and signals which are interpreted and organized by self into a "coherent" explanation of the current state of being (whether healthy or not).

As noted above, the inventory of meanings for these reflections and explanations was derived from particular discourses of health and the body. These "received" meanings were not blindly accepted; their cogency was continually tested in daily practice and tempered by personal experience. This was manifest in in the fact that respondents' simultaneously maintained two types of health concepts, one ideal typical, and one personal and experiential, and continually compared one to the other. This constant comparing and evaluating suggested that healthiness involved an ongoing spiral of experience, reflection, and refinement of meanings of "health." This spiralling process gave to the experience of health a sense of movement, processualness, and fluctuation.[53]

The Expansion of the Content of Health Discourses

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[53]In this respect, health was an experience of "becoming" akin to the existentialist idea of self as "becoming" (Kotarba 1984).

Another contemporary phenomenon which contributes to the experience of health as processual and fluctuating is the continual expansion of the content of discourses of "health." The rubric "health" has come to subsume a wide range of human experiences related to the body, to personal characteristics, and to structural phenomena related to family, work, and income.[54]

According to my data, the term "health" has become a comprehensive and grand concept. The meaning of health in contemporary terms has grown to include numerous "positive" aspects of "being alive" such as being able to do things, being "physically fit," having a good genetic heritage, being optimistic, and so forth. The neologism "lifestyle," which has come to be equated with being healthy, is indicative of the increasing inclusiveness of the meaning of "healthy" in contemporary life. "Life" and "style" are comprehensive terms, laden with connotations of alive-ness or being, of conscious and non-conscious behaviors and habits, and individuality (among other things). As the data showed, the idea of health as lifestyle is reinforced by

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[54]Cite the 1940 WHO definition of health as the absence of disease. Ironically, this definition which has been considered to be limited in scope by contemporary definers of health, is in some respects an adequate definition for contemporary times because it implies that health is <u>everything but</u> disease. This definition seems close to an adequate portrayal of the contemporary meaning of health.

public media statements which equate personal action and responsibility with being healthy. The expansion of the meaning of health to include life itself is probably at the root of respondents' comments implying that health is a moral category, a value and a "good" to be sought after.

CONCLUSION

In conclusion, my data suggests that health is both an idea and a lived reality. Rather than being a biological essence, healthiness is a social phenomenon. The experience of being healthy involves both intersubjective and intrasubjective processes. Being healthy includes abstract conceptualizing and concrete practice by active subjects. The body is a focal point, the organismic base (Turner 1986), of these conceptualizations and practices. Bodies are created and constructed as healthy. Ideas circulating in social discourses of health are the source of meanings for this constructing process.

Individuals' processes of conceptualizing, constructing, and practicing are informed by discourses related to health, but they also inform those discourses because they involve continual testing and refinement of received ideas in light of personal experience. Ideas are received, but they are tempered within the selfsoma process and are thrown back out

into the lived world in the form of language and practice. In this sense, self, body, and discourse are interconnected and mutually transforming.

Health can be seen as one interpretive framework, informed by discourse and related to the body, for making sense of daily phenomena. As an interpretive framework, it overlaps with other interpretive frameworks related to the body, such as gender. In lived experience, the sense of self as healthy, as gendered, and as body are intertwined, and are realized simultaneously in concrete habits and practices of daily life.

At the social level, health actions and activities thus become another of the many instances in which social meanings and symbols such as gender are accomplished, attributed, produced and reproduced. Health actions constitute moments in the self-as-social-process and they reflect an individual's unique self/soma process.

Health, conceptualized as a social phenomenon, has implications for sociological social psychological theories of health, self, and gender. These implications are the subject of the following chapter.

CHAPTER V

SUMMARY AND IMPLICATIONS

Health as a Social Phenomenon

The purpose of this reasearch was to examine individuals' concepts of health and how these are constituted in everyday life. As the Analysis and Findings Chapter discussed, my data suggest that health is a social phenomenon. In that chapter, I argued that there is a kind of constituting reflexivity to healthiness. That is, healthiness is both constituted by and constitutive of culture, and thus, is an active modality of culture. I argued that notions of health and healthiness are discursively-formed, interpretive frameworks for organizing bodily experience along socially and culturally acceptable lines, but, as interpretive frameworks, involve clarification and rendering by self-analytical subjects. Healthiness is more than a simple effect of social and cultural discourses; it also involves the continual creation and recreation, or "bringing to life," of symbol and meaning by interpreting, acting, and embodied persons.

This chapter addresses the implications of this conceptualization of health and healthiness for social psychological theory.

The Intrasubjective Selfsoma Process: Implications for Interactionist Theories of Self Construction

The data on being healthy have implications for interactionist theories of self construction. Interactionists conceptualize the self as social process (Cooley, 1902; Mead, 1977; and Blumer, 1969). In this cognitively oriented view, self is not static or predetermined. Through role-taking and interaction with self and others, an individual continually creates a sense of self as individuated, as subjective "I," and as Self for others, as object "Me." Perception and cognition play a key role in individuality. Self and sociality are not separated. The social and processual self is conceptualized as a relational self which arises and develops within the context of interaction.[1]

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[1]According to Mead, each self "has its own peculiar individuality, its own unique pattern. Because each individual self within that (social) process reflects in its organized structure the behavior pattern of that process as a whole from its own particular and unique standpoint within that process...(Mead, 1977:234). The society within which this self develops is an "on-going process of action" and not a predetermined structure of relations. Social acts have as a common focus, "social objects," which "integrate the actions of the participants by providing a shared field for response... (They) can be material things... or less tangible phenomena such as norms and rules" (Ferguson, 1980:27). Social acts are "the source of the established and regulated social behavior that is envisioned in the concept of culture" (Blumer, 1966:541), but they also are the basis of uncertainty because actions can be initiated, terminated and changed at (continued...)

