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Culture, Bodies and the Sociology of Health

Edited by

Elizabeth Ettorre

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CULTURE, BODIES AND
THE SOCIOLOGY OF HEALTH

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Culture, Bodies and the Sociology of Health

Edited by
ELIZABETH ETTORRE
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ASHGATE

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Introduction
Re-shaping Bodies in the Sociology of Health

Elizabeth Ettorre

'Fleshing Out' Sites of Illness, Leisure and Risk

Twenty-first century bodies are located in age, gender, race, ethnic, able bodied and class ranked positions, while these bodies are shaped simultaneously as sites of health, disease, leisure, technology, labour, emotions, attractiveness, consumption, style and risk. The body is a central element in the construction of the social and the focus of the private sphere, while the body has become the template upon which cultural identities are fashioned and through which public emotions and social problems are being played out. Embodied persons are 'productive bodies' capable of activities that change the nature of their lives, while also being 'communicative', 'powerful' and 'thinking' bodies (Burkitt 1999: 2) located in relations that transform their natural and social worlds. With regards embodied persons within biomedicine, there has been a lack of attempts to deconstruct 'the mobilising signifiers of health and disease' and more importantly, no one is able to exist as a fully embodied subject *vis-à-vis* medicine (Shildrick and Price 1998: 4–5). *Culture, Bodies and the Sociology of Health* is dedicated to the question of the body in health and illness and brings together critical scholars who interrogate bodies within the broad field of the sociology of health and illness. Our aim is to begin to open the discourses which fabricate our bodies and our health and illnesses and to demonstrate that our embodiment is 'provisional' (Fox 1998: 30).

The biomedical discourse on the body has become embedded in our modern culture over the past 300 years. Critical of medicine's lack of attention to the notion of lived bodies as fragmented, political sites, social science scholars have begun to situate bodies and issues of embodiment centrally within the domain of sociology of health and illness. Nowhere are these embodied matters more clearly demonstrated than in relation to health and illness (Williams 2004: 73). See also Frank (1991, 1995, 2004), James and Hockey (2007), Lupton (1994), Lyon and Barbalet (1994), Nettleton and Watson (1998), Shilling (2005), Turner (1986, 1992), Williams and Bendelow (1998), Williams (2003). In this context, Kelly and Field (1996) argue that in most types of sociological narratives about chronic illness, the body remains theoretically elusive and that medical sociology

has understated the central facts of bodily difficulties which are entailed in illness and disability. They contend that the existence of the body is seldom denied but its presence has a kind of ethereal quality forever gliding out of view (p. 242). At the same time, clinicians, experts and others working in the field of biomedicine continue to devise ways to transform the boundaries of healthy and sick bodies and to medicalize them.

Medicalization of the body is a dramatic part of the pervasive industrialization of the body; it is the 'apogee' of the modern political economy in which the human body is simultaneously celebrated and degraded under the banner of production, consumption and social governance (O'Neill 2004: 66–67). In an excellent piece on medicalized bodies, Hughes (2000) discusses how for biomedicine the body is 'pre-social' and has no history and furthermore, that sociological bodies differ from the medical body in that the former is contested while the latter is 'real' with an objective, scientific status (pp. 12–13). In referring to Foucault's *Birth of the Clinic*, Hughes contends that medicine becomes biomedicine when its scientific endeavours focus on charting the contours of normality and that biomedicine is concerned with a regular functioning of the bodily organism and identifying where this body has deviated, what it was disturbed by and how it is able to be brought back to working order (p. 15).

In a real sense, biomedicine has privileged a type of technoscientific, biological determinism to explain social injustice as natural and necessary, while economic inequalities, resulting in the experience of disease, inequalities in health, the subordination of women and people of colour, and the untimely HIV-related deaths of millions on a global scale are considered an epiphenomena of biology (Urla and Terry 1995: 2). Examining the links between the body and deviancy, Urla and Terry contend that biomedicine has been instrumental in privileging 'embodied deviance', the term they give to 'the scientific and popular postulate that bodied of subjects classified as deviant are marked in some recognizable fashion' (p. 2). Their main contention is that medicine along with the other modern life sciences with their powerful and outdated Western epistemologies has surveyed, observed, assessed and reported on bodies, while at the same time clinicians construct bodies through particular investigative techniques and culturally lodged research goals (p. 3). These authors (Urla and Terry 1995: 3) demonstrate quite forcefully that bodies are not natural entities with a generic core; rather bodies are effects, products or symptoms of specific techniques and regulatory practices – bodies are points on which and from which the disciplinary power of scientific investigations is exercised. The clear lesson we learn from this work is that bodies, whether sick or ill, bad or good, moving or stationary, are never free of relations of power. This is because medical and lay discourses always already bind bodies into larger systems of knowledge production and moral discussions.

While it is true that medical sociology has produced important contributions to the renewal of the body's conceptualization (Berg and Akrich 2004), an emergent and indeed important task of social scientists interested in health and illness is to bear witness to all forms of embodied oppressions and to contextualize both the

'healthy' and 'ill' body as a politically, morally inscribed entity, its biology and histories/herstories shaped by practices of surveillance, containment and control. Medicalized bodies are bodies embedded in moralities of health and illness, appearing as shaped by the 'individuality', 'freedom' and 'rationality' concerns of conventional bioethics. Yet, at the same time, post conventional moralities of health locate classed, raced, ethnic, gendered, disabled and aged, bodies as being 'leaky bodies' that is as bodies which undermine traditional binaries and challenge ontological and epistemological closure (Shildrick 1997) as well as biomedical fixity. When moral judgements are made about how ill health and health 'in bodies' affects relations of power, inclusion and exclusion (Ettorre 2005), bodies become more malleable and unstable as they are designated as healthier and less sick or vice versa.

While 'health' and 'ill health' are terms that are culturally and socially defined, all cultures have known concepts of these terms. These concepts vary from culture to culture according to how sick and healthy bodies become visible and more importantly, the magnitude and breadth of what Rosi Braidotti (1994) calls the scopic drive – a drive compelling bodies to be deeply involved in an 'ethics of risk' (Shildrick 1997: 212). Whether sick or healthy, bodies within biomedicine are viewed as empirical objects to be quantified, classified, surveyed and ultimately, controlled. Alongside these complex processes, new forms of social mediation are being developed under the guise of biomedicine. Late modern medicine or the new public health privileges risk and widens the relevant points of contacts between professionals and patients into different sites, locations and social interactions toward the social body (Bunton and Burrows 1995: 207).

As implied above, bodies, whether ill or healthy, normal or pathological, etc. are never free of relations of power. That drug use or obesity can be seen as examples of 'dis-ease' which stigmatize sufferers and that these sufferers may be rejected by a 'healthy', 'normal' population, tells us that the medical and lay discourses on health and illness or the scientific and popular ways of representing healthy and ill bodies are never value free. This is why Frank (1995) calls for an 'ethics of the body' as a model for those who are suffering or ill to embody empathy and 'be' with others in 'communicative' bodies. He contends that we need to research suffering and map stories which allow ill people to connect their stories to others and to recognize what stories they have not yet told (Frank 2001: 361). While Frank exposes how sick bodies are able to maintain ethical communication in the midst of corporeal 'breakdown', Braidotti (2006: 111) contends that an ethical view of communication is always already about accepting the impossibility of mutual reciprocity, central to neo-liberal forms of ethics and neo-liberalism itself. Braidotti argues for a bio-centered egalitarianism which undermines the individualism and sameness (i.e. we are all the same) of neo-liberal forms of ethics. For her, a bio-centered egalitarianism attempts 'to think the interconnection of human and non-human agents' and re-think the ethical and political position of 'a non-unitary subject' (p. 111). In effect, she replaces the unitary subject of neo-liberalism with a non-unitary subject of bio-centered egalitarianism who experiences co-dependency

and multiple belongings and redefines responsibility as a commonly shared sensibility (p. 149). Thus, for Braidotti, when we communicate with each other, we must respect our mutual co-dependency and accept at deep levels each others' multiple belongings (i.e. gender, class, race, ethnicity, age, health, nationality, and ability). Most importantly, we must accept diversity within the context of the neoliberal craving to keep us all the same. In the face of the spectacular effects of contemporary technological transformations in our world particularly in the field of biomedicine, we need to reassure those we communicate with how our lives are mediated by technologies and that it is 'OK' to feel overwhelmed given that we are surrounded by multi-layered and internally contradictory phenomena. Furthermore, history shows us that technologies become embedded in customs, procedures and societal structures (of which biomedicine is a part) that seem to inscribe themselves on the actions and identities of embodied individuals and often appear as fixed to new generations – the development of 'technological bodies' has long been steered by warfare and the economy (Shilling 2005: 179–80). Here, we need to present to others an honest picture of the technologies we use and why we use them. As Briadotti (2006: 160) implies, we need to be ethical subjects of sustainable becoming, that is we need to develop a sensibility to transformations and be able to sustain these transformations without cracking. Thus, our ethical becoming aims at joy and not destruction.

In an enlightening piece on how some feminist post-structuralist critiques have little to offer as an epistemological foundation for feminist health activism, Kathy Davis (2007: 61) contends that feminist theory does not need to distance itself from feminist health activism in order to develop an improved critique of science. Rather, in order for this gap between theory and action to be bridged, three reconceptualizations in feminist embodiment theory need to occur – reconceptualizations of 1) the body, 2) embodied experience and 3) epistemic agency. While acknowledging that this gap results from some feminist theorists rejecting experience as a 'suspect concept', Davis argues further that experience, specifically women's experience, provides an essential starting point for understanding the embodied and material effects of living under specific social and cultural conditions (p. 57). While *Culture, Bodies and the Sociology of Health* is implicitly feminist, Davis's contentions are useful for constructing this text's epistemological framework within current sociological thinking on health, illness and medicine. Simply, 'pondering experience' and attempting to deconstruct the key signifiers of health and illness provide useful tools for retrieving embodied experience as a theoretical resource when considering medicine, culture and society. To retrieve analyses of embodiment as concretely lived and experienced, the theoretician acknowledges how changes in 'techniques of ontological abstractions' (i.e. shifts in technological forms) are caught up with shifts in self understanding along with reconceptualizations of the embodied self (Cregan 2006: 7). The astute theoretician observes these shifts through historical comparisons within a culture or society or across different, contemporaneous social or cultural forms, thus wanting to avoid obsolete or Eurocentric notions

of the body and uphold contradictory forms of embodiment (p. 7). Aware that modern medicine is extremely technocratic, contributors to *Culture, Bodies and the Sociology of Health* draw on different bodies in different contexts and cultures as a resource for what it feels like to be healthy or ill, normal or pathological, good or bad, and moral or immoral.

Whether we see sufferers of ill health or 'dis-ease' as Frank's ethical communicators in the midst of corporeal collapse or Braidotti's ethical subjects of sustainable becoming, experiencing co-dependency and multiple belongings and redefining responsibility as a commonly shared sensibility is not the point here. Rather, the main focus is on the fact that medical discourses always bind bodies into larger systems of knowledge and ethics production. In an age of biopower, many disciplinary strategies (i.e. techniques of measurement, visualization and classification technologies) surround the body in a constant, continual never ending effort to construct and normalize bodies (Braidotti 1994: 60). *Culture, Bodies and the Sociology of Health* is an attempt to show that while our current social realities are entirely medicalized and medical sociology has not played a pivotal role in the theoretical progress of sociology (Turner 1992: 159–60), we want to change this state of affairs and offer contributions which require greater theoretical reflexivity. This demands a sufficiently grounded reflexive and critical sociology linked to the project of modernity and favouring the decolonization and rationalization of the lifeworld through active engagement in civil society and the public sphere (Scambler 1996 cited in Scambler 1998: 63).

A key issue addressed by contributors concerns how social science scholars should begin quite reflexively to situate bodies centrally within the sociology of health and illness. In particular, contributors focus their attention on a key question: How are social scientists best able to contextualize the notion of 'healthy' embodiment and to understand the conditions and experiences of 'healthy' embodiment *vis-à-vis* organ donor recipients' (Chapter 1), 'doped' (Chapter 2), running (Chapter 3), consuming (Chapter 4), medicalized (Chapter 5), ageing (Chapter 6), 'obese' (Chapter 7) and pregnant drug using (Chapter 8) bodies? As can be seen, these issues reflect the specific embodied focus of each chapter in the book.

If, as we know, medical and other sociologists (Charmaz 1983, Frank 2001, Wilkinson 2005) are able to transform a somewhat restricted medicalized view of the chronically ill person's pain into a broader view of suffering, social scientists pursuing a quest for a greater understanding of health and illness should create wider, more stylized 'infirmity identities' and embodiments that defy closure, while resisting scopic regimes, such as medicine, which authorize and legitimate a morality of health. In his/her own ways, each contributor contextualizes the boundaries between bodies and society and how these boundaries are becoming increasingly obscured. Thus, the particular focus of this book is more on how the construction of these boundaries structure power relations under the banner of health and how bodies of healthy and ill people have been shaped through various biomedical discourses, their morphologies transformed into 'alien' subjectivities.

While numerous, complex issues are raised in these chapters, each one reveals in its own way, the body, as being inscribed by culture and indeed, secured by culturally embodied differences. In this context, the boundaries between bodies and society with special reference to health are examined through the cultural meanings of kidney transplantation (Chapter 1); pathologizing of elite athletes (Chapter 2); non-elite road running (Chapter 3); perusal and use of fitness magazines (Chapter 4); the cultural gaze of the internet (Chapter 5); gerontological theory, gender and the body (Chapter 6); the 'genetics' of obesity (Chapter 7) and pregnant drug-using bodies as polluted (Chapter 8). While the main focus of this book is on the body in the sociology of health, the chapters are arranged under three broad headings, bodies and technoscience, bodies and representation and abject bodies.

Bodies and Technoscience

Contemporary biomedicine upholds various technologies as emblematic of how successfully medical expertise has been able to manage, alter, control and 'cure' the human body. In contemporary society, we are witnessing the immense explosion of medical technologies into many areas of modern social life. Cultures have become increasingly dependent upon advancements in technoscience. In turn, these resultant advancements sustain biomedicine as a dominant paradigm on the body in Western thought, as biology becomes increasingly the filter through which humans are expected to interpret the world (Lundin 1997). Interestingly enough technologies, such as genetic technologies, affirm political processes and in the field of reproductive genetic technologies, we can speak of 'prenatal politics' (Ettorre 2002). Most definitely politics are embedded in the use of medical technologies and we need to map out the implications of medical technologies for the material practices, complex processes, embodied experiences and cultural and social formations they produce. On the one hand, subjects of technologies are situated at intersections of the medical world, individual interest and relational obligations as well as being co-producers of technological practice (Cambrisio, Young and Lock 2000: 11). On the other hand, the application of specific ideological beliefs, knowledge and medical procedures are seen to be played out on 'docile bodies', viewed as the visible, organic or 'raw' material needed to fulfil the successful implementation and employment of various technological processes. The workings of technocience in biomedicine expose a modern unease that technological interventions on human bodies transform sick bodies from fragmented subjects with concerns for 'sustainability', 'responsibility', 'agency', and 'empathy' to fixed objects of medical care focused on 'beneficence', 'sameness', 'mutual reciprocity' and 'rationality'.