Existential sociologists have challenged this interactionist viewpoint, arguing that self is more than a cognitive production; rather, rationality merges with feelings and with the physical body-self in an ongoing process in which self is always "becoming" (Manning, 1973; Kotarba, 1977; 1984; 1988; Kotarba and Fontana, 1984; Lester, 1984; Douglas, 1986; Baldwin, 1988). Kotarba (1977) has suggested in his work on chronic pain that there is a private experience of the self, existing outside interaction with others and involving the body, which is a significant part of the process of constructing self.[2] This notion of a private experience, related to the becoming of self and involving the body, is also apparent in the data on being healthy.

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[1](...continued)
any time by actors in the social act (Ferguson, 1980). "Thus the relation between social objects and social acts is one of intricate dialectical interaction. Social objects do not contain their own intrinsic meaning, for they receive meaning only through human action. At the same time, social acts are held together by the orientation of the actors toward particular social objects" (Ferguson, 1980:29).

[2]Kotarba argues that chronic pain is an example of an example of self-experience which is invisible and not available in interaction unless the chronically ill person chooses to reveal it. Kotarba's point is that there are dimensions of self-experience which call into question interactionist theories which conceptualize self as constructed within an interaction context. See the section on Self and Body in Existential Sociology in the Theory Chapter for a more in depth discussion of Kotarba's point.

With respect to theorizing about self construction, the data on being healthy suggest that defining oneself as "healthy" is an instance in which the body plays a significant role in the construction of self, and that this defining occurs in and through a private, intrasubjective negotiation process, namely, the "selfsoma process." This private negotiation process exists alongside of the shared, intersubjective, negotiation process of interaction (the self-as-social process). (As is discussed in the chapter on Analysis, it is also informed by the self-as-social process because self is one interactant.) Self is constructed through both private and shared negotiation processes. Self "becomes" not only through the shared intersubjective experience of the self as social process, but also through the private intrasubjective experience of the selfsoma process. In short, my data suggest that the interactionist view needs to be augmented to include the intrasubjective negotiation processes which contribute to the process of self construction.

Intrasubjectivity, the Private Realm of the Body, and the Body as a Source of Meaning

The notion of an intrasubjective process in which self is continually taking account of the body and its processes raises a number of theoretical issues. One issue pertains

to the role of the body in the "becoming" of self. In the selfsoma process, self constructs the body, but self is also subjected to body in the sense that the body gives forth signs and sensations which must be interpreted (as signs of healthiness or other states of being). Theory needs to consider phenomenological, intrasubjective experiences in which "body datum" is presented to the self and there is no socially derived meaning available to self for "explaining" the body datum.[3] In other words, theory needs to address the problem of how individuals "understand" bodily phenomena which have not been defined by discourse.[4] Is there a negotiation process between self and body through which new meaning is derived? Or is no meaning derived? Is this a self-experience which is "beyond" intersubjectively-known language, and therefore, outside the self as social process? If so, what is the language of these negotiations and of

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[3]A more nihilistic question would be whether it is possible to experience bodily phenomena which have not be given meaning through discourse.

[4]This harks back to existential notions of dimensions of self-experience which lie outside interaction with others. Scarry (1985:5) has pointed out in regard to pain that "...its resistance to language is not simply one of its incidental or accidental attributes but is essential to what it is....physical pain has no referential content. It is not of or for anything. It is precisely because it takes no object that it ... resists language." Levesque-Lopman (1988) writes of women's experiences of being pregnant in which the body is experienced as having a momentum of its own, independent of the conscious self. Feelings of healthiness constitute a similar case in that they are invisible, exist outside language, and are often of inexplicable origin.

what is that territory beyond language comprised? More important, is the body a source of meanings not only for self, but also for society? And, in the latter case, a source whose private language must be translated into the language of the intersubjective social realm. This would suggest that in addition to the traditional view of intersubjectivity as the source of meanings for intrasubjectivity, that intrasubjectivity informs intersubjectivity.[5]

The possibility that some bodily signs and signals may be instances of phenomena existing "outside" discourse has implications for postmodernist theory which identifies discourse as the source of meanings for self and others. Postmodernism says little about these bodily feelings, signs, and signals, because it is essentially about cognition and perception, and as in more classical conceptions of mind and body, the body is cast as surface

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[5] This may be one of the reasons that fasting is considered to be a political act. The self/soma interaction is understood phenomenologically to be unique, personal and particular in content, but universally present in others like oneself. (See Schutz's concept of reciprocity of perspectives in the chapter on theory.) The intersubjective understanding of fasting as political comes from our own intrasubjective experience of self and body. In this case, the intrasubjective selfsoma process is a source of meaning for intersubjective interaction.