Within the context of the donation of kidneys in the Republic of Ireland, Ciara Kierans in Chapter 1, 'Transplantation, organ donation and (in) human experience: re-writing boundaries through embodied perspectives on kidney failure',

demonstrates how discursive practices on transplantation bring together organs, donor bodies, recipient bodies, identity, kinship and the public as a coincident location or biosocial space. For her, the convergence of the self and others through 'dead' and live organ donations has been accomplished through the convergence of ontological, biological and social domains in the discourse on transplantation. Key issues for her are the embodied consequences of dialysis and harvesting from the brain dead; the ontological implications and status of hybridity for bodies of organ recipients as well donor bodies and the immune system as the embodied ground of transplantation. Within the context of biomedicine, kidney transplantation has deep cultural consequences for human embodiment, social identity and medical governance. Most importantly, it has the power to shift our comprehension of the boundaries of life itself. Drawing on ethnographic work on kidney transplantation which Kierans conducted in the Republic of Ireland, she shows recipients' accounts of transplantation and introduces a new type of embodiment, the 'body-in-transplantation'. Her theoretical stance employs the notion of cyborg as a sensitizing concept indicating that science and technology continue to weaken the boundaries separating flesh and machine (Shilling 2008: 1). She contends that cyborg concepts have been both key practical and conceptual devices for describing the associated embodied, social and political implications of organ transplantation. The main aim of her paper is to uphold the importance of the recipient who has been traditionally absent from theorizing in much of the anthropological literature on organ donation and transplantation. She demonstrates quite effectively that the renal recipient does not necessarily encounter transplantation according to the hopes of clinicians, the public or researchers. As a final appeal, she asks those, social scientists in particular, involved in analysing this area of research to take a moral stance and be vigilant in ensuring that the embodied sufferings of all involved in this area become visible.

Taking a different tack on bodies and technoscience, the authors of the next two chapters view the body as a location for sport, positioning embodied subjects differentially within this cultural sphere (Shilling 2005: 104). Partaking in sporting activities implicates bodies engaging in cultural, material practices that give new meaning to temporal movements in social space outside biological, physiological and morphological body features and functions. Traditionally in popular culture, the movement of the body combined with the continual improvement in the efficient function and form of for example, a running body, emphasizes the body as a machine. A continuum of technologies from the banal to the spectacular capture this body and the idea of 'going to the gym' would not exist without the idea of the body as a high performance machine (Howson 2004: 89). Here, the concentration is on improving this 'machine'. Improving and maximizing performance, in particular for competition is the key. The focus of the sporting body on functioning, objectification and quantification implies that while this body can in principle be for leisure, play or recreation it is increasingly rationalized into a self-disciplined and self-regulated labouring body. In sport, social practices labour upon, discipline and transform the body (Shilling 2003: 96–7). In the course of this process of

embodiment, gendered, aged and 'abled bodied' bodies are marked out and altered by existing social inequalities that form women's and men's bodies, young and old bodies and disabled and 'able bodied' bodies. This process appears to strengthen normalized body images.

With regards biomedicine, the health of the body is not one that can be simply measured by being disease free but is one that must also be able to demonstrate its fitness through the appropriate body pursuits to achieve a desired, healthy body image. Biomedicine directed towards sports requires the existence of highly trained, highly paid, drug-free, record breaking bodies, while these bodies provide a basis on which rationalization in society can be naturalized and viewed as the fulfilment of human destiny rather than as a technologically directed process imposed on humans (Shilling 2005: 113). This is regardless of the fact that these bodies undergo multiple, biotechnical measurements of their physiological capacities such as blood volume, heart rate, oxygenation, etc. (Lorber and Moore 2007: 71). For an athlete, adding drugs and foods known as 'nutracueticals' to one's diet does not seem like a major step or technological intervention; it is just another part of the training routine (p. 71). However, being a 'juiced up' or a chemically improved, sporting body means an athlete is not adhering to anti-doping regulations.

In this context, Chapter 2, 'Normalized Elites: Rethinking Doping as Abnormal Practice' by April Henning focuses on the emergence of sports medicine, the subsequent trend towards medical technology as a training tool for elite athletes and the chemically enhanced, sporting body through what has been termed over the years as 'doping'. Hemming shows how issues of doping encircle most elite sports and how elite runners' bodies are concurrently classified as 'top athletes' by a number of key stakeholders as well as in the media. She draws a great deal on reporting on elite runners in the US-based specialist running magazine *Runners World* and other media. It becomes quite clear that athletes' bodies were gradually becoming a captive group of subjects as they provided indispensable promise for investigations by medical researchers. Looking critically at the regulatory regime of anti-doping in sport, she unearths a fundamental dilemma. Elite athletes as a grouping are both pathologized and normalized within the anti-doping culture. On the one hand, their bodies may depend on any available technology to enhance their performance which goes directly against the anti-doping culture, on the other hand, if their bodies do not depend upon any available technology this embodied 'lack' removes them from the expected values and practices within the culture of elite athletes. This is regardless of the fact that their lifestyles and values vary from those of non-elites athletes. Hemming's exposé signals the need for an understanding of athletes by anti-doping agencies – an understanding that is open to the defining features and representations of elite athletes' bodies as shaped in different way from the rest of the population.

In Chapter 3, 'Embodying a Healthy Running Body in a British Non-Elite Road Running Community', Carole Sutton also focuses on the running body but she does this primarily within the genre of autobiography. Her story is all about

how she has attempted over the years to embody a 'healthy running body'. This 'running story' is embedded in the method of autoethnography, which had its origins in anthropological work with the notion first being used by David Hayano (1979) in conjunction with the related notion, 'ethnographic autobiography'. While writing autobiographically is often seen negatively as a form of inexcusable self-indulgence, especially in academia, it is especially important for women to construct an authentic self in opposition to distorting cultural ideas in academia which shun the text as constructing subjectivities and corporeality as a subject of discourse (Oakley 2007: 23). Employing the method of autoethnography, Sutton opens up key concerns which enveloped her body's passage from an inactive to an active lifestyle. To set the scene, she examines initially the attractiveness of running in an international framework. She also reflects on the self-regulated running body within the context of consumer culture. Here, the modern individual in consumer culture is made conscious that he/she speaks not only through his/her lifestyle which becomes a 'healthy' life project but also through the aestheticization and stylized effect of his/her body on changing cultural contexts (Featherstone 1991: 86). While she uses an autoethnographic approach, she can be seen to identify herself alongside other 'postmodern witnesses' who have opened the way for health researchers to use autoethnography as a viable research tool (see Ettorre 2006). Certainly, in the last ten years, the area of health autoethnography has grown considerably, particularly in the field of nursing research (Foster, McAllister and O'Brien 2006, Ettorre 2010). By drawing upon personal data from her running diaries, she is able build a powerful embodied narrative of her running experiences and illustrates her, at times difficult, progression from a lone runner to a member of a non-elite road running club. One subtle theme which emerges is how while running may provide socially approved opportunities for both men and women to engage in such displays, there are definitely discernible gendered codes of conduct concerning degrees and forms of display (see Howson 2004: 75) for running bodies. In the end, we see how the intimate material she presents us with becomes the springboard for her further research on contemporary running bodies.

Bodies and Representations

The authors in this section of the book focus on social representations of the body, body practices and disciplinary regimes related to consumption, the internet and the discourse of gerontology, respectively. What is key here is how bodies are represented in order to be manipulated, managed and normalized through the relentless and constant engagement with the techniques of power, biopower. Shilling (2005: 2) argues that new forms of cultural consumption exhibit the sort of discipline, physical control and stylization commensurate with the display of a hyper-efficient embodied, performing self in consumer society. The rise of consumer society has given rise to a new body – the consuming body, a site for the

nurturing of taste, the production of desire and the selling and consuming of goods, services, and pleasures (Falk 1994). Consumption involves the pursuit of embodied lifestyles through the acquisition of desired goods that suggest shared symbolic meanings and codes of stylized conduct. Identifiable regimes of modification or discipline are used to improve or perfect our bodies. We can identify bodily regimes of dieting, weight-watching, self-starvation, body-building, weight training, running, cosmetic surgery, reconstructive surgery, liposuction, yoga, competitive sport, military drills, meditation work, taking drugs – laxatives, and so on.

In Chapter 4, 'The Visible Body: Health Representations in a Consumer Society', Rui Gomes' bold contention that the moment we are living in, 'contemporaneity', emerges as a new visual regime marked by the growing power of visible techno-representations of present day bodies. His ideas on 'contemoraneity' shape his conceptions of body experiences as a product of medical-normative and moral discourses on the body. Doing a content analysis of media discourses in social identities construction in Portugal, he contends that uncertainty is a sign of the present day body crisis which appears alongside the image of a perfectible body. Gomes argues that images of (un) regulated bodies are not only empirical characteristics of these 'deviant bodies' but also the effect of discourses about bodies which emphasize the importance of the links between body shape and health in our consumer societies. Also important are 'new' body leisure activities such as yoga, tai-chi, bio-energy, relaxation techniques, etc. which are emblematic of the contemporary fascination with the embodied self. Gomes argues that this narcissistic fascination implies conquest of one's body 'innerness' and is the basis for self representations of one's embodied performances. For him, these are relatively novel self-representations which articulate a normative narcissism. These body leisure activities or self-knowledge technologies produce 'prerogatives' of the self from which emanate a movement of consciousness as well as an awareness of cultural responsibility. His conclusion is that we must contest the belief that each body is solely accountable for his/her condition, improving his/her body's reliability, remaining 'young' and his/her commitment to self-preservation.

While the majority of us are engaged in some kind of body project, body training or body discipline, this may reach an extreme or excessive level in one's efforts to perfect the body. If we strive for this ideal or perfectible body, we may be seen as well disciplined but we may also be seen as 'sick'. This is because biomedicine has identified anxieties, phobias, and obsessions underlying various illnesses. Two of these anxieties, phobias, or obsessions, self-starvation and the desire to amputate part of a limb, are analysed in Peter Conrad and Ashley Rondini's work, *The Internet and Medicalization: Reshaping the Global Body and Illness* (see Chapter 5). They begin their piece with the assumption that the world wide web has become a medium for endorsing or criticizing medicalized approaches to human troubles. Indeed, the internet has facilitated the extension of medicalization debates on a global scale. The individuals involved in Conrad and Rondini's two embodiment quandaries employ the world wide web to advance

their opinions and assert their demands. Anorexics search for demedicalization and a certain amount of legitimacy, while wannabe amputees desire the opposite, medicalization in order to be cured. The authors contend that web activities of pro ana sites demonstrate the emergence of a global 'counter narrative' in opposition to the medical opinions that are accessible universally. On the other hand, 'wannabe amputees' or 'transabled bodies' share their desire to having their 'disorder' recognized as a medical problem, Body Integrity Identity Disorder or BIID. While the former group's bodies may be emblematic of our culture's obsession with non attainable ideals of attractiveness and conventional body shape and size, the latter group challenges established conceptions of disability, choice and medicalized bodies. While all of us experience the social and cultural burden to shape our bodies according to precise body images, pro ana bodies expose identifiable regimes of conceivably excessive discipline and bodily control, while 'transabled bodies' depict particular regimes of possibly extreme bodily modification – all done in the context of improving or perfecting one's body. What the construction of these bodies tells us is that while there may appear a variety of social bodies to choose from in society, the sorts of regimes in which medicalized bodies are conceived have different meanings for different individuals. Throughout human history, and in different cultures, we have decorated, clothed and modified our bodies in different ways to fulfil particular cultural and social purposes. Indeed, the body is a bearer of symbolic value and a form of physical capital: a possessor of power, status and distinctive symbolic forms that is integral to the accumulation of various resources (Bourdieu 1984). Nevertheless, individuals and groups have unequal opportunities for producing symbolically valued bodily forms and converting them into other resources. In this sense, medicalization may appear as an additional extra, but it appears as essential in helping to shape the desires and body practices of both anorexic bodies and wannabee amputees.

Most dominant groups in society tend to have the ability to define their bodies and lifestyles as superior, worthy of reward, and as, metaphorically and literally, the embodiment of superiority. One group which suffers from this embodiment of superiority is older people who are typically regarded as lacking rigour and intelligence and often become object of derision and ridicule (Biggs 2002: 167). With these ideas in mind, Jason Powell looks at how the ageing body acquires meaning as well as the uncertain representations of the ageing body in western culture in Chapter 6, 'The Ageing Body: From Bio-Medical Fatalism to Understanding Gender and Biographical Sensitivity'. To understand gender and the ageing body, Powell speaks to the question as to how a meaningful body is able to relate to social and cultural exertions. Of particular interest is his desire to consider the significance of the ageing body and ageing identity *vis-à-vis* feminist theory as an interconnector of gender and aging. In addition, he demonstrates why a biography of ageing is needed in the field. Powell deconstructs traditional gerontology and exposes the notion of the lifecourse as a linear trajectory, time as a finite resource, ageing as a one-way process (Featherstone and Hepworth 1998: 149) and getting old or increasing in age as an unchanging set of life 'stages'.

Powell's awareness of the need for an embodiment view on ageing reveals that the modern discourse on the ageing body as in decline or dying is yet another discourse imposed by medical science (p. 153). His challenge directed towards gerontology, specifically American gerontology, is an attempt to expose the fundamental ontological problems with disengagement theory. He contends that at heart, disengagement theory helps to mould negative cultural narratives, images and representations of ageing. The problem is not only disengagement theory's functionalist roots but also the effective ways it obscures how older people can 'intertextually' create positive narratives of old age by re-constructing these negative representations and explain more clearly their own embodied representations of their own identities. The evocation to consider biography as being essential when considering gendered older people's meanings and experiences of embodiment is innovative and refreshing. It is a confrontation with traditional gerontology with its paradigmatic, 're-territorialization' of the ageing body which denies difference, agency, subjectivity and the material body to old people, mirroring the embedded traditions of bioscience and contemporary cultural practices towards ageing. For Powell, to appreciate biography in this field is to re-construct gerontology into a more reflexive study which is deeply aware of the limits of gendered representations and perhaps, more importantly which is fully cognisant of how effective social science needs to clarify our grasp of the relationship between states of individual consciousness and social and cultural life.

Abject Bodies

In relationship to the body, biomedicine tends to overlook difference, agency, subjectivity and the cultural implications of materiality. In contrast, a more recent social science mandate has been to bring whole, sentient bodies back into our social consciousness. One key aim has been to generate an awareness that the traditional neglect of the body reproduced in a non-reflexive, imperialistic, hegemonic sociology naturalized bodies and legitimated control of privileged bodies over less privileged ones. In this context, feminists have documented the types of regulation, restraint, provocation and resistance experienced by gendered bodies. Anne Witz (2000: 2) contends that our disembodied sociological heritage includes a history of 'her excluded body' and 'his abject body' and she cautions that the recuperated body in sociology is in danger of being the abject male body. This is a warning which must be heeded. While we need to reclaim the lived experiences of both the excluded and abject body, we should become increasingly aware that what bodies experience, feel, suffer, bear, desire and consume should be the foundation stones for our sociologies (Frank 1995).

Regardless of the culture, society or defined social space in which certain individuals find themselves, some are viewed as more abject than others. Here, abject refers to the realm outside of culture which threatens to reduce culture to chaos; 'it is shapeless, monstrous, damp and slimy, boundless and beyond the

outer limits' (Brook 1999: 14). Being abject places the one who is perceived as being abject in a liminal state. Being abject emphasizes that one has failed as an acceptable member of society and confirms the essential monstrosity of one's body – their abjection. As long as the monstrous remains the absolute other in its corporeal difference it poses a few problems and can be clearly put into an oppositional category of 'not me' (Shildrick 202: 2–3). Abject is not about affirming positive aspects of embodiment and subjectivity. Rather, abject denotes negativity. In examining the relationship between abjection and disgust, Ahmed (2007: 88) argues that when we think about how bodies become objects of disgust, we come to see how disgust is crucial to power relations and how becoming an abject body is all about the powerful role disgust has in the 'hierarchising of spaces as well as bodies'.

The notion of abject bodies as referring to the space outside of culture is clearly shown in Chapter 7, 'Where the excess grows': demarcating 'normal' and 'pathologically' obese bodies by Shirlene Badger. Badger shows how obesity is viewed as a public sickness, in everyday parlance as well as a corporeal manifestation. She contends that regardless of complicated knowledge bases regarding the causes of obesity between and within various disciplines, the obese body is perceived to be fairly obvious circling around a straightforward 'equation of input and output'. Her chapter demonstrates quite clearly that representations of this abject, obese body hold progressively more power in political, health, scientific and lay discourses. Those with obese bodies connect with these representations in a variety of ways and Badger argues that there is an array of norms that can be ascribed to these bodies – normalizing some body parts, while pathologizing others. This occurs through a wide range of regulatory regimes as well as become embedded in the subjective experiences of those with obese bodies.

Badger uses data drawn from an ethnographic study that focused on 'genetics of obesity'. The study included observations of obese children and their families interested in investigations on genetic causes for obesity. Embodiment runs throughout her chapter as she concentrates on the bodies of obese children and how they perform in different contexts. Abjection also is at the central core of her arguments. In this context, abjection is a kind of sickness; a horror at the body's vulnerability to a blurring of self (O'Connell 2005: 218). Thus it is not surprising that the sorts of images which emerge about respondents' bodies are both bizarre and commonplace. By plotting stories using snapshots from her ethnographic work, Bader designs these stories as two types of moments: fictional and political and she does this in order to demonstrate that these moments are proof of the 'generalizability' and 'assumed knowing-ness that is inferred on the obese body'. In this chapter, 'The Bridget Jones moment' helps to merge fiction and reality to highlight the numerous ways the obese body that can be played out at any given time. For Badger, the disease of space and preoccupation with the obese body of the younger generation conflicts with the specifically normalized opinions of the older generation about the larger body. This is an issue which needs to become more visible in contemporary society.

In Chapter 8, 'Bodies, Drugs and Reproductive Regimes', Elizabeth Ettorre looks at the reproducing body as a 'type of embodiment' that is available to drug using women within the regulatory regime of reproduction. For a woman drug user, being abject involves her body being disciplined by specific rituals and regulations of containment, invoking notions of embodied, monstrous deviance, abnormal activities, inexcusable performances and involvement in what is perceived as 'bad' material practices. While the cultural representations of pregnancy and drug use are presented, the author analyses the regulatory regime of reproduction with special reference to the power of normativity surrounding pregnancy and drug use. The author makes visible the 'real' material sites upon which the 'madness' and disorder of female drug use are inscribed. Many discourses (e.g. biomedical, legal, media, drugs, etc.) regulate this gendered body and shape it as a deviant, abject and 'monstrous' – one to be disassembled and reassembled and coded into diseased objects of knowledge and sites of intervention (Urla and Terry 1995).

In this chapter, we come to understand that the pregnant drug using body is not only the abject body who threatens to leak but also the 'bad' body whose leakiness contaminates the rational, public world of the logocentric economy. This body infects or contaminates the intimate, private spaces related to goodness and badness, inside and outside, self and other and mother and fetus. Reproductive bodies, both drug using and non-drug using, are necessary within 'the somatic society' as they become visualized through the 'scopic drive'. A main aim of the chapter is to see the importance of resistance to the dominant ideologies of reproduction by those, such as pregnant drug users, who can be seen to embody a political identity, opposition to this sort of visualization and a type of adversarial consciousness. In a 'cyborgian' sense, this means that many, if not all forms of women's embodiment are deeply related to their adaptation to normality and cultural management on a global scale. Female bodies do matter in this global assimilation or manipulation. Attitudes towards, values about, discourses on and tools of prevailing technologies surrounding pregnancy and drug use enforce and shape novel cultural relations for women's bodies on this global scale. A cyborg identity gives potential embodied agency to those declined secure 'race, sex and/or class membership' such as women drug users who are able to have the cultural know-how in interpreting networks and/or technologies of power. What becomes clear from this chapter is that the drug field cannot retreat from these systematic regulatory practices. That the technologies surrounding drugs use and the scientific discourses about drugs are employed to inflict enforced representation and constant abuse on the basis of race, gender and class may appear at first glance as shocking. However, it is a truth which needs to be told.

While we will see in reading the work in *Culture, Bodies and the Sociology of Health* how medicalized bodies are pressed into constant normativity, those with ability to read 'webs of power' may champion their own survival and social justice. Yet, resistance is not always cultivated by those who are subjects to biomedicine. While the chapters in this book are empirical and theoretical explorations which illustrate the importance of contextualizing the body as a cultural entity, they

demonstrate that the spaces and boundaries between healthy bodies are becoming more diverse than ever before on a global level. A key element of these explorations is how a morality of health embedded in our cultures has been concerned with constructing the material, fleshy body as well as surveying, managing and controlling it and its movements. After reading these texts, we become clear that uncovering the more hidden aspects of the cultural fabrication of health requires detailed examination of the regulatory practices used by experts in biomedicine and the material requirements of our global consumer culture which target bodies. This development involves an understanding of the intricate processes by which the age of modernity marks the emergence of the material bodily self at the centre of our theoretical attention. Re-shaping bodies in the sociology of health means that we must re-shape our political awareness of the body as well – a goal which has scholarly interest for all social scientists interested in embodiment theories and reflexivity.

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PART I
Bodies and Technoscience

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Chapter 1

Transplantation, Organ Donation and (In)human Experience: Re-writing Boundaries through Embodied Perspectives on Kidney Failure

Ciara Kierans

New Medical Technologies: Biopolitical Arenas

Organ transplantation is one of the most potent symbols of what social scientists have come to term 'the new medical technologies'; powerful tools, treatments and procedures that emerged as a result of rapid technological development, innovation and the shift to the paradigm supplied by the new genetics. They have, in turn, profound implications for human embodiment, social identity, forms of medical governance, the distribution of medical resources and our understandings of the borders of life itself (Casper 1994, Davis-Floyd 1994, Dumit 1997, Lock et al. 2000, Rabinow 1996, 2000). In all their various forms, medical technologies involve deeply embedded ways of organising and reorganising the parameters of health, healing and the human body. Integral to contemporary biomedicine, and part of the 'taken-for-granted' background against which it operates, medical technologies have been, for some time now, a critical resource for social scientists who wish to examine the complex ways in which the practices and productions of medical knowledge connect up with power relations, the human experience of health and illness and new possibilities for living and dying (Foucault 1998 [1976], Latour 1993, Rabinow 2000). This chapter elaborates on these themes, providing an introduction to work in this area with specific emphasis on the technologically mediated relationship between the reconfigured body-in-transplantation and the experiencing subject.

'The Shock of the New': Lessons from the Past

A few words of caution are needed before proceeding. The growth of social scientific studies of technology and medicine in recent years testifies to our contemporary preoccupation with the new. It is critical, however, that we do not fetishise technology as an exclusively contemporary problem. It is important to

remember that current attempts to think systematically through the multiple ways in which technology impacts upon society owe a great deal to work that came before. Discussed at length by both Marx and Durkheim, and representing central themes at all stages in the development of sociology and anthropology, technologies have long been recognised as both determinants of social structures and as phenomena forged within the crucible of social relationships (Durkheim 1982 [1912], Marx 1968 [1852], Turner 2007). Within early work on this subject, a key role was given to the body-in-society, as the productive source of technological innovation (Marx and Engels (1940 [1846]). At the same time, the body was also increasingly cast as a key site at which power could be exercised, as bodies come to be increasingly invested, invaded and reconstructed by processes made possible by technological innovation and advancement – principally those associated with the rise of the modern factory system and the disciplinary forces it was able to harness (Foucault 1977).

When carried forward and applied to the new medical technologies (the focus here), these insights about the duality of technology, as both master and slave, product and cause, agent and effect of socio-cultural change, retain their validity. Indeed, it is precisely these ways of thinking about the social, cultural, economic, political and embodied implications of technological practice, which reflect what the philosopher Michel Foucault sought to capture through his studies of 'biopolitics' and the production of 'bio-technico-power' (Foucault 1998 [1976]). This modality of power centralises the ways in which the human body, individually and collectively, can be altered and augmented 'making good the deficiencies and finitude of one's natural endowment' (Jackson 2005: 120). Tracing biopower thus helps us to see the complex network of connections between, on the one hand, developments in medical knowledge and innovations in medical practices and, on the other, the various social and cultural systems these developments emerge within but which also, once in place, part determine the shape those developments will go on to take and the points at which those processes will terminate.

Turning from theoretical questions to more substantive empirical ones, the main methodological lesson to be drawn is this: when setting out to understand practices like transplantation the researcher must move beyond restricted conceptions of either the medical setting or technical act alone, to take up positions where it becomes possible to see the role those practices play in much larger socio-medical processes. This is easier said than done. These larger processes are highly complex and their significance deeply contested. As a result, the new medical technologies have come to represent, at one and the same time, material promises of utopian futures as well as harbingers of coming human-generated catastrophes (Turner 2007). From bioengineering to nanotechnology, scientists, engineers and doctors conjure the prospect of 'living forever' through awe-inspiring advances in such diverse fields as therapeutic cloning, stem cells and 'immortal' cell-lines, 'smart' pharmaceuticals, and micro-medical disease detection processes that operate at the molecular level (Turner 2007, Williams 2003). Meanwhile, those working at the other end, on the development of reproductive technologies, tell us that we

are progressively extending our ability to control the manner in which human life comes into the world by removing the residual uncertainties which surround our entrance on the stage through the gradual 'taming' of the 'wilder' aspects of conception, pregnancy and birth (Casper 1995, Davis-Floyd and Dumit 1998, Rapp 2000). As Marx prophesised, our biological 'species being', our 'bios', appears to be being brought under our direct control (Arendt 1969, Marx 1970 [1846]). At the same time, however, those self-same technologies have given rise to deep-seated anxieties about the hubris of knowledge, captured in speculation about unforeseen dangers: fears about iatrogenetic risk in nanomedicine exacerbated by uncertainties in the ways we evaluate the toxicity of nanoparticles (Renn and Roco 2006); about increased population survelliance as genetic screening becomes further embedded as a technology of government (Armstrong 1995, Kaufert 2000); over the bioprospecting of cell lines and the struggle between indigenous communities and multinational biogenetic companies over 'rights' to genetic 'property' (Lock 2007); over the commodification of the body parts used in organ transplantation (Scheper-Hughes and Wacquant 2002). All these fears and more besides combine to suggest that if the new medical technologies provide a map of the future, it is one in which monsters lie.

Utopian visions and dystopian anxieties notwithstanding, these technological advances, according to Paul Rabinow, stand to be a greater force for reshaping society and life itself than the revolution in physics, because of their far reaching consequences for identity, kinship and reproduction, what Rabinow has termed 'biosociality' (Rabinow 1996). The human genome project, to take one of the more remarkable examples, has forever altered our understandings of biology and nature, once viewed as immutable and fixed, but now fundamentally repositioned within the domains of society and culture, collapsing prior and held-to dichotomies of nature/nurture, science/culture, human/machine, individual/group and local/global (Hellman 2007, Rheinberger 2000). Moreover, how we understand this 'power'-full domain, has, according to Jackson, been somewhat too restrictive to medicine, obscuring the wider influences of venture capital, political and corporate imperatives. Michael Jackson suggests we have too often neglected how new medical technologies are embedded in the structures of global capitalism, 'particularly, in the ways in which corporate and state interests in the north compete for control over this new form of power – in roughly the same way that the terms eugenics – the "old genetics" – once disguised insidious state programmes for the manipulation of individual fates and national destinies' (Jackson 2005: 120). As a consequence, for Jackson, analysis of the new technologies must begin 'not with an attempt to evaluate their ethical, economic and political implications for our future, but with a critique of the ways in which these technologies are already implicated in global patterns of inequality and injustice' (Ibid, 120). These position-takings seem to call for clear-eyed evaluation on biomedicine, one neither rejectionist nor duped. However, the extent to which the social sciences might go about providing this is a matter for debate. What I want to do next is look at the main ways in which social scientists have gone about orienting to these problems.

To do this, I want to propose three analytical starting points from which a range of social theorists have chosen to open up the problematics attached to technologies. They will form an analytical backdrop against which my later discussion on organ transplantation and 'recipiency' will be placed.

New Medical Technologies: Key Methodological and Analytical Constructions

Some key analytical positions have been drawn upon to help us make sense of this rather dispersed domain of inquiry incorporating many biomedical specialities, theoretical concerns and methodological standpoints. Representing alternative ways of addressing similar sets of problems, but beginning from different starting points and moving in different directions, they, in turn, help us to think about how transplant technologies have come to be written and understood within the social sciences. Just as importantly, they also highlight what has been neglected or rendered invisible through the production of debate. While not wishing to review an entire field of research, I want to draw attention to these three dominant modes of thinking about technologies as they relate to intersecting bodies of academic work. For the purpose of this chapter, they will be considered in terms of (1) assemblages, hybrids and cyborg constructions; (2) the social practices and procedural work of biomedicine and (3) anxieties, transgressions and boundary concerns.

Assemblages, Hybrids and Cyborg Constructions

A core construct is that of the cyborg. Cyborgs may be considered as sensitising concepts, theoretical and rhetorical devices that force us to look at the new social relationships produced through biotechnical and biorobotic practices, and the human body as neither entirely natural nor artificial. In her *Primate Visions*, Donna Haraway defines the cyborg as an entity in which,

> ... two kinds of boundary are simultaneously problematic: 1) that between animals (or other organisms) and humans, and 2) that between self-controlled, self-governing machines (automatons) and organisms, especially humans (models of autonomy). The cyborg is the figure born of the interface of automation and autonomy (Haraway 1989: 139).

Haraway draws on Marx, to show that cyborgs become a route to looking at 'the new social means of technoscientific production'; new ways in which we organise our lives (Haraway 1989). This has involved an inevitable re-evaluation of our changing positions as subjects-in-the-world by focusing on the new forms of embodied experience that have become possible through social-technological relations. In health and medical arenas, cyborgs emerge as the result of a wide range

of interventions from prostheses, sensory technologies and implantable devices alongside technologically aided ways of seeing, scanning, screening, testing, researching and so on (Casper 1995, Davis-Floyd 1994, Ihde 1990, 2007).