In a similar vein, Johnson (1988) has suggested that bodily movements and experiences are used as metaphors to explain intangible phenomena. For example, "feeling high" is a physical metaphor used to describe an affective state.

upon which are inscribed meanings received from discourse. The concept of the selfsoma process suggests that the body may be both a surface and a source, a condition for cognition so to speak. Moreover, it may be that intrasubjectivity has its own discursive realm; one which parallels the external discursive realm, draws upon private discourse, and is constituted in the negotiation process between self and body.

The Body as Problematic for Theory; The Concrete and Particular Body of the Everyday World as Gendered and Its Implications

As noted in an earlier chapter, defining one's self as healthy involves a sense of self and a sense of body.[6] The sense of body is an essential and significant ingredient in the construction of self as healthy. It is a socially-derived interpretation and creative construction of the biological body which emerges in and through the selfsoma process. The sense of body (as healthy or otherwise) is derived through action in the world (practical activity) and the on-going, intrasubjective processes of self and body, and is given meaning by self using concepts circulating in

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[6]See the Analysis Chapter for further discussion of this concept.

discourses of health and the body.[7] The latter constitute "an interpretive framework" (Kotarba 1984) for comprehending and managing bodily experience and for defining and constructing self.

The Body as Explicitly Problematic

The notion of a sense of body makes the lived body explicitly problematic for theories of health. The body can no longer be considered only as an abstract universal concept,[8] but must be considered in its concreteness as a situated lived experience; an experience involving simultaneous processes of interpretation of one's own and other's particular bodies (the body as object) and of communication of one's Self as healthy, as social member, and so forth (the body as medium). In short, theories of health need to take account of the body as personal and particular. In turn, this brings into theoretical focus the processes and practices through which the body is constructed and known in its concreteness and particularity.

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[7]Turner (1986:59) states that "physiology is always mediated by culture" and that "the body is always socially formed and located."

[8]See Butler's (1989) critique of Merleau-Ponty and phenomenological theory for a discussion of the tendency in phenomenology to cast bodies and lived expereince as ahistorical theoretical constructs.

In the commonsense world of my respondents, the body as concrete and particular was evident in respondents' use of their own and other person's bodily signs and signals, or "body insignia," as indicators not only of physical health, but also of ontological health, or the healthiness of the self. Bodies were seen to bear personal and particular self-inflections.[9]

The body as symbolic of concrete and particular selves was also apparent in respondents' comments which differentiated between male and female bodies and the needs and "appropriate" health activities for each.[10] In other words, gender played a key role in constructing bodies as concrete and particular. Respondents cited different bodily symbols of health for males and females. For example, "healthy" female bodies were often referred to as thin, while male bodies were brawny. Respondents rarely referenced the healthy body in universal, non-gendered terms (except in their comments on the human need for sleep, food, and rest); rather, the healthy body was considered in its context of who and where.

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[9]In another context, Sacks (1981) references this concept in his comment that: "Walking, at its most elementary, is a spinal reflex, but is elaborated at higher and higher levels until finally we can recognize a man by the way he walks, by _his_ walk" (p.224).

[10]See Analysis Chapter.

The Gender "Subtext" of Healthiness

That gender is a significant aspect of the lived experience of health follows from the view that the body is the site of identity and self construction, and that gender is a fundamental social construction of self.[11] Ideas about gender are cultural constructions of different bodies and their requirements; they are constructions that have a biological base.[12] Since the body is the focal point of self-construction as well as health construction, gender becomes a "subtext"[13] of the everyday lived experience of health. Ideas about the healthy body are intertwined with notions of gender and the self. The temporal and social processes of self, gender, and healthiness are bound up with each other in the body.

This confluence of concepts of self, gender, health, and the body was reflected in respondents' appraisals of their own and other's healthiness. Decisions about what actions to

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[11]Kessler and McKenna (1978) argue that it is the basic social construction of self. See Theory Chapter for further discussion.

[12]Turner (1986) refers to the body as the "vehicle" of the self in his discussion of Foucault, social order, the government of the body. See also Merleau-Ponty's concept of the phenomenal body and the philosophical problem of both having and being a body.

[13]See Fraser's (1989) discussion of "gender as a subtext" in the work of Habermas.

take to be healthy or "health doings" were colored by ideas about appropriate masculine and feminine behavior. In short, how self and other were known as "healthy" had a gender subtext.

Implications for the Epistemology, Mead's Concept of the Generalized Other, and Schutz' Concept of Reciprocity of Perspectives

The notion of the interconnectedness of self, body, and gender in the lived experience of health has implications for the sociology of knowledge and epistemology, Mead's theory of the "generalized other," and for Schutz' theory of the reciprocity of perspectives.

Theories of Knowing

The Body, Epistemology and Theories of Health

The specificity and locatedness of knowing and claims of "truth" has been cogently argued by Collins (1989) in her discussion of Black feminist scholars' dilemma in trying to elucidate Black epistemologies to non-Black audiences. Citing Mannheim (1936), Mulkay (1979), and Kuhn (1962), Collins calls into question the content of "truth" and the methods used to arrive at that truth: "All social thought ... reflects the interests and standpoint of its creators...

> knowledge claims must satisfy the epistemological and political criteria of the contexts in which they reside.... a knowledge claim that meets the criteria of adequacy for one group and thus is judged to be an acceptable knowledge claim may not be transferable into the terms of a different group"...(vocabularies may be similar, but) "the ideas themselves may defy direct translation (Collins 1989:751-772).