Among the many examples to chose from, Monica Casper's work on reproductive technologies has been particularly instructive of what we get from using the cyborg concept. Through an examination of the ways in which pregnancy and the bodies of women are put to an increasing range of uses, and with consideration for both the ontological and epistemological construction of cyborgs, Casper questions why we should classify anyone or anything as a cyborg in the first place. While Haraway talked about the new social relations of techno-scientific production, she was not simply talking about the degree to which technology penetrates our everyday lives, she also meant that there are real social, political and economic outcomes to these processes, that necessitate us keeping power as central to our understanding of the cyborg. Casper's work does just that, as she charts some of these outcomes in relation to the highly contested uterine space of a pregnant woman's body (Casper 1995). In doing this, she draws on six ways in which cyborg theory can be used to critically examine current developments in medical practice and reproductive technologies and the ways in which pregnant women come to be redrawn into these hybrid ontologies. These include: (1) technologies of vision, such as ultrasound, which enable a foetus in utero to be seen by those outside; (2) technologies of diagnosis, such as amniocentesis, which transforms the foetus into clinical data, and re-configures when pregnancy might be considered to start or end; (3) technologies of life, through postmortem maternal ventilation, altering our understanding of motherhood from a natural embodied state; (4) technologies of death, for example abortion, and the ways in which foetal cyborgs acquire new uses for research and therapy; (5) technologies of pain, such as foetal wound healing mechanisms or cosmetic surgery, where foetal cyborgs are reconstructed through research on animals and in vitro simulations; (6) technologies of healing. Incorporated here are are numerous examples of standardised technological interventions in the course of prenatal care which lead to the construction of medical cyborgs, such as, the use of pharmacological agents, nutritional supplements for foetal development, foetal blood sampling and so on and the prospective inclusion of gene therapy, foetus-to-foetus transplantation and experimental foetal surgery. Casper argues that these technological practices have made possible the emergence of a plethora of foetal cyborgs and technomoms transforming them from natural, organic entities into a very different kind of site within medical practice. These technological complexes change what it is to be a mother and help us to recognise that mothers are not everywhere the same.

Turning to organ transplantation, in very similar ways cyborg concepts have been both key practical and conceptual devices for describing the associated embodied, social and political implications. These include the ways in which the boundaries of the body profoundly change through dialysis (Hables Gray 2001) the reconstitution of categories of life and death through technologies of harvesting from the brain dead (Agamben 1998, Hogle 1999, Lock 1996); the

reconstruction of the relationship between self and other through cadaver and live organ donation (Sharp 2006); the ontological implications of hybridity for the experiences of organ recipients (Kierans 2005) and the ontological status of the donor body (Hogle 1995a).

That transplantation practices impact profoundly on the organic unity of the body have for some authors been seen as a threat to the embodied self, an end point in biomedical dehumanisation (Young 1997). For others, cyborg possibilities can be experienced as a means of embracing new conditions for living through extending the boundaries of embodiment. In her attempts to fully engage with hybrid forms, Donna Haraway conjures a vision of the future which suggests ' … a cyborg world might be about lived social and bodily realities in which people are not afraid of their joint kinship with animals and machines, not afraid of permanently partial identities or contradictory stand points' (Haraway 1991: 154). In contrast to the horrors, hybridisation can be considered part and parcel of the human existence and social life in societies and cultures, past and present.

> We are all Creoles of sorts: hybrid, divided, polyphonic and parodic, a pastiche of our Selves. The contemporary body-self is fragmentary, often incoherent and inconsistent, precisely because it arises from contradictory and paradoxical experiences, social tensions and conflicts (Van Wolputte 2004: 263).

As I will go on to show these aspects of contradiction, partiality and disjuncture are useful for thinking about organ 'recipiency' and how renal patients, in particular, piece together new ways of living and experiencing their bodies. Hybrid lives not only reveal new ways of being alive and living, but profoundly alter the phenomenology of bodily experience and bodily processes. These are brought dramatically into relief through the technologies of dialysis and transplantation, where the body's internal mechanisms are no longer concealed but visible, audible and tangible (Kierans 2001, 2005, Leder 1990).

Social Practices and the Procedural Work of Biomedicine

There has been a tendency to see new medical technologies as constellations of material objects. Social scientists have reacted to this by treating them as phenomena brought into being as the outcomes of particular cultural and institutional practices (Barnes and Bloor 1996, Knorr-Cetina and Mulkay 1983, Latour 1987, Rabinow 1996, 1999, Latour and Woolar 1986). These authors have been major contributors to a growing body of ethnographic work with a concern for how science and technology gets 'done', is put to work, within their local contexts and have been hugely influential in helping us to navigate the disjunctures between bodies of knowledge and knowledge construction and the differences between the reconstructed logics of scientific knowledge versus the logics-in-use of scientific practices (Kaplan 1968, Rabinow 1996, 1999). For sociologists of

scientific knowledge, scientific communities – like any other community – are characterised by networks and forms of social interaction, and their work – like any other forms of work – couple the informal and accidental along with the formal and procedural.

Consequentially, biomedicine, technology and disease are in no way independent formations, privileged a priori as external to culture. Medicine and its objects are not objects-in-themselves, but, as Anne Marie Mol explains, objects-in-action, enactments, ways of doing things, part of the highly differentiated and mundane work of those who practice medicine (Mol 2002). It is through these everyday practices, that the objects of interest here, diseases, organs, body parts, pharmacological processes, technologies, interventions, organisational rules and bureaucracies, come into being, emerge or recede, becoming matters of concern and action for specific groups of people.

Transplantation technologies therefore emerge as part of a complex socio-technical apparatus, an assemblage composed of bureaucracies, bioethical legislation, power relations, different types of medical personnel, cultural constructions of death, dying and the body, specialist diagnostic methods, technical procedures, pharmaceuticals, machines and regulatory frameworks, and so on, all of which work to make transplantation possible. The distinctions between scientific protocols or procedures and ways of implementing and applying them have also been fruitfully problematised by researchers of this kind and there are key examples which focus on transplantation and organ procurement.

In a paper focusing on how protocols for organ procurement are 'worked through' at the local level, Linda Hogle, for example, describes how the standards in assigning donor cadaver status – which are assumed to be employed uniformly across institutional settings – are very often reinterpreted, modified or resisted in local contexts (Hogle 1995b). Veena Das provides a similar account of the disjuncture between 'rules and their execution' in her work on transplantation in India, where she describes the complex cultural interpretations which are brought to bear on the legislation on brain stem death (Das 2000). She points out that protocols and rules are not descriptions of events, but subject to intense negotiations between different stakeholders in the clinical environment. Margaret Lock makes similar points when comparing transplantation practices across cultures. With attempts to 'pin death down' in the debates on brain death, Lock explains that while standardised criteria for determining death in Europe and North America have been in existence for two decades, the guidelines and procedures are not necessarily referred to in the same ways, with often conflicting accounts about the value of confirmatory procedures (Lock 2000). When comparisons are made to societies like Japan, the ground of argument becomes even more contested:

> In North America … a brain dead body is alive, but no longer a person, whereas in Japan, such an entity is both living and a person, at least for several days after a declaration of brain death. Because, in the Japanese case, the social identity of brain dead patients remains intact, a brain dead body cannot be easily made into

> an object and commodified, but continues to be invested with 'human rights' (Lock 2000: 256).

In discussing the surgical management of organ procurement in the US, Sharp remarks on the unusual fact that though organ donors have legally and officially been declared brain dead, they are nonetheless given anaesthetic. When exploring the matter further through interviews, Sharp's questions were met by a wide variety of responses, from the need to suppress residual spinal activity to the importance of relaxing the donor body so that it will not move during surgery, to quelling residual anxieties among surgical staff (Sharp 2006).

What people who have adopted these perspectives on science and technology have taught us is that we should be cautious in accepting that pictures of complex technocractic processes are necessarily guides to how they operate. Representations, as a result, only acquire their meanings within systems of practice (Wittgenstein 1953). On their own, they tell us nothing. This body of studies helps to produce an understanding of technologies in-use, designating for them a cultural and human ground of action. They also enable us to move technology out of the 'black box', where it often resides as a specific kind of object with discernable causes and effects (Latour 1987).

Anxieties, Transgressions and Boundary Concerns: Technology at the Intersections

As was discussed earlier, it is almost impossible to introduce the subject of technology without concern for the anxieties provoked and unsettling worries that something precious has been transgressed. In discussing the ambiguities attached to technology with reference to genetically modified crops and gene technologies, Jackson, for example, returns to the fact that we find little that is actually new in current debates about the dangers posed by advanced technologies. Biotechnology, in Jackson's view,

> simply updates and re-dramatises the human anxieties that have always come with new technologies – anxieties that express deep misgivings about our human ability to comprehend and control any new phenomenon. In the case of gene technologies, the manifest lack of consistent and confident institutional or governmental control only exacerbates this crisis of agency. One simply does not know enough about the new technology to be able to feel that one can manage or predict its repercussions (Jackson 2005: 112).

Technologies embody our fantasies and our fears. They are both a fountain of hope and a font of despair, with the potential for profits *and* losses (Williams 2003). Margaret Lock has described the Shiva-like character of prevasive biomedical

technologies as 'potential creators of happiness, but destroyers of society as we know it' (Lock 1995: 391).

Technologies, in other words, are increasingly being treated as mediators in struggles between the 'old ways' and 'new ways', giving rise to endless polarisations in attempts to make sense of, resolve, or resist their effects on our lives. Indeed, this has become a common rhetorical starting point for many theorists, part of their efforts to elaborate the borders or boundaries between uncommon zones of activity and the ways in which they have come to be breached (Brodwin 2000, Younger 1990, Fox 1993, Scheper-Hughes 1998). These arguments have tended to trade on our understanding of the body as inherently symbolic of social processes, which as Mary Douglas puts it, is 'a model which can stand for any bounded system', whose 'boundaries can represent any boundaries which are threatened' (Douglas 1968: 38).

Organ transplantation is exemplary in this regard as it tests many different boundaries at once: the borders between the immune system and the environment (foreign organisms); between machines, humans and animals; between the biological and the social-cultural; between procurement and 'recipiency'; and between altruism and gain. A complex domain of medical techniques and technologies, transplantation traverses the lines drawn between nations, cultures, economies, and the divisions between rich and poor, reconfiguring in the process what it means to be a person. Transplantation has raised, and continues to raise difficult bioethical and cultural questions about the status of the dead body, understandings of personhood, and, particularly as the demands for organs rise, the criteria we use to distinguish life from death. In one way or another, these multi-level boundary concerns draw our attention to a range of interconnected sites at the local and global level where issues relating to transplantation practices – i.e. procurement, organ selling, donation and 'recipiency' – serve to reorganise the relationship between self and other, private and public, resentment and gratitude, sickness and health. These relationships are, in turn, made more problematic by such things as the unevenness of access to life-saving procedures and the shortage of organs globally, problems increasingly rendered as public health crises and so matters for collective action (Randall 1991).

In relation to this, Lesley Sharp has questioned the responsibility the transplant industry bears in generating its own patients and creating a technological imperative, thus increasing the national demand for organs and exacerbating shortages. According to Sharp, 'transplantation is in essence the capitalist's dream because the supply can never answer the pressing and ever-increasing social desire for these coveted goods' (Sharp 2006: 18). This alters the construction of transplantation as an altruistic, patient-centred enterprise to an increasing international and extraordinarily expensive for-profit market-based industry (Williams 2003). The commodification of organs in particular, and body parts in general, though far from a new problem, has given rise to a darker side to organ procurement, captured in stories of organ-stealing (Sheper-Hughes 1996, Younger

1990). What Haraway treats as a positive becomes a negative when exploited for monetary gain, as body parts acquire financial utility.

Commodifying organs has become a rhetorical starting point for many researchers, reflecting how 'global capitalism, advanced medicine and biotechnologies, have incited new tastes and desires for the skin, bone, blood, tissues and reproductive and genetic material of the other' (Scheper-Hughes 2002). Nancy Scheper Hughes, Lawrence Cohen and their colleagues at *Organs Watch* in the University of Berkeley have been particularly active in drawing attention to an array of problems associated with the global exchange of organs. These include:

- race, class and gender inequalities and injustices in the acquisition, harvesting and distribution of organs;
- the widespread violation of national laws and international regulations against the sale of organs;
- the collapse of cultural and religious sanctions against body dismemberment and commercial use of body parts in the face of enormous market pressures in the transplant industry;
- the emergence of new forms of debt peonage in which the commodified kidney occupies a critical role;
- the coexistence of 'compensated gifting' of kidneys within extended families and coerced gifting of kidneys by domestic workers and by prisoners in exchange for secure work and reduction in prison sentences;
- popular resistance to newly mandated laws of presumed consent for organ donation;
- violations of cadavers in hospital morgues and police mortuaries in which organs and tissues are removed without consent for barter or sale;
- wasting of viable organs in the context of intense competition between public and private transplant units;
- medically substantiated allegations of kidney theft from vulnerable patients, mostly poor and female, during routine surgeries (Scheper-Hughes 2001: 35–6).

The traffic in organs described above can easily be mapped to global inequalities in capital and labour, and show organ procurement to be a social justice issue with repercussions for different populations across the globe. It goes without saying that as a social justice issue, these are critical concerns. However, it is also an area where it is hardest to draw unambiguous lessons from. This is because anthropologists, in reflecting on these anxieties and concerns, become participants in the very processes they are commenting on and as a result problematise the status of what they are talking about. What is presented are evaluative points not descriptions of empirical phenomena. My point is not simply a methodological one, but also a moral and an ethical one.

We need to think about the ways in which these points are made. The polemical rendition of organ givers and organ receivers might be considered an analytical

short-coming with moral consequences. It can sensationalise and prioritise procurement, while masking the problems of recipients and disguising the fact that inequalities and suffering characterise relationships at both ends of the chain of supply and demand. In much of the anthropological literature on organ donation and transplantation, the recipient is curiously absent from theorising, with little presence beyond the part they play in the biomedical narratives that are being ruthlessly critiqued. They typically feature as caricatures: privileged western consumers, cherished patients, their biographies and medical histories known, and their proprietary rights over the bodies the poor, living and dead, are virtually unquestioned. They are juxtaposed with those who through poverty and necessity are forced to sell the organs upon which their health depends or as grateful patients, media items in the broader transplant success story. This is not dissimilar to ways of constructing medical professionals and biotechnical entrepreneurs as unambiguously 'the bad guys' in the contemporary story. The problem with polemical stances such as these is that as one takes positions, the problem, under-fire, is taken-for-granted. It is uncritically accepted.

In trying to cope with the anxieties surrounding transplantation, these polemical renderings persist, invoking age-old distinctions between self and other, body and machine, science fiction and scientific fact. The arguments suffer from what George Marcus and Willis before him cautions as 'anaemic' analysis (Marcus 1998, Willis 1976). In other words, in the attempt to deliver a unified, ethnographic counter-narrative to dominant representations of organ transplantation, researchers produce a 'bloodless' account where the phenomena investigated come to be caught in the borders between different zones of human affairs, and the researcher politically positions their thinking to highlight some issues at the expense of others. This has made it difficult to fully understand transplantation as moral, bioethical and biopolitical phenomenon across a range of interconnected arenas at both the local and global level and at the sites of donation and 'recipiency', which are inevitably interconnected.

What this means is that we need to see the human body as more than a 'soft machine' animated by powerful interests (although it is that too), but as an important empirical site for examining the embodiment of culture, society, power, economic relations and technology. Jackson argues – in a similar fashion to Haraway – that we need to consider the ambiguity and complexities that arise from technologies, less as a conceptual problem or logical anomaly, but as what he refers to as 'an inherent condition of intersubjective transitivity – where we are one moment merging with another (or another thing), the next distancing or separating from it' (Jackson 2005: 125):

> This fluent experience of being self only in relationship to not-self, of subject only in relation to another that is 'object' sets the scene, in my view, for the ambivalence we experience when confronted by new technologies – for a technology is, intersubjectively speaking, no different from another person, a tool, a thing, a stranger, or the earth; it has the potential to become a part of us, a

> condition of the possibility of being ourselves, but it is also a perpetual reminder of what we stand to lose in any relationship with what we see as 'other' (Ibid 2005: 125).

There is no denying that the anxieties thus provoked help us to understand the implications of new medical technologies and highlight a wide range of concerns. However, the tendency towards juxtapositions makes some aspects of the transplantation story poorly understood. This has been particularly true in the case of renal recipients. In the next section, while drawing on these approaches, I will focus on a concrete example, showing how the discussion thus far helps us to think about the subject position of the renal patient.

Renal Transplantation: Technological Grounds and Embodied Consequences

The renal patient's experience is one totally mediated by technological factors from the moment a fistula[1] is fitted to make dialysis possible. From very early on, the patient experience is one characterised by unique and altering embodied states. During dialysis, for example, the body is enormously elaborated and dramatically thrown into relief. The cleansing of our blood, a process, ordinarily visceral, hidden and largely taken-for-granted is the problem that dialysis is organised in response to. On dialysis, internal bodily processes seem to be turned inside out, creating both existential anxieties and possibilities. This relationship between patient and machine is one with radical consequences for all aspects of everyday life: eating, drinking, cleaning one's body, sexual intercourse, working, leisure activities, travelling, conducting personal relationships, making plans and so on. Thomas Csordas reminds us in his presentation of a 'paradigm of embodiment' that the body is our existential ground (Csordas 1990). It is correlative with our cultural world. What shows up for us, therefore, in our world, is constituted only in so far as we bodily connect with it (Merleau-Ponty 1943). What shows up in the experiences of renal patients is profoundly constituted by the body's newly acquired technological dependencies. And as I will continue to describe, nowhere is this more pronounced than in transplantation. Here the cultural logics which extend from transplant technologies have profound, often unexpected and controversial consequences for the subject positions and lived experiences of renal recipients and the wider community.

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1 A fistula is an access point usually created in the wrist by connecting a vein to an artery. This helps generate an increased blood flow through the vein causing it to enlarge and become thick, providing ease of access for needless and a sufficient blood flow to make dialysis possible.

The Immune System: The Embodied Ground of Transplantation

It is important to describe the significance of the immune system, designated here as the embodied ground of transplantation. The immune system structures the relationship between an organism and its environment, organising the relationship between self and other; donor and recipient. The immune system also provides us with a conceptual apparatus for thinking about the biopolitical character of transplantation: how medical knowledge, innovations and practice have particular implications for social and cultural processes.

Described by Emily Martin through metaphors of disease-as-combat, a cellular army with an arsenal of fighter cells, the immune system functions by the capacity to discriminate between self and non-self, recognising 'foreign entities' that enter the body by means of antigens and (r)ejecting them by the production of antibodies (Martin 1994). This mechanism of self/non-self discrimination is key to the protection of the organism and lies at the foundation of modern immunology. However, it also presents a paradox. The work of the immune system is to respond to threats to the organism; it is there to protect the body. However, in organ replacement therapies, the immune system becomes a barrier to treatment and healing. It is both an ally and an obstacle. In order for transplantation to occur, the immune system has to be suppressed, it has to be tricked into treating what is other or foreign as part of the self. This inevitably has the effect of reducing the organism's capacity to protect itself. This compromised status will have dramatic consequences for the organ recipient, consequences they are little prepared for.

The tangle of issues centred on the immune system and its role in contemporary medicine have drawn the interests of a number of theorists across the social sciences. Both Martin and Haraway, for example, have focused attention on the immune system as paradigmatic of major shifts within the sciences more broadly (Haraway 1993, Martin 1994). It is readily designated as a postmodern object: eminently ambiguous and contradictory, challenging any assumption that there can be a single way of thinking about biological objects. Haraway explains that the immune system has no single point of presence. Its signification is distributed throughout the body. It is multi-local, without borders (Haraway 1993). For her, it is

> a map, ... a plan for meaningful action to construct and maintain the boundaries for what may count as self and other in the crucial realms of the normal and pathological (Haraway 1993: 79).

As Haraway notes, ways of playing with the immune system displayed in transplantation practices point to the massive expansion and growing confidence in techniques that enable us to construct and reconstruct bodies as we see fit. Transplantation practices therefore reflect a world in which it is possible to think of the human body as an assemblage of interchangeable parts, created using sophisticated genetic tool kits; a world where the body has come to be constructed

as a coded text whose 'secrets' yield only to the proper reading conventions (Haraway 1993). Transplantation is one area in which scientists are imagined to manipulate and play with immunological signifiers and processes, strategically interrupting them where necessary. However, rhetoric and practice have a tendency to diverge. Despite the promise of immunological recognition and tissue typing for the rise of an effective transplant medicine, one that could work with the body on its own terms, scientists have actually had to work with it on their terms and that has been a very different proposition. Transplantation is less about the recognition of molecular sameness and difference but the suppression of the entire system, though the advances gained with immunosuppressive drugs, like cyclosporine. This is about disenabling the body rather than enabling it. It is this process of misrecognition, based on immune-suppression, and the use of cyclosporine which has allowed transplantation to develop so quickly over the last twenty years.

Anthropologists like Lawrence Cohen have pursued the implications of immunosuppression on donor populations, and explains that because we no longer have to screen large populations for suitable blood and tissue matches, many more persons can now serve as donors. He refers to this as marking a shift from a biopolitics of *recognition* to the more pragmatic biopolitics of *suppression*, disabling the recognition apparatus so that operability and not sameness/difference becomes the criterion of the match (Cohen 2002). However, as stated earlier, I do not wish to reflect the established polemics constructed between organ givers and organ receivers but recognise how a biopolitics of suppression has implications for both. I focus attention specifically on the profound implications suppression has for the bodies of recipients and the re-contoured worlds they find themselves navigating.

In suppressing the recipient's immune system, the renal patient is more susceptible to infections and viruses. The side effects of daily immunosuppressive drug therapy can be devastating – changes in body image, weight gain, excess bodily hair, a range of new conditions, recurring sickness – ongoing problems that the patient may never escape. Sickness continues in addition to ongoing cycles of medical intervention, testing and check-ups. As a consequence, the body responds aggressively. Far from being the docile object theorised within the sciences, it proves to be willful, recalcitrant and subversive.

The renal recipient does not always encounter transplantation according to the hoped-for expectations of medical practitioners, the general public or even social scientists. Transplantation involves a parallel reconstruction of the local cultural worlds of these patients to that of the local biologies implied in immunology. In otherwords, both locals are compromised through receipt of the new organ. To demonstrate this, I want to draw on some of my own ethnographic work on kidney transplantation conducted in the Republic of Ireland and to show, through narrative extracts, how renal recipients piece together their accounts of transplantation. Paying attention to the particular, culturally sited ways in which the boundary line between the biological and social comes to be blurred through transplantation, provides us with insight into how the human experience of suffering is constituted

and the ways in which patients make sense of therapeutic outcomes, and the notion of a 'gift of life', that transplantation is expected to extend to renal patients.

At the time of interview:

> *Lilly was a married woman in her sixties, from Co. Galway. She had undergone four transplantations up to the time of interview.*
> I could only but feel negative. I had been on dialysis for so long and was more secure there. My friends were there … and all my support. For me transplantation means leaving all that and being with people who don't understand. It's impossible to stay in the unit but to be asked which makes me happiest, I have to say that I felt so much better in myself on dialysis.

> *Padraig was a married man in his fifties from Co. Wicklow. He received his kidney from his sister which was considered to be a good match.*
> Life after transplantation was a huge high. I just couldn't do enough living. Everything in my life improved, my relationship with my family, my work, my leisure activities. But after about five months of euphoria, life slipped backwards, and the problems everyone else has to cope with crept back into my life. I worry about rejection … It's there as a constant reminder that I am always going to be a renal patient. It particularly springs to mind when I catch a cold or get a chest infection. We are all afraid of dying – the whole meaning of life changes. I don't think these thoughts are shared by the healthy.

> *Jack was in his sixties and lived in Co. Cork. He was retired and separated from his wife.*
> After the transplant, changes took place I … I have a different perspective. We are not the people we were before. It's the whole condition. I can't separate one stage from the other. I'm always questioning the side-effects of the medication … I had a parathyroidectomy. They took out three and a half that had grown to the size of golf-balls. After transplantation, your calcium rises. It's the reverse to being on dialysis. My bone pain was so severe that I was unable to walk and had to use crutches. I had my transplant on 2nd January, 1989, my parathyroidectomy in March and was on crutches until December of that year. If anyone touched me, I was a babbling wreck.
>
> I knew I'd have to look after it – I did respect it and I never miss out on the medication, but I didn't know there'd be all these drugs beforehand – I thought once you were transplanted that was that. I didn't know the names of any of these drugs or told they were anti-rejection drugs.

> *Derek was in early fifties, married with children and living in Dublin*
> I was put on immuran, cyclosporine, steroids, blood pressure medication and lasix. The cyclosporine caused my gums to grow down over my teeth, hair to grow, weight gain and tremors. The steroids had the effect of giving me a false appetite and putting weight on my neck and abdomen.

> I have been damaged in some way and something that is damaged is not going to last long. I have a plan, which is to retire in five years time and to hopefully have a good quality of life. My family worry about me and they ring up after every check-up. I have gout again and that worries them. My friends are always concerned. I don't think I would be as concerned if it was somebody else and that makes me feel guilty. I have mood swings and feelings of being tired. I get symptoms as if I were going back into failure. That said, my quality of life is better since transplantation.
>
> *Julia was single in early forties and living in Co. Louth*
> I had panic attacks after the transplant. It was reinforced by my rising blood pressure. I turned to prayer – something outside of myself … I never think of myself in the future now, that's the biggest change. I won't even plan a week ahead. I won't even plan holidays. Even if longevity was guaranteed, I don't think it would change. I worry about my nieces and my nephews regarding the genetic aspects. I have a sense of vagueness. I want to feel in control, independent. The future is a hazy prospect for me. I feel pressurised when I have to come up with a plan. Where I am, for the moment, is fine for me, but it is often not good enough for others.
>
> *Anne was single, living in Dublin and in her early thirties.*
> Of course, it is wonderful to be freed from dialysis. No one can argue about the benefits of having a new kidney. But … well, it's not that simple… After the surgery, I felt so protective about my new kidney. I hardly wanted the doctors to go near it. I remember, they had to do a biopsy on me and I was so frightened that they would damage it … I don't agree with the notion that transplantation is some great renewal of life. The side effects of immunosuppressants are very hard to live with. It is especially hard, y'know, for women to cope with extra weight and all the body hair that cyclosporine causes. I know it really affects me. I hate getting my photo taken. I don't even like looking at myself in the mirror. Since my transplant my family treat me as being well. People have forgotten. They make demands on me, do y'know. You are always misunderstood and when you try to explain your difficulties. Some people say, '[s]ure couldn't you get killed crossing the road' or '[a]ren't you lucky that they can do this for you'. The expectation is that you should be over the moon, but being upbeat is difficult. Terrible fears just can't be acknowledged. I worry in ways that I never did on dialysis….
>
> I don't plan much anymore – I can hardly think of myself in the future.

There are clearly many different issues involved here, but I want to draw out some commonalities. Like many patients with chronic conditions, what backgrounds the illness experience is a complex socio-technical apparatus, not fully visible to the participant (Mol 2002). Medical interventions and therapeutic outcomes for the chronically ill do not come to final end points. They continue to be underpinned by an

array of seen and unseen medical procedures, protocols and practices incorporating, for example: a complex and changing legislative and ethical framework governing organ procurement, which includes criteria for selecting suitable donors and for assigning brain-death (Sharp 2006); technological innovations such as the ventilator and dialysis machine without which transplantation would be impossible (Lock 2000, Younger 1990); the informal and subjective decisions and working schedules that shape doctor-patient interactions and the selection criteria for placing dialysis patients on transplant waiting lists; the localised cultural criteria that shapes national legislation favouring live donation in some countries and cadaver donation in others. What has to always be kept in mind is that transplantation is a phenomenon caught within systems of practice, and in relation to which, the renal patient's experience is far from under their control.

The lived experience of renal 'recipiency' is without doubt a contradiction to medical and public expectations. It is also a marked divergence from the expectations the same patients have while on dialysis. As stated in earlier publications on dialysis (Kierans 2001, 2005), people look forward to transplantation, seeing it as the route to a 'new lease of life', a time where they will no longer have to depend on a machine. Dialysis patients describe themselves as future-oriented, and it is this capacity to project into the future that enables them to cope with their regimen. Once transplanted, however, there are growing concerns that one can no longer lay claim to a clearly-defined future, that the kidney might reject, that one might return to dialysis or die. This lack of resolution or disjuncture is what Haraway explains as a function of hybrid or cyborg embodiment. As a result, people talk about disengaging from the future; a continual experience of the present; a dissolution of the border between past and future. This is often attributed to the ways in which transplantation is conventionally constructed through biomedical discourse, emplotted around horizons of hope and held in place by the idiomatic expressions employed within society, donor awareness groups and physicians: 'a new lease of life'; 'a gift'. This is what patients are offered; an understanding that they will be healed; that they will be well again. They embrace collective narratives spun around transplantation practices, only to find that the reality is often quite different.

The 'gift of life' metaphor dominates personal and public expectations about transplantation. But as the anthropological record testifies, from culture to culture gifts bind giver and receiver, and necessitate reciprocity (Mauss 1967). One does not get something for nothing. There are new pressures on the renal patient post-transplant, that of being a good recipient. This carries responsibilities that are regularly described as unbearable, the responsibility to be well when one is not; to be healthy; independent; to be champions of donor campaigns; to fulfil a powerful medical narrative, and, in so doing, to mask and silence the continued sickness and suffering and the devastating consequences of immunosuppressive drug therapy and changes to body image. These are experienced in connection to the guilt that someone may have died to give them this new lease of life, but also in relation to

the complaint that family and friends often disengage from the continued suffering and psycho-social affects of 'recipiency', unwilling to see them still as patients.

Renal recipients describe not being the people they once were, and it is not uncommon to hear remarks, like those made by Anne and Julia, of having a vague or hazy sense of oneself. Renal recipients emplot their accounts around the unexpected lack of an ending and the dismantling of their expectations. New worries about graft rejection, the isolation of recipient experience and the necessity of having to cope with the side effects of immunosuppressive drug therapies have created an extra burden of suffering, made worse by the fact that few wish to engage with it.

In reflecting back over her condition, Julia said,

> Throughout this condition, we tend to stack things ahead of ourselves … You see the road ahead isn't a straight one ... It is a lesson we all have to learn and that is that transplantation is not the be all and end all and people often feel cheated by that – they are sold an idea that things are going to be perfect and they are not.

Many of the patients, however, who offered painful accounts of their experiences of transplantation, were also the same patients who regularly talk at patient support meetings, in the media and at donor awareness campaigns. I listened to them publically espouse and promote the benefits of transplantation and privately complain about their fear, loneliness and continued experiences of sickness. These contractions and grey zones are a fact of transplantation's ambiguities, and reasons while the polemical renditions provide no access to the complexities of the human experience. It is not surprising that these contradictions also reflect the institutionalised commitments and obligations patients feel towards their doctors, the donor, donor families and to their own family and friends. The compromised status of 'recipiency' captures the essential character of transplantation and demonstrates that a lost physiological sovereignty has it implications not only at the level of a compromised immunology and physiological vulnerability but extends its reach to the existential and social world of the patient. As Mary Douglas reminds us, anxieties arise at precisely these points of intersection, where social and cultural organisations meet personal experience (Douglas 1970).