Collins' point that standpoints are grounded in specific epistemologies is relevant to the problematic of the body and healthiness.[14] As the data suggested, the body as healthy is interpreted and experienced as gendered. That is, ideas about what constitutes healthiness are tied to concepts and practices related to the body as male and masculine or female and feminine. Considering this in light of Collins' point, I suggest that being embodied female or male is a contributing ground for a specific epistemology and standpoint, and that the "truths" held by differently bodied knowers may vary in content and process even though they share common vocabularies.[15]

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[14]This is not surprising given that Collins is addressing the phenomenon of being Black in society which is an experience grounded in the color of the body.

[15]Gilligan (1983:173) has noted in her work on moral theory that: "My research suggests that men and women may speak differnt languages that they assume are the same, using similar words to encode disparate experiences of self and social relationships. Because these languages share an overlapping moral vocabulary, they contain a propensity for systematic mistranslation, ... At the same time, however, these languages articulate with one another," each augmenting and expanding the other (e.g. an ethic of responsibility augments hierarchical ordering, and the network of care is expanded to include self as well as other).

I am not arguing that all like-bodied knowers share a common epistemology and standpoint, nor am I arguing that the body is the sole epistemic ground. I am arguing that the body is a starting point, as object and subject, for all knowers in the world, and that it is a critical epistemic ground which exists in dynamic relation to other "grounds" such as race, age (both body-related) and culture.

With respect to theorizing about health, this is not to suggest that we propagate a chaos of perspectives.[16] Rather, it is to propose that, when considering health "truths," we make problematic the social relations and contexts related to the body which underpin and frame these

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[16]Although the idea of theory as unifying and universal is itself open to debate. As feminists theorists have argued, insisting that theory encompass multiple points of view (and identities) is only a problem if we start from the classical idea that theory must be coherent and universal. As Harding (1986:164) points out:
"...tensions, contradictions, and ambivalences within and between theories are not always bad.... We should explicitly recognize the ambivalences and contradictions within both feminist and androcentric thinking, and learn how to cherish benficial tendencies while struggling against the social conditions that make possible regressive tendencies in both. I am not suggesting that we should _try_ to produce incoherent theories, but that we should try to fashion conceptual schemes that are more alert to the complex and often beneficial ways in which the modernist world is falling apart." I would add that we need to move away from a conception of "competing" theories to a conception of "simultaneous" and contiguous theories.

"truths."[17] By doing so, we expose another filament of "the complex web" of relations through and within which the social experience of health is constituted and from which "truths" emerge (Baca Zinn et al, 1986).

Knowledge as Practice

Related to this is Hawksworth's (1989) point that knowledge is a form of situated human practice, and that

> "..'knowing' presupposes involvement in a social process replete with rules of compliance, norms of assessment, and standards of excellence that are humanly created.... Knowledge, then, is a convention rooted in the practical judgements of a community of fallible inquirers who struggle to resolve theory dependent problems under specific historical conditions" (1989:549).

Applying this concept of knowledge as human practice to the data on being healthy brings into the theoretical foreground the issue of the body as one of the primary ""historical conditions" of practice, and therefore, the issue of whether knowing (as a form of practical activity) is gendered. This would suggest that there is a gendering of knowing which is tied to historically located concepts and practices of the body. In other words, knowing is not simply a matter of mind, but is also a matter of body.

[17]The argument extends to the researcher as embodied knower engaged in discovering "truths" about social life.

This is not to suggest that the body qua body structures experience. (To do so would move the discussion to the nature versus nurture debate in epistemology.) Rather, it is to point out that the lived experiences of being bodied female and being bodied male are distinct, and therefore, that an adequate theory of knowing will take into account the structural and interactional dimensions of this experienced particularity.[18]

To return for a moment to question of the nature/nurture debate, the debate does have relevance to this discussion, but not in its capacity as an explanatory tool. Instead, it must be considered as a factor in the social experience of being bodied. As Harding (1987:300) points out, the culture/nature conceptualization is more than imaginary:

> "The culture/nature dichotomy structures public policy, institutional and individual social practices, the organization of the disciplines (the social vs. the natural sciences), indeed, the very way we see the world around us. Consequently, ... we are forced to think and exist within the very dichotomizing we criticize....Even as we analytically and experientially notice how inextricably (culture and nature) are intertwined, ... we cannot afford to dismiss them as irrelevant as long as they structure our lives and our consciousness."

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[18]There is a growing literature within feminist theory which addresses the relationship between the particulars of female and male bodily experience, ontology, and epistemology. See Reinharz (1983, 1987), Whitbeck (1984), Overall (1988), and Levesque-Lopman (1988).

Mead's Concept of the Generalized Other

Mead proposed that interaction is undergirded by what Mead termed "the generalized other." The generalized other is

> "a composite role constructed from the roles of the others in one's social group and ... an internalized standard of behavior (which) provides a basis from which a person views himself and his behavior....By organizing and then generalizing the attitudes of particular other individuals toward their social situation, and then internalizing this stance as an accepted standard of conduct the self becomes and individual reflection of the general systematic pattern of social or group behavior in which it and the others are all involved" (Ferguson, 1980:31).