Conclusion

It is not easy to tell a straightforward story about transplantation. This is not a phenomenon easily packaged in terms of its gains or losses for different populations but perhaps as researchers we should not try, partly because in Jackson's terms '... we can never grasp intellectually all the variables at play in any action or all the repercussions that follow from it, partly because they are so variously and intricately nuanced, and partly because they are embedded in singular biographies as well as social histories' (Jackson 2005: xxv).

We do know, however, that transplant technology and its associated techniques, in addition to improvements in immunosuppressive drug therapy and diagnostic procedures, are increasingly sophisticated and reliable. They are also more widely available, and to more people, than ever before and are being used to treat an expanding range of diseases. We cannot say that these are *not* welcome and, practiced in the right way, they can be an important tool for human benefit. National debates about the quickening in the demand for and distribution of organs, and the creation of durable but morally questionable links between patient-recipients and donor-populations, have taken a variety of different forms, raising newly problematic distinctions and boundary concerns. In order to navigate these issues, it is important that these controversies are situated in the lives of its protagonists and participants and underpinned by an ethics of care reflected by a concern for all those lives affected by these practices.

To do this, we might take our methodological cue from Appadurai (1986) and follow the 'social life' of organs as they operate within these technoscapes, crossing different borders in different parts of the world and the costs and benefits associated with every stage of the journey they make. This means we need to work outward from the technologies themselves, tracing those implications for the practices, processes, experiences and social formations they thus engender. Our analytical task is to a large extent a moral one and that is, in light of the new medical technologies, to learn what is at stake for others (Kleinman 1999), but to be cognisant of the ways in which we insert ourselves as researchers, advocates, humanitarians and practitioners into the ethnographic story lest, in our efforts to do good, or in the production of a juxtaposition, we render visible the embodied sufferings of some at the expense of others.

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Chapter 2

Normalized Elites: Rethinking Doping as Abnormal Practice

April D. Henning

In October 2007, former Olympic gold-medalist Marion Jones pleaded guilty to lying to federal prosecutors when she was asked about her use of performance enhancing drugs in her quest to become a champion sprinter (Zinser and Schmidt 2007). In early 2008 Jones was stripped of her five Olympic gold medals and sentenced to six months in prison (Schmidt 2008). Shortly following Jones' case, 2008 Olympic marathoner Deena Kastor gave an interview to *Runner's World* magazine where she was asked her views on Jones' sentencing for doping violations. She responded saying, 'It was very disappointing. Anytime you have fame and money on the line, you're going to have people who cheat to get to the top ... What makes it even more troubling is that she [Jones] was such a hero for so many people; to have cheated her way into their hearts is just awful' (McDowell 2008). Kastor's view of doping violations is a common one, as elite athletes in all sports who are found to be in violation of anti-doping regulations are often condemned and vilified by fans, the media, and other athletes. They are viewed as cheaters, stripped of awards and medals they have won, and face punishment by governing bodies, and sometimes face federal prosecution. At the same time, however, that athletes are being attacked by a chorus from these several audiences, there are voices in another crying out against anti-doping regulations, calling for the removal or partial removal of current restrictions against doping. Herein lies the problem with the current system of anti-doping: elite athletes are pathologized as a group with values and beliefs deviating from social norms, while at the same time they are treated as if they are normal members of society who share normative views about values and lifestyle by anti-doping agencies. These two very different views raise the question, what has shaped the current system of anti-doping and the surrounding debates?

There is an underlying tension between the two ways elite athletes have been characterized in the media: normal and abnormal. Elite athletes face a paradox when it comes to how they are characterized by the media. On the one hand they are expected to conduct themselves in a way that is considered 'clean' by non-athletes, including avoiding doping practices or any behavior that would make a competition unfair. In short, they are expected to be like normal non-elite athletes, except to post results worthy of the elite title. On the other hand, they are expected to fulfill the role of elite by taking advantage of a lifestyle that includes professional coaching

and medical support and training techniques not available or accessible to non-elites. Consumers of elite athletic competitions understand that these athletes are not ordinary, run of the mill recreational athletes, but are professional competitors who train to compete at an elite level. By definition, elites are removed and set apart from the categories of average or normal that most recreational athletes and non-athletes would fall under. However, fans, media, and governing bodies still hold elite athletes to a somewhat normative standard regarding how they train and compete and this standard is problematic when issues of doping arise. When an elite athlete is found to have violated anti-doping regulations the image of the normal athlete collides with its abnormal counterpart, leaving the athlete in a sort of limbo. On one side relying on any available technology to improve performance deviates from expectations of fans, officials, and the media, while on the other not relying on any available technology deviates from accepted values and practices within the elite athletic subculture.

Though questions of doping surround most elite level sports, the focus here will be on elite runners and how these runners are simultaneously cast as normal and abnormal by themselves, coaches, medical professionals, and in popular media. Elite runners have a well-documented history of debates surrounding performance enhancement and questions of doping within the sport, and these situations exemplify the challenges elite athletes across the spectrum of sports have faced. Drawing heavily on coverage of elite athletes in the specialty running magazine *Runner's World*, as well as other media outlets, I will interrogate what developments have led to both the view of the athlete as abnormal, as well as that of the elite lifestyle as normal or analogous to non-elite athletes. I argue that the tension between these two opposing views results from the differentiation of elite athletes from non-elites by coaches, medical professionals, and athletes themselves on the one hand, while the media and strict anti-doping advocates downplay these differences on the other. To illustrate this argument I will first offer a short background of the rise of sports medicine and the trend towards medical technology as a training tool, as well as a look at the movement towards the current system of anti-doping in sport. The next section will demonstrate how elite runners' lifestyles and values differ from those of non-elites, as well as how elite runners have been normalized through the media. I conclude by calling for an understanding of athletes by anti-doping agencies that is responsive to the differences of elite athletes from the rest of the population.

Background

Athletes, Medicine, and Technology

Physicians are now a fixture on the sidelines of most elite sporting events, and many athletes have an entourage of medical professionals to aid in their training. Though the bond between the two fields is now firmly in place, medicine and

athletics have not always been so entwined. In his volume on sports medicine, Ivan Waddington (1996) argues that two processes, the medicalization of sport and increasing competitiveness, brought about a change in the way athletes train and are viewed by the medical establishment. Waddington sees the medicalization of sport—making medicine relevant to participants in sport when it had not been previously—as largely responsible for the development of the field of sports medicine following World War II. In this period medicine changed from having a tangential interest in athletic bodies to making medicine and medical interventions necessary for athletes.

John Hoberman (1992) notes that beginning in the interwar period, medical professionals were interested in athletic bodies as a source of information about human physiology. Sports medicine began as a chapter within medical books before moving on to become its own field within the medical profession (Waddington 1996). Citing an early text on sports medicine by J.G.P. Williams, Waddington argues that from very early on in the establishment of the sports medicine field, physicians regarded athletes as chronic patients whose physiological differences from the average person made them more similar to the traditionally invalid population than to non-athletes (Ibid). Viewing athletes as more prone to injury and illness than non-athletes, medical researchers' focus on working with elites worked to bring athletes into the medical subculture. Athletes became reliant on the medical establishment to be repaired when injured, to stay healthy, and to realize their natural physical potentials (Ibid). Athletes became permanent patients, viewed by the medical profession as a population inherently needing the aid of medicine even in the absence of a specific condition or ailment (Ibid). A second development in the era following the war was an increase in competitiveness of sport and the importance of sport to politics (Ibid). The new political pressures brought on by the Cold War increased the desire for more effective medical interventions that could give athletes an edge over the competition. The increased competitiveness of sport, coupled with the rise of sports medicine and the medicalization of athletes led more athletes to turn away from traditional methods of athletic training, and these methods were replaced and supplemented gradually by new technologies coming from sports medicine and other associated fields (Ibid).

As regular access to medical professionals and treatments increased, athletes began to undertake treatments, techniques, and use supplements developed with the goal of some type of enhancement in mind. Though athletes themselves have long sought ways to gain a winning edge, Barri Houlihan (2003) argues that it is since the rise of performance enhancement as a goal of sports medicine that the search for supplements for athletic bodies expanded. Supplements for athletic bodies have come in the form of dietary supplements, sports nutritional supplements, and medical interventions (Waddington 1996).[1] Dietary supplements, therefore,

1 The National Institute of Health (NIH) defines dietary supplements using a four part definition developed by Congress in the Dietary Health and Supplement Education Act. According to the NIH, a dietary supplement 'is intended to supplement the diet; contains

are intended to install from the outside what the body is missing on the inside. For athletes, supplements provide a way to build upon traditional training and dietary methods—concentrated, drinkable protein powders in place of eating large quantities of food, for example. By the early 2000s the sports-supplement industry had become a multi-billion dollar industry with nearly $20 billion in sales within the United States alone in 2007. While supplements are used by non-athletes as well as athletes, Baume, Hellemans, and Saugy (2007) cite several studies that suggest many athletes, both elite and recreational, use dietary supplements with the belief that they may have performance benefits. The main reasons for athletes to take supplements are: 1) supplementation of a food-based diet 2) performance enhancement 3) fulfillment of an exercise-specific nutrition requirement 4) achievement of a specific sports related goal 5) correction of a nutrient deficiency (Baume, Hellemans, and Saugy 2007).

Anti-doping

As the medicalization of athletic bodies and efforts to medically enhance performance increase, defining doping in a way that clearly distinguishes between what is legitimate sports medicine and what crosses the line into doping territory has become increasingly difficult. Early suggestions for a clearer definition of doping by differentiating between those substances and practices that are 'natural' and banning anything 'unnatural,' or in terms of food vs. non-food were made without success (Gardner 1989). Doping is often considered a problem in that it constitutes a form of cheating (Houlihan 2003, Miah 2007). The anti-doping movement gained momentum amid concerns by athletic governing bodies that the spirit of sport and competition was being undermined by the use of doping agents, such as anabolic steroids and synthetic hormones, and growing concerns of participants and governing officials over athletes cheating by artificially enhancing their performances in competition or doping. In response, athletic governing bodies, such as the International Olympic Committee (IOC) called for monitoring of athletes use of certain substances believed to be performance enhancers. Following this call, national governments, sporting organizations, and international governing agencies adopted new policies against doping, known collectively as anti-doping.

Houlihan (2003) traces the evolution of these policies and the rise of testing agencies, most notably the World Anti-Doping Administration (WADA). Established in 1999, WADA is comprised of a Foundation Board, an Executive Committee, and several sub-committees. The Foundation Board and each committee is composed of equal numbers of representatives from both the Olympic

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one or more dietary ingredients (including vitamins; minerals: herbs or other botanicals; amino acids; and other substances) or their constituents; is intended to be taken by mouth as a pill, capsule, tablet, or liquid; and is labeled on the front panel as being a dietary supplement' (NIH 2007).

Movement and governments (WADA 2009a). The IOC created WADA for several purposes: to define what specifically the problem of doping entails; to institute regulations around doping practices and substances; and to conduct biological tests of competitors to ensure that they are in compliance with the anti-doping rules of competition (Houlihan 2003). Houlihan notes that there were several fundamental justifications for the anti-doping movement, including protecting the spirit of the competition, to protect the health and well-being of the athletes, and to protect those who model their behavior after elite athletes' (Ibid).

The current definition of doping developed by WADA is based on its prohibited list. This list, updated annually, lists all those products and procedures that are considered doping agents or practices (WADA 2009b). WADA differentiates between what is banned while 'in-competition,' 'out of competition,' and at all times, as well as defining some sport-specific bans (Ibid). WADA is the body that sets international standards which member organizations then use as a guide in developing anti-doping testing programs. For track and field the International Association of Athletics Federation (IAAF) is the body responsible for collecting blood and urine samples and administering tests to determine if doping agents are present (IAAF 2009b). The IAAF plans out testing procedures, schedules, and sets parameters for what constitutes a positive test for a banned substance. The IAAF also keeps track of athletes' whereabouts to ensure random testing can and does occur, and sets up testing protocols to ensure samples are not compromised before, during, or after the sample is taken and the test is administered (IAAF 2009b).

Scholars have taken two sides in the debate over the current anti-doping regulations: 1) doping is an ethical problem and public health risk that must be controlled, 2) doping has become a part of sport and current policies attempting to regulate and prevent doping are futile and must either be abandoned or modified. Thomas H. Murray (1983, 2008) looked at the how the fear of being left behind the competition forced drug use on athletes in an attempt to understand under what circumstances an athlete would engage in doping practices. Murray concluded that athletes were often pressured to take performance-enhancing drugs and that the decision was often not an independent undertaking by athletes. Murray further argued that anti-doping programs and policies are necessary to prevent athletes from being coerced into taking performance enhancers, especially if they do not want to engage in the practice but feel they cannot compete otherwise (Murray 2008). In his view, anti-doping is also a necessary development to maintain the level playing field that athletes seek for competition (Murray 2008).

Ben Mitchell (2008) considers gene doping as posing serious risks for young and/or amateur athletes. These risks are both in terms of the health risks and problems it may pose to young athletes, and in terms of maintaining an ethic of fairness in competition. Similarly, Pipe and Hebert (2008) considered the pharmacologic nature of many doping agents and contended that these products represent a deviant set of values that could erode public trust and pose possible health risks. They, like Murray, view anti-doping programs as a necessary component in protecting and promoting the values of fair play in sport (Pipe and

Hebert 2008). Each of these researchers has taken the view that doping poses some sort of potential risk to athletes and their health, and to sport and the value placed on fair play.

Conversely, researchers such as Eugen Konig (1995), Shogan and Ford (2000) have argued doping practices are a constituent part of sport—they are part and parcel of elite competition. In Konig's view, practices and agents considered to be doping are actually consistent with the use of other accepted technologies that have come to be defined as a natural part of sport. Konig asserts that these technologies are viewed as fair or natural only because they do not violate the current rules of play and not because they are essentially different from those labeled doping. Similarly, Andy Miah (2006) argues that 'human enhancement technologies can enrich the practice of elite sports rather than diminish them.' In Miah's view, the need to protect individuals from enhancements is lessened by the breadth of enhancements available to elite athletes.

Hoberman (2007) looked at doping in endurance events, such as marathons and endurance cycling events. He noted that only a handful of positive doping tests have been found in marathoners while a much higher proportion of cyclists have been found guilty of doping violations. He argues that the principles behind current anti-doping philosophies are grounded in the allegedly prudish and rigid Victorian idea that there is a contradiction between high level performance and doping. However, this idea is not consistent with the historical record of these endurance events, as they, according to Hoberman, have long records of doping. Yet modern marathoners post low rates of positive tests for doping agents, leading Hoberman to question whether they are simply not being caught rather than cutting back on a historically common practice. Each of these views questions the current anti-doping programs based on the organizations' presumptions about what sport should or should not be. These researchers find fault with the logic that underpins many anti-doping policies, finding them insufficient at best and harmful to sport and the athletes at worst.

Taken together, these views encompass both sides of the debate surrounding doping in sport. The approach adopted by current anti-doping agencies, including WADA and its affiliate organizations such as the IAAF, largely reflects former view on athletic doping. In its mission statement, WADA describes part of its goal as working 'towards a vision of the world that values and fosters doping free sport' (WADA 2009c). WADA views doping as an ethical matter within sport that requires a strict code of regulations and rigorous enforcement. In this system, all athletes are held to a uniform standard of conduct that prevents them from exceeding the bounds of what is deemed acceptable behavior and practice.

Based on these differing positions of doping and anti-doping issues, I argue that there are two conflicting portrayals of elite runners that have led to the debate surrounding the current system of anti-doping. The first is that elite runners lead different lifestyles from non-elites and, as a medicalized population, they subscribe to the view that technological and medical advances to aid in performance are useful, acceptable, and normal. This scenario lends itself to

views like those of Konig and Miah, that sport is not harmed by doping, but that doping is an extension of what runners already do legally. The second view is that elite runners are really not that different from the non-elite population in their goals and lifestyles and should therefore be content to compete, and value competition, without the aid of performance enhancers. This view follows a logic similar to that proposed by Murray and Mitchell, i.e., that athletes should be protected from pressures to use performance enhancers and that sport should be protected from the upset to the rules of fair play that athletes have come to expect and value. These opposing views of elite runners, as both normal and abnormal, have collided and are reflected the current debate over doping and anti-doping policies.

Dueling Views of Athletes

Pathologizing Athletes

The view of athletic bodies as something distinctly different from non-athletic bodies came about, in part, through the field of sports medicine. As described above, sports medicine emerged as a way to treat athletic bodies in ways that had not been previously considered for non-athletes. The medical establishment's shift from viewing athletes as research subjects or patients with specific injuries to viewing them as permanent patients, brought performance enhancement to the fore of sports medicine (Houlihan 2003). Physicians were no longer treating or fixing acute injuries or specific ailments, but were focusing efforts on improving the performance of the uninjured athletic body in competition. This contrasts to other areas of life that have been medicalized. The current US medical system is focused on repairing the sick body, while preventative medicine focuses on well bodies and maintaining health (Park 2009). Sports medicine is unique in that it takes well, very fit bodies and attempts to not only maintain them, but to improve on them through medicine and technology. Athletic bodies are then differentiated further; not only are they treated by medical professionals as having different needs from the normal population, but these differences are highlighted by both further medical interventions and by training methods that demand a non-normative lifestyle and mind-set.

As such, the medicalization of sport coupled with the adoption of non-traditional training methods has led to the pathologization of elite runners and their bodies both medically and socially. Coaches and medical professionals recognize athletes, including elite runners, as different from the rest of the population. Two examples of programs that actively seek to set potential elite runners apart from non-elites are the Nike Oregon Project and the Hansons-Brooks Distance Project. These programs are designed to recruit distance runners with the best prospects of maturing into champion distance runners, seeking to relocate runners to project 'campuses' in order to train exclusively with other recruits on the team. These

teams are housed and supported by the program sponsors, Nike and Hansons-Brooks (Tilin 2002, Hansons-Brooks 2008).

In order to be invited to participate in programs like Nike's or Hansons-Brooks', prospective runners must have already distinguished themselves from mainstream, non-competitive runners in some way. Hansons-Brooks listed the following time requirements (male/female) for participation on its website, 'The standards these athletes had to meet to be eligible for the Olympic Development program are 29:00/33:45 for the 10k, 14:00/16:15 for the 5k, and 2:20/2:42 for the marathon' (Hansons-Brooks 2008). As the program focuses on post-collegiate recruits, these requirements serve as a mechanism to separate the good, but average runners from the good, potentially great runners. In describing its goals, Hansons-Brooks states that, 'This opportunity provided by the Hansons is the best out there for runners coming out of college who have demonstrated the ability and wish to continue running, but haven't quite advanced to the next level … Everything here focuses around time to train. Our lifestyle is most accurately described as being like college only we don't have classes or homework' (Hansons-Brooks 2008). Hansons-Brooks also cites the desire to form a community of runners within the community they are located to foster excitement about running. These goals demonstrate that the Hansons-Brooks programs focus is on removing those deemed to have the potential to become professional elites from a more normative lifestyle and transplanting them into a fully athletic lifestyle.

Central to these running projects is the all-encompassing focus on training that provides potential elites with an environment where they can focus solely on becoming competitive. To become competitive at the elite level, runners are expected to undertake physical training and diet regimens that are often much more strict and demanding than the average non-athlete. Runners' bodies are worked and trained to become not only fit, but fit in an activity-specific way. Simple caloric, vitamin, and mineral intake needs are higher in elites than in non-elites due to the former's extra expenditure of energy. These differences mean that the lifestyle requirements for elite runners' bodies to maintain health and fitness are far different from the average person. Kara Goucher, elite distance runner and member of the Nike Distance Project, described these differences in recalling her training for the New York City Marathon: 'While training for New York, my watch alarms went off at 8 a.m. and 5 p.m. I'd get up, work out, eat, and go to sleep. Then I'd wake up at 5 and do it again' (Rinkunas 2009: 71). Elite runners involved with the Nike Oregon Project often run twice daily, and many run near the 100-mile per week mark with some logging even more miles (Rinkunas 2009). Such intense training schedules are all-consuming, even for elite runners in running projects, and would be far less practical to maintain outside a setting where training were central to daily life.

Knowledge of and access to cutting edge technologies that can improve their performances over the competition also sets elite runners apart from non-athletes. In a sport like elite, competitive running where winners and losers are often separated by tenths or hundredths of a second, coaches and runners realize

the potential value in using technologies to further set themselves apart from both non-athletes and other elites. The Nike Project is coached by former elite distance runner Alberto Salazar, a convert to relying on technological advances to aid in distance training. As he described his training philosophy from his time as a competitor to *Wired* magazine, 'I had a blood-and-guts mentality. I didn't think I needed sports drinks or water' (Tilin 2002). Now a vocal advocate of using technological and medical advances to aid runners, Salazar's influence is seen on the campus of the Nike Oregon Project. Discussing his use of technologies, Salazar says, 'As you improve, you have less room for improvement … That's when you really start adding things. You don't leave any stone unturned' (Ibid). As a medicalized population, this willingness to add new technologies to traditional training methods is expected, as members of medical subcultures often value new discoveries in ways that those outside of the subculture do not need to.

Elite runners, especially those subscribing to the view that more technology is better, have access to technologically advanced training equipment and facilities not usually afforded to non-athletes. The Nike facilities include state-of-the-art equipment not found in the average fitness center or gym, including equipment such as antigravity treadmills, heart-rate analyzing software, vibrating muscle platforms, hyperbaric chambers, and altitude rooms and houses (Tilin 2002, Rinkunas 2009). This equipment is not often feasible outside of elite training or medical facilities, partly due to the cost and labor required to purchase and maintain the equipment. An Alter-G treadmill like the ones used at the Nike facility can cost $75,000 to buy outright, compared to regular non-antigravity treadmills which can be purchased by non-elites for a fraction of the cost (Alter-G 2009).

Salazar and the Nike project also use a training technique involving living high and training low, whereby athletes live at high altitudes, either simulated or actual, and train at lower altitudes. The goal of this method is to increase the athletes' hematocrit, the ratio of red blood cells to the total volume of blood (Tilin 2002). The increase in red blood cells is intended to increase the capacity for oxygen carrying and delivery in the blood. More efficient delivery of oxygen to muscles allows athletes to develop speed and strength more quickly, as well as reducing bodily recovery time (Houlihan 2003). Physiologists employed by Nike collect and analyze blood samples to determine what the athletes' blood make-up looks like to determine the best living and training altitudes for maximum performance. This live high, train low technique is not realistic for most non-elite athletes. Nike provides the Oregon Project athletes with homes that have rooms, often bedrooms, that are sealed off and have high altitudes simulated with altitude machines (Tilin 2002). Altitude machines, like other training equipment available to members of the running projects, are expensive and pose potential health risks. Programming the machines incorrectly can lead to problems associated with altitude sickness—potentially serious problems that can include headaches, fainting, and nosebleeds. Athletes living in a Nike Project house have experienced some of these effects after the altitude had been mistakenly set at a near-Himalayan 14,000 feet, not 12,000 as they thought. One runner reported difficulty catching his breath, while another

suffered from sleeplessness and low energy (Ibid). What the live high, train low method offers is a way around WADA's ban on blood-doping. Blood-doping can take several forms; the most common type used by athletes involved the removal of athlete's blood and the separation of the red blood cells from the rest of the blood. Shortly before competition the blood cells are then transfused back into the athlete. WADA determined that such blood doping measures constituted doping and placed the practice on the prohibited list. However, WADA has placed no such ban on altitude training, including the use of altitude simulation machines. The live high, train low program used athletes such as the Nike runners thus serves as a way to raise the runners' hematocrit without violating doping regulations. While the effect of the two practices is similar, WADA has seen fit to distinguish between blood doping and altitude training.

As medicalized athletes, elite runners have regular contact with medical professionals to keep their bodies healthy and to enhance their performances. Goucher described her entourage of medical professionals that aid in her training: a chiropractor/active release therapist, a sports psychologist, and a massage therapist (Rinkunas 2009). To this entourage Goucher adds a regular, full-time coaching staff, a personal trainer, and a Pilates instructor. This level of access to and frequency of medical care not associated with chronic illness is one that is rarely found outside of a fully funded, professional athletic setting.

As described above, the shifting view of athletes as patients that need repair to patients that can be enhanced laid the groundwork for the development of supplements intended to give athletes a boost in training and competition. Gatorade is one supplement that was designed with the intent of improving athletic performances. Now a mainstay in the sporting world, including at fluid stations during elite running races, Gatorade was designed in 1965 by medical researchers at the University of Florida who wanted to develop something to aid the University's football team, the members of which often suffered from the stifling heat and humidity of Florida's climate (Gatorade 2009). The result was a drink that contained a solution of electrolyte and carbohydrates to replace those that are lost in the course of play. Athletic bodies were considered so different from non-athletic bodies in their levels of exertion in the harsh conditions, that they required their own innovation to replace fluids and carbohydrates lost while they were training or competing, and medical researchers were happy to oblige. Other products, including gels, liquids, bars, and chews, have followed Gatorade's lead and designed supplements geared toward athletes and improving performance. These supplements and replacements are set apart from regular food in their nutritional content and their form. Gels, for example, often come in small, easily transportable packets that are designed to be taken on the run. The jelly-like texture and highly concentrated formula of carbohydrates and electrolytes serve to make them unappetizing and unnecessary for many non-athletes. WADA currently has no bans on these supplements, though it has banned the use of some others, such as ephedrine (WADA 2009b). It has also regulated some substances such as caffeine, placing it on the list of agents in its monitoring program in 2004. Initially

placed on WADA's prohibited list, medical researchers continued to study and debate the effects of caffeine in enhancing athletic performance. In 2004, WADA determined that caffeine did not enhance performance in a significant enough way to keep it on the banned list (Ibid). The initial ban of caffeine was curious, as it is a naturally occurring substance commonly found in food and drink. WADA has banned the use of other naturally occurring substances, including an athlete's own red blood cells as described previously.

Coaches, medical professionals, and athletes themselves recognize that elite runners are different from non-athletes. They have different bodily needs from non-elites—they require more sleep, have greater caloric and nutritional needs, and specialized medical staff to aid their physically demanding life and training styles. These differences from the average person are highlighted in each article and interview to show readers, in part, that these athletes do not lead a lifestyle commensurate with that of non-elites. Their lifestyle differences are pointed out in medical terms—their rigorous lifestyle needs and their seemingly high need for access to and actual contact with medical professionals—and in social terms—these athletes do not have the same daily life experiences as most non-elites.

Normalizing Athletes

Those who follow a more normative, non-elite athletic lifestyle make up much of the readership of the popular magazines, newspapers, and websites that discuss athletes' lifestyles. While there are plenty of column inches devoted to highlighting the extraordinary characteristics of athlete's lifestyles and training regimens, sportswriters and interviewers also have a second purpose in their coverage of elite athletes: to normalize them. This normalization happens in several ways in sports writing, and these efforts seem to directly contradict the way elites are set apart, both in sports writing and in actuality, from non-elites.

First, portions of elite athletes' lifestyles are displayed in broad strokes to show how they are similar to non-elite athletes. Miniature food journals showcasing what an athlete's average meal or weekly food log would look like are one technique used in popular literature, especially showing up in *Runner's World*. These lists include the regular foods that any person could or would eat for any of the three meals or snacks in a day—even desserts and box devoted to so-called 'Guilty Pleasures' appear (Lorge Butler 2008b). Absent are the specialty food products and vitamin, mineral, or herbal supplements. The inclusion of food that is easily recognizable sends a message to the non-elite athlete reader that these athletes really are not that different from them. They eat apples, bananas, sandwiches, and even sneak in a cookie or dessert here and there, just like a normal person might. The omission of the specialty foods and supplements—those things that set elites apart—are almost unnoticeable, as the food log seems so average.

Even with the omission of specialty foods in these articles, many are not hard to find. As more and more products and supplements are developed for athletes, many become available to mainstream consumers. Sports bars, gels, and shakes are now mainstays at recreational, non-elite races and events, and Gatorade is carried in supermarkets and drug stores. Marketing these products as scientifically formulated for athletes lets the non-elite consumer into the elite world for a brief time. Bringing these and other products to the mainstream makes them less revolutionary and less mysterious. When non-elite runners use these products they become familiar. No one questions the fairness or legality when watching a runner guzzle Gatorade or other sports drinks, the way no one questions eating a post-run banana. Even some products that promise to enhance an athlete in some way, such as the energy drink FRS, which is endorsed by elite cyclist and two-time marathoner Lance Armstrong, are benign in a society where energy drinks are ubiquitous (FRS 2009).

In a similar vein as food journals are miniature training logs of elite athletes. Often these appear in the context of larger articles on an elite's recent success or preparation for an upcoming race. The elite training logs show the basics of a workout schedule such as distance and type of workout on which days, while leaving out details as to how fast or at what pace elites run the distances. Again not only are the details that set apart the elite workout from the non-elite—the speed—mostly left out, but so is the entire context. There is no mention of the accompanying medical entourage, training technologies, or personal coaching that elite runners have at their disposal. A similar section in *Runner's World* titled 'The Workout' features miniature versions of workouts done by elite runners or recommended by well-known elite coaches (Rinkunas 2009). Once more the lack of details such as the pace for the workout, or the full-scale warm up to cool down details, work to show how similar the elite training plans are to the ones used by non-elite runners. Adapting the elite workouts for the non-elite runner is intended to aid the non-elite with training ideas to improve their own performances, just like the workouts are intended to do for elites. Juxtaposing the broad training schedule with an elite success story sends the message to the reader that if he or she can train like an elite and maybe obtain similar results. This portrayal is in stark contrast to articles that feature the aforementioned devices and training equipment used by elites, as there is no mention of employing underwater running, hyperbaric chambers, or altitude training in 'The Workout' recommendations.

To fill in some of the gaps, several well-known running coaches have written books to guide non-elites to running better. One of the first of this kind is *The Runner's Handbook* first published in 1978 by coaches Bob Glover and Jack Shepherd. One feature of all editions of this book is that it lays out training programs and workouts in detail, including target paces and times in neatly organized charts. The charts run from near-world record paces down to the much more pedestrian first-time runner paces (Glover and Shepherd 1996). According to Glover and Shepherd, the difference between elite and non-elites is simply a matter of pace, strategy, and proper preparation in the form of training, diet,

and cross training. Seemingly, anyone following the principles and guidelines in Glover's book can achieve elite levels of speed without one of the specialized lifestyles afforded to the runners involved with the Nike Oregon Project or the Hansons-Brooks Distance Project.