Mead also maintained that social acts have a temporal dimension, that is, they occur in the present, but they have a history (past) and a purpose (future).

As the data on being healthy suggest, a sense of body as gendered is a significant dimension of self experience. In terms of Mead's theory of the generalized other, this has several implications. One is that there may be more than one body-related "internalized standard of behavior" available to social members (given that selves ares seen to be attached to either male or female bodies). Another implication is that if the generalized other is grounded in male-bodied experience, then female bodied persons who internalize this standard of behavior are internalizing a

standard grounded in bodied experience different from their own, and thus "know" themselves within this (male-bodied) generalized other as "other" (as female-bodied). In other words, a woman's sense of self as body would be as an "other" within the generalized other; she would "know" her self from a constant relational or comparative stance to the generalized other. This is not only a phenomenological problem in and of itself, but also raises the issue of other body bound identities, such as race and age, and whether they operate in a similar fashion within the generalized other.

Related to this is the problem of the relationship of these body bound identities within the generalized other. How are they related? hierarchically? laterally?[19] If individuals internalize a generalized other which contains hierarchically related viewpoints, that is, if the generalized other is constituted out of dominant group perspectives, then the generalized other may not be the generic collective viewpoint driven by morality and the

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[19]The recent feminist work on moral theory bears on this question. In this work, feminists have found that the prevailing moral understanding grounded in notions of rights and justice is not a universal moral code, and that other codes grounded in notions of relatedness and care also exist. These differing moral understandings have been found to have a gender link, with men usually subscribing to the code of rights and justice, and women subscribing to the ethic of care. See Gilligan 1983, 1987 and Benhabib 1987.

natural good, as Mead suggested it was. Rather, it may be one of the means through which a gendered social order is maintained. Mead's generalized other may function prominently in the acquisition and continuance of a sense of self as gendered (or as of a certain race or age).

This helps explain theoretically the sense of self-as-inferior experienced by women and other out-group people; in other words, they have internalized a generalized other which casts them as inferior. It also has repercussions for sense of self as healthy since the experience of healthiness is tied to a sense of self and a sense of body. That is, internalizing a sense of body self as different and inferior would affect one's sense of being healthy.

Schutz' Concept of the Recirpocity of Perspectives

The problematic of the body as differentiated also raises questions with regard to Schutz' theory of the reciprocity of perspectives.

Schutz suggested that intesubjectivity is grounded in a "reciprocity of perspectives;" that is, the taken for granted belief that self and other are similarly situated such that if places were exchanged, the perspective would remain the same (Schutz 1962:12).

Since the body is essential and significant in the construction of self and since the body is seen in the lay, common sense world as dichotomous, as either male or female, this poses questions concerning how selves attached to dissimilar or similar bodies interact and phenomenologically "understand" each other. If the intersubjective understanding (the reciprocal perspective) related to body is missing from the interaction, then what do individuals do to "make sense" of the other? How do we make sense when there is no reciprocity of body experience? Is substitute "data" employed? Similarly, if the intersubjective understanding related to body is present, does this mean there is more available for making sense of the other? Perhaps the strength of sisterhood and brotherhood bonds grounded in a phenomenological, intersubjective sense of body.

The biological body as a ground of (socially constructed) being also has implications for Schutz's concepts of stocks of knowledge and typifications. These may need to be expanded to include the concept of a diversity of typifications and "differently configured" stocks of knowledge grounded in the body as a source of multiple and varied being(s).

Summary: Self, Body, Health, and Gender

The data on being healthy has a number of implications for social psychological theory. First, the data suggests that the experience of being healthy involves a sense of self and a sense of body, which is emergent in the selfsoma process. The <u>intra</u>subjective selfsoma process parallels the <u>inter</u>subjective self-as-social process; each informs the other in the lived experience of health. With respect to theory, this suggests that theory needs to be expanded to include the <u>intra</u>subjective, private dimensions of the self construction process.

Second, the problematic of the body in health suggests that the body as healthy needs to be considered as a concrete, particular, and gendered lived experience (and not as a universal abstraction) involving practical activities and interpretation in the everyday world. As the data showed, the body is explicitly problematic as both an object and a medium of health. In the commonsense world, the body is considered to be concrete, particular and situated; gender is a primary organizing principle. This leads to the third implication that there is a "gendering" to knowing which is tied to the body as a ground of subjectivity and a condition for practical activity and to knowledge as human practice.

Related to the above is the theoretical implication that the problematic of the body in health (and in illness) may not be limited to only two bodies -- to two discrete, abstract and universal male and female bodies --and that by focussing on only two bodies, the differences of embodied, lived experience within and among men and women are obscured (Di Stephano 1990).

Moreover, there are also race, class, age and other categories of the body which are integral to embodied, lived experience. As Turner has pointed out, even though the interpretations of difference and sameness of the body are textual (an effect of discourse), embodiment itself is more than a conceptual construct; it is also agency and potentiality (Turner, 1986). Thus,the body can be seen as one more element in a "dynamic of interaction" (Dill 1987) in which race, class, age, and other aspects of self interact with each other, each influencing the other; a dynamic of interaction from which are created lived experiences and self definitions of health and healthiness which are quite different from person to person.