The increasing number of road races and the opening of former qualify-only marathons to mass runners may have also lessened the perceived distance between elite and non-elite runners. Since the first charity runners, a Team in Training group, ran the New York City Marathon in 1988, other races have included participant slots for charity runners (TNT 2009). The five marathons that make up the world marathon majors series—Berlin, Boston, Chicago, London, and New York City—all now have a non-qualifying time option for entry into the race (WMM 2009). Each race sets aside a designated number of slots for these charity runners, who do not have to meet any qualifying standard other than membership with one of the associated fundraising groups. Since each of the world majors has an elite field of both male and female runners, non-elite runners are able to feel as if they are running in the race with, or against, the elite field. Adding an entry component not based on qualifying times not only opened races to a wider audience, but it also normalized the idea of running a marathon. No longer was it something only elites or competitive non-elites could do, it is something in which anyone willing to raise money for charity could partake.

Highlighting the similarities of family and work demands between elite and non-elite runners further closes the gap between the two groups. Far different from the lifestyle differences focused of the sort discussed above, these articles and interviews focus on the 'real world' pressures faced by elite athletes that are similar to what non-elites face. The working mother narrative, where elite female runners with children are portrayed as a normal working mom, is one that allows the fastest growing demographic of new runners, women over 40, and others in similar positions to relate to the plight of the woman who seeks to be a mother and to have a professional career. A *Runner's World* feature in the September 2008 issue focused on female runners who were not full-time elite runners (Lorge Butler 2008a). Titled 'Olympic Effort,' the main thrust of the article was how these women, all of whom qualified to run in the Olympic qualifying marathon, balanced their training with children and full-time careers outside of running. Three of the five women in the article are mothers, four of the five have professional jobs away from running and all discuss how they fit training into their daily routines. What is striking about this feature is that it exemplifies the tension between being an elite and a non-elite. The women are elite in one specific way—that they all qualified to run the Olympic marathon qualifying race. However, none of them are elite in the sense that none of them were expected to or did qualify for the Olympic team, while the women who did qualify were experienced, professional runners. The runners featured in 'Olympic Effort' were simultaneously highlighted for both the ordinariness and their extraordinariness—they exemplify the attempt to narrow the divide between the two.

While elite runners often recognize that they are not like non-elites, some come to view these otherwise abnormal behaviors as commonplace. Altitude machines and twice a day training runs become the norm. An early member of the Nike Oregon Project Karl Keska described his feelings toward the program: 'I'd like to do well in an Olympic marathon. As frightening as it sometimes sounds, this seems like a very natural and normal environment for helping me reach my goal' (Tilin 2002). Salazar himself takes the view that if all the technologies and equipment become normal, elites will be more willing to follow the technologies further to greater success. As he told *Wired*, 'If they [elite runners] improve a lot, then they'll say, gee, yeah, let's take another look at that vibration platform' (Tilin 2002). In this view, when the attitude that doing whatever it takes to get faster, to win, becomes the norm, new devices and technologies would become easier to adopt.

Tension

Casting elite runners as both normal and abnormal results in a conflict that has led to the current debates over doping and anti-doping. On one hand, elite runners are often portrayed as more similar to non-elites than different. Coverage of elite athletes highlights the routines and techniques that are similar and familiar to non-elites. They must do things that all individuals must do to stay healthy and competitive in their chosen fields, and often they must face obstacles such as family pressures, injury, and other traumas that can get in the way of even the best laid plans. This view, exemplified by Deena Kastor's shock and disappointment that an athlete would step outside the bounds of normative behavior and take or use something to enhance their performance, echoes those scholars who hold that doping should be treated as an ethical issue within sport. The normative view of organized sport is that it is a space where 'fair play' and the 'level playing field' are valued above all (Murray 2008). Therefore, a set of regulations is necessary to determine what is and what is not allowed in sport and to then enforce these regulations.

On the other hand, elite runners have a completely abnormal lifestyle. Elites who participate in professional running projects are literally set apart from non-elites, as they reside in special housing in a specified area, provided by their sponsors, with the intent to focus primarily on their training (Hansons-Brooks 2008). As a medicalized population, elite runners become used to relying on medicine not only to treat an ailment, but for new ways to become better, faster runners. This lifestyle and the attitudes that value technology and scientific progress for enhancing performance become norms within this subculture. Viewing elite runners, as well as other elite athletes, as not conforming to a normative lifestyle and value system is the basis for stances taken by scholars such as Miah and Hoberman. The use of performance enhancers is simply an extension of the technological approaches that are already undertaken by elite runners and other elite athletes. The expectation

that a population that has come to rely on and value medicine and technology will suddenly cease their current practice and return to more traditional methods is unlikely.

Detractors leveled further critique at agencies such as WADA because of the seemingly arbitrary and sometimes contradictory nature in which agents and techniques have been identified as doping. Some practices are banned while others that have the same basic effect are not, such as the prohibition on blood transfusions but not on altitude training or the use of altitude simulation machines. Banning one set of practices because the effect is considered unfair but allowing another that has the same effect is not only confusing, but also contradicts the rationale behind anti-doping efforts: to protect the 'level playing field' notion of fairness these agencies feel is foundational to sport.

Anti-doping agencies have not completely ignored the argument that athletes are different from non-athletes. The flexibility in the way doping has been defined by these agencies leaves open the possibility for change and does not necessarily preclude any substance or practice *a priori*. Current definitions of doping rely upon and assume rules regarding anti-doping, and offer no fixed or concrete example of what constitutes doping; doping is violating anti-doping, anti-doping is preventing doping. These circular definitions can be problematic in terms of understanding what doping is, how a substance or practice becomes defined as doping, and what the implications of these prohibitions are. However, what can be easily understood is that doping and anti-doping are fluid and dynamic terms without fixed meanings. WADA's definition of doping is based on engaging in an activity banned by WADA in its list of prohibited substances and practices. The prohibited list is reviewed, altered, and reissued on an annual basis, with substances and practices added to or removed from the list each year. This review process allows for the addition of newly discovered substances to the list, as well as the removal of previously banned substances or practices. This means that if something labeled a doping agent is found to not have the effect or pose the threat it was originally thought to, it can be removed from the list.

Though some flexibility does exist in these anti-doping programs, critics of this approach hold that there are so many potential enhancements available that anti-doping programs based on strict codes of ethics will ultimately be insufficient in the effort to stymie usage as athletes will seek ways around the prohibitions (Miah 2006). As athletes continue to rely on new advancements in medicine and training technologies, medical researchers will continue to seek new ways to improve athletes' performances. Due to the value placed on the use of technology to enhance performance by many coaches and athletes, programs seeking to monitor these technologies must walk a tightrope between the two extreme views of this debate—that anti-doping programs should be ever more rigorous and athletes should be strictly monitored, or that anti-doping is doomed to be ineffective and all restrictions lifted.

It is for this reason that I argue for a reordering of the way anti-doping agencies view athletes in their consideration of what practices and substances athletes should

be allowed to utilize to enhance their performances. This new way of looking at includes, first, recognizing that elite athletes are not normal in terms of their lifestyles and attitudes towards medicine. By definition elite athletes are different from everyone else—they represent the upper echelon of sporting achievement. As they are expected to perform in their chosen sport in a way that is not expected of non-elite athletes, it follows that their lifestyles would reflect this difference. They train more frequently and with more intensity and focus than non-elites. As a result of their being brought into a medical subculture via the rise of sports medicine, they have come to rely on, and value, medicine and technology to aid in this pursuit of excellence. As non-elites do not engage in the same practices or utilize the same technologies as elite athletes, it should not be surprising that the two groups have different attitudes regarding what is a logical extension of techniques and practices already in use and what is considered extreme. Recognizing that athletes are not normal in these ways can clear the way to understanding that what would be viewed as abnormal for non-elites may actually be standard practice among elites.

Second, anti-doping agencies must recognize that there is and can be no real standard of normal among elite athletes, as the ultimate goal of elites is to be as abnormal as possible. Elite athletes compete to be the best in their field, and being the best also means being the most different from everyone else, including other elites. In order for elite athletes to achieve this ultimate goal they adopt highly abnormal lifestyle and training techniques. If they train in the same way as everyone else they cannot become different—competition is built on the pursuit of the special, the different, the abnormal.

An understanding of athletes that takes these two ideas into consideration may work to create a system of anti-doping that does not fear, but instead respects the non-normative lifestyle and values of elite athletes. The system of anti-doping that can walk this tightrope between two extreme views of athletes and how they should be regulated must be open to acknowledging and incorporating technologies and values that may not be fully understood or appreciated by those outside the culture of elite athletes. However, a system that works within these differences and not against them has the potential to be more effective at protecting the spirit of sport and competition than the current approach.

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Chapter 3
Embodying a Healthy Running Body in a British Non-Elite Road Running Community

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Introduction

In this chapter I explore some of the issues surrounding my body's journey from a sedate comfortable lifestyle in my early 30s to a more physically active and sporty lifestyle by my late 30s. The chapter first documents the popularity of running in a global context. I then consider the self-regulated running body, nature and consumer culture. Using an autoethnographic approach allows me to explore some of my personal running experiences and reflections, drawing upon personal data from running diaries which recorded training sessions, race results, and some limited comments on how I felt at the time. I have used these running diaries as the basis for remembering and re-remembering the past as an embodied narrative. I chart my own journey as a lone runner and my progress as I join a non-elite road running club. Finally, I consider some of the emerging themes in relation to the literature and my future research.

Setting the Scene: The Rise of Long-distance Running by 'The Masses'

As I moved from a non-runner to a marathon runner I was aware of the development of road running both professionally and as a mass participation sport, particularly in relation to the marathon. Since the 1970s this growth is evidenced by the increasing prevalence of city marathons and the number of participating competitors, both men and women and across a wide age range. The modern marathon distance of 26.2 miles or 42.196 km was established in 1908 at the London Olympic Games (Bryant 2005). Despite women participating in city marathons and European athletics championships it was not until the 1984 Olympics that the first women's Olympic marathon was held. Outside of the Olympic movement large city marathons, for example, London, New York, Paris and Amsterdam are interesting examples of where both elite and non-elite competitors, club and non-club runners, tread the same route, albeit in different finish times, and for different rewards. These races have also become a vehicle for raising charity money with some organisers reserving places for charities who in turn allocate to fund-raising participants. Some of these participants will

have been previous non-runners who have been motivated to start running as a way of raising money for their preferred charity. Another example of this type of charity running includes in the United Kingdom the women-only Cancer Research ‘Race for Life’ 5km series. They started in 1994 as one race with 680 women and have grown to 230 races in 2009 with an estimated total of 750,000 women participating. Similar charity raising events are held in other countries around the world, for example, the American Cancer Society ‘Relay for Life’ with 3.5 million participants.

An examination of road running results ‘capture’ the emergence of women’s increasing participation in running and a snapshot of the underlying upward trend can be found in participation statistics from the New York City, Paris, Amsterdam and Helsinki marathons. The following statistics were obtained from the respective marathon organisations’ websites. In 1970 the New York City marathon had a total of 127 starting participants and only one was a woman. By 1980 the participation numbers had risen to 14,012 of which 14 per cent were women. By 1990 there were 25,797 starters with 20 per cent being women and these figures continued to grow as in 2009 there were 43,660 runners of which 35 per cent were women. Similar growth and proportions of women can be found when examining the data of finishers for recent London marathons. In 2004 there were 29,770 finishers of whom 24 per cent were women and in 2009 there were 35,351 finishers, 31 per cent were women. Data from the Helsinki marathon for 2004 revealed similar proportions where 24 per cent of the 4,939 finishers were women. Data from the 2005 Amsterdam marathon show that 16 per cent of the 5,336 finishers were women; this being a similar proportion to the 2009 Paris marathon finishers where 16 per cent of the 30,334 finishers were women. The smaller proportions of women at Paris, Amsterdam and only slightly less at Helsinki may be due to structural factors relating to the registration process. These three marathons operate a direct registration system whereas both London and New York operate a more complex system that is partly ballot based in an attempt to manage the excessive demand for places. It could be argued that the quota regime adopted by the ballot systems may result in proportionally more women applicants getting actual places (figures on applications were not available) though this then leads to the inevitable question of why aren’t there equal proportions of men and women. The direct registration systems may better represent the general level of participation in women’s running however even direct registration with its ‘first come first served’ approach inevitably excludes individuals, especially as online web-based registration and card payment becomes the norm (e.g. 51 per cent of the 2006 Paris marathon registrations were made via their website).

Examination of the finishers’ data from the 2009 New York City Marathon shows that distance running attracts men and women from across the age range. The age gender profile for the New York City Marathon 2009 is shown in Figure 3.1. The profile for men and women is different with a higher proportion of women finishers in the younger age groups compared to men. This may reflect the growing popularity of women only races, especially those run by charity

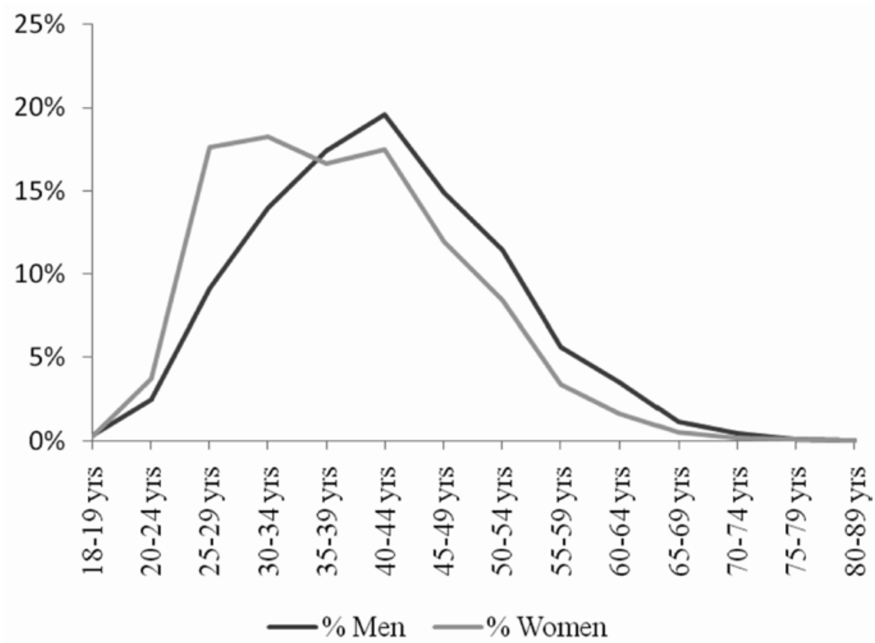

Figure 3.1 Age profile of men and women finishers: New York City Marathon, 2009

Source: Data taken from the New York City Marathon Demographics on Finishers statistics http: //www.nycmarathon.org/results_finisherDemographics.htm. Accessed 01/12/2009. Total finishers: men = 28,485; women = 15,175. Chart compiled by the author.

organisations, as well as reflecting family or child care responsibilities with the noticeable decline in women aged 35–39 years.

In summary the evidence from race statistics highlights the rising popularity of running and global marathon endurance running events. While woman have also increased their participation it has not reached equity with men. Having established the popularity of road running in the next sections I will explore the relevant literature relating to the running body as self-regulation and a consuming body.

The Self-regulated Running Body in Sport, Fitness and Health

In the following section I examine some of the literature related to understanding the body, focussing in particular on technologies of the body, gender and the body, how sporting activities are organised and measured, and finally, the consuming body.

Technologies of the Body