The Linkages Between the Material World and the Conceptual World

The lived experience of health provides a window on the linkages between the material world and the conceptual

world. As my respondents' narratives suggested, notions of what constitutes "health" are constructed out of the conceptual raw materials of cultural discourses of health and are refined through personal experiences of being bodied (i.e of both being and having a body). Health discourses organize meanings, actions, and relations, but the organiz_ing_ is done by acting individuals in everyday practical "health" activity.[20] In contemporary western society, these practices are focused on the body (e.g. body maintenance) and are conflated with other body-related notions such as gender, age, class, and so forth. Thus, the lived experience of health brings into theoretical focus the matter of the self as temporally located, _active_ subject (not as solely discursively determined actor) interpreting

[20]In her essay on "Femininity as Discourse," Dorothy Smith (1988:39) points out that Foucault's concept of discourse reduces "the subject to a mere bearer of systematic processes external to her" and focusses theoretical attention on the textual level (i.e. the level of organization and methods of thought) rather than on the level of social relations and practices which undergird and produce the textual. Smith argues that attention must be shifted to the level of lived, actual processes and practices which produce the textual level of symbol and meaning. Smith calls these "textually mediated behaviors." This is not a rejection of Foucault's thought, but rather is a refocussing on a different aspect of the same phenomenon. Smith's point is that theory needs to attend to the "complex of actual relations" and "the material practices which (bring the textual) into being and sustain it" (p.41). Health actions may be instances of textually mediated behavior.

both material and conceptual "health" phenomena and taking action.[21]

In this respect, health is not a universal fact, but is a constituted reality crafted out of the particulars of time, place, and body. There is both a conceptual and practical on-going constructing of health by analytical, bodied individuals. Even though health comes to be seen as an organic and inherent reality independent of selves, it is a creation of those selves.

Health actions can be analyzed as instances of social interaction in which the self and social order are negotiated. Health actions are "social acts," in interactionist terms, and the "social objects" pertinent to the experience of being healthy are the self and the body. Gender is one of the emergent aspects. Social order is negotiated, produced, and reproduced through interpretation and construction of selves as healthy and as bodies.

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[21]A major critique of the postmodernist point of view by feminist theorists has focussed on the postmodernist erasure of the Subject and subjectivity, or as Haraway (1988) calls it, "the view from nowhere." Feminists have argued for a reinstatement of the subject in postmodernist theory. See Alcoff (1988) and Nicholson (1990) as an introduction to this debate.

In sum, I have argued that the experience of being healthy is a window from which we can view the convergence of the phenomenological and the social. Being healthy is not simply a conceptual product of discourse and intersubjective interaction, but is also a lived experience of being bodied which involves action (practical activity) in the world and an on-going intr<u>a</u>subjective negotiating process between self and body. Gender is an integral aspect of this process.

With respect to social psychological theory development, this raises the body to a new position of explicit saliency and refocuses analytic attention on the actual everyday ways and means that discursive ideas are enacted and the social order is sustained in an array of practices in the everyday lived world. Meanings of self, body, and health, while appearing to be universal, are constituted and materialized through active interpretation and enactment by historically located, embodied selves.

APPENDIX

INTERVIEW GUIDE

After introducing myself and thanking the respondent for their time, my introductory comment runs along the lines of: "why don't we start by having you say a few things about yourself. Where you were born, what you do, and what some of the things that are important to you are." (Want to see if health is mentioned.)

QUESTIONS RE: CONCEPTS OF HEALTH

[The emphasis in this phase of the interview is to elicit both global and personal definitions of health and healthiness. I'm trying to find criteria used for judging the presence of health in oneself and in others, both generally and as a man or a woman. I'd like to tap individuals'interpretations and expectations of their condition. I also want to get a feel for the extent to which the individual's health concept and criteria are reproductions of the biomedical definition.]

Are you - do you consider yourself - a healthy person? Why? Why not?

How do you know you are healthy? How do you account for why you are healthy? (See also later question on control over health.)

What is 'being healthy' for you? not being healthy?

What kinds of things do you do to be healthy? Could you do more? Would you like to do more?

ESTIMATING THE EXISTENCE OF HEALTH IN OTHERS

(I'm also looking here for possible differences in interpretations and expectations re: males and females.)

How do you know if someone else is healthy?

When you see or meet someone, does the idea of whether or not that person is healthy come to mind? (taps health as observation point)

If and when you do observe that someone is healthy, do you remark on it?

If you were in the same room with a 65 year old man, how would you decide whether or not he was healthy? a 25 year old man? a man your own age?

ditto: 65 year old woman, 25 year old woman, a woman your own age?

How do you judge how healthy your closest (female) and (male) friend is? In general, do you find being healthy to be the same for males and females?

DEFINITIION OF HEALTH

Health has been defined in numerous ways. If you were asked to define it, what would your answer be?

SELF/BODY RELATIONSHIP

Using respondent's terms, ask about self/body relationship: e.g. for respondent who mentioned feeling strong in her running:

When you feel "strong in your running" is this strength in your body, your self, or both?

Do you ever feel like you have a body and you have a mind?

(Here I will have to play with whatever response I get. If the person dichotomizes readily, then I'll probe along those lines. If not, then I'll have him/her elaborate on homogeneity.)

HEALTH ACTIONS PAST AND PRESENT

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When you were a child, what kinds of things were you expected to do to be healthy?

Were there differences between what was expected of your brothers? your sisters?

What kinds of things did your mother do to be healthy? your father?

Did either of your parents jeopardize their own healthiness for your sake? your sibs?

Do you still do some ofthe things you did as a child to be healthy?

(If there has been a change:) How do you account for the change?

Do you think that when you are eighty, you'll have made more changes? If so, why?

We all have aches and pains. Which ones do you get? What do you do for them? Do you think other (men) (women) handle them the same way?

Think for a moment about the last time that you hurt yourself. what was it and what did you do? (I want to probe here for internal body vs, external body phenomena, so I'll have to find my way based upon the respondent's answer. If they start with external, I'll move to internal and vice versa.)

QUESTIONS RE: RISKTAKING

What risks do you take with respect to your own healthiness? (Publicly declared health hazards) Do you smoke? drink? drive fast? use seat belts? tend to be sedentary? Do you think these actions have any relationship to being healthy? Do you think other men/women your age act similarly?

Do you take precautions when using household chemicals (oven cleaner, flea powder, paint thinner, bleach, etc.)? Describe precautions and explain their purpose.

Using above answer for content of question, ask about cutting corners and taking on increased health risk. For example:
if the person normally wears a mask and gloves to flea powder the cats, propose a hypothetical situation in which the person is in a big hurry, but has to get the job done; then ask, how they would handle such a situation. Do they think others would handle it similarly?

For females: What would you do if you found a breast lump? What do you think a man should do if he has chest pains? Think of a man you know, how do you think he would act in this situation?

For males: What would you do if you had chest pains? What do you think a woman should do if she finds a breast lump? Think of a woman you know, how do you think she would act in this situation?

QUESTIONS RE: EXPOSURE TO MEDIA, HEALTH INTEREST & CONCERN

How often do you read health columns or listen to health programs on the radio or tv?

Do you have health books at home or would you like to?

Do these usually cover all the aspects of health that you consider important?

How often do you consult health advice literature? do you usually find the kind of information you're looking for?

How do you use this information?

How informed are you about health?

How frequently do you think about your health? Do you worry about your health?

QUESTIONS RE: COSTS AND BENEFITS OF COMPLIANCE WITH OFFICIALLY RECOMMENDED HEALTH PRACTICES

Do you change your behavior in any way in response to health warnings?

QUESTIONS RE: PERSONAL VULNERABILITY

Are there things which hinder your efforts to be healthy?

Is there a particular illness to which you think you are susceptible?

QUESTIONS RE: BELIEFS ABOUT CONTROL OVER HEALTH

What do you think should be done about the cancer problem?

In those cases where the person has mentioned some specific illness, how do you account for your hypertension, diabetes, etc?

QUESTIONS RE: SOCIAL STRUCTURE

Can you suggest any social changes which would make it easier to be healthy?

If you could arrange things in a way which would make you healthy, how would they be?

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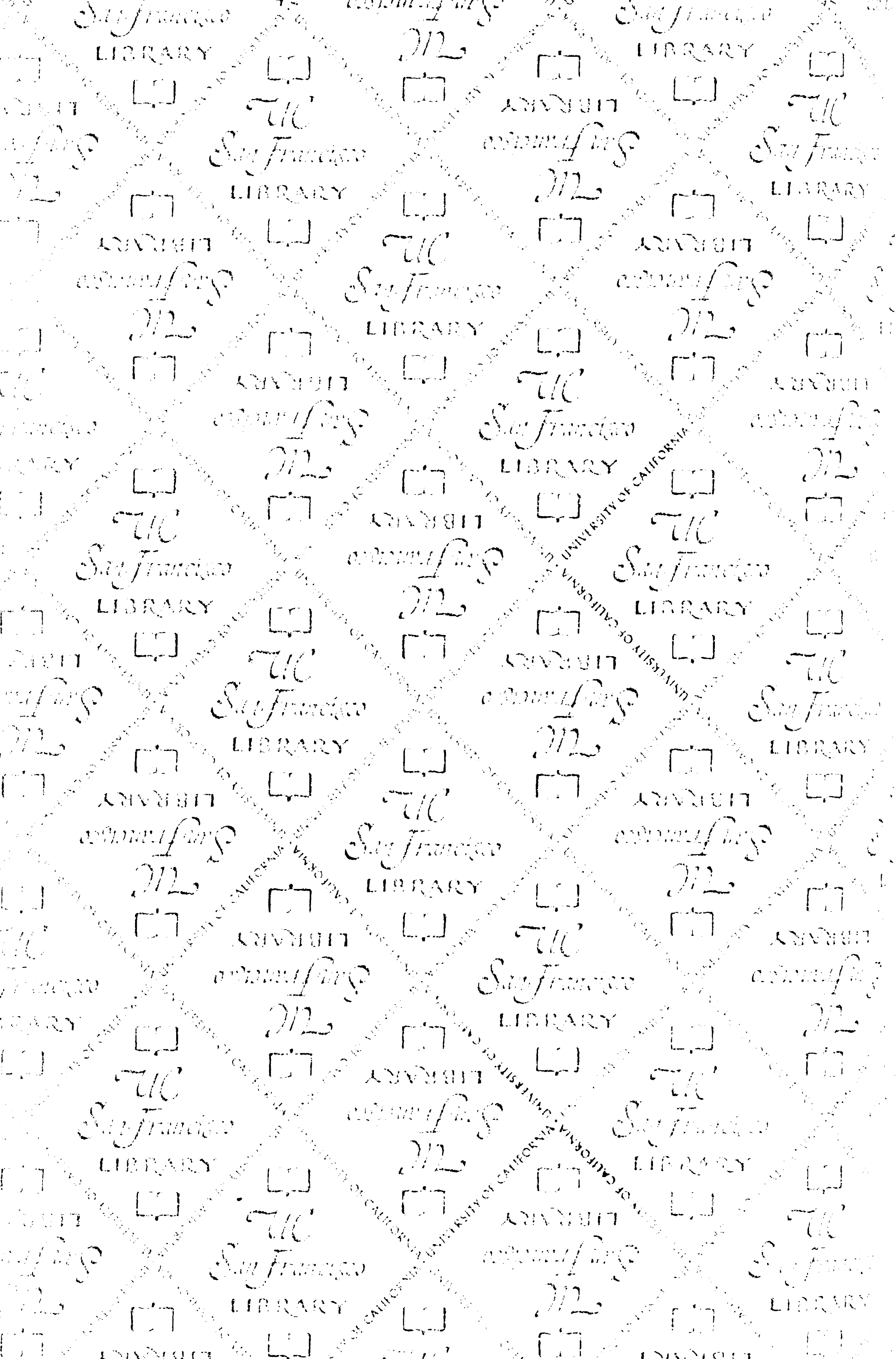
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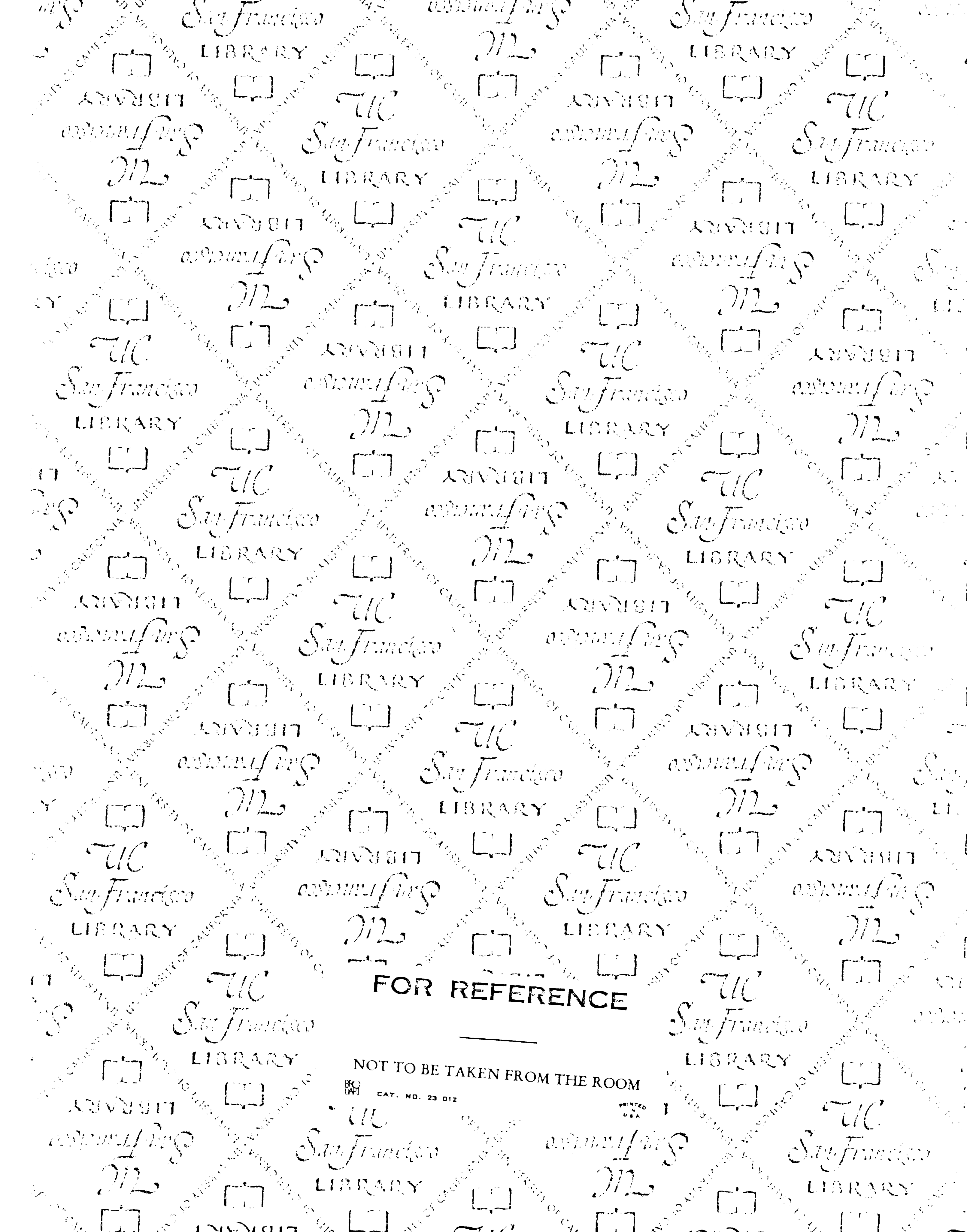

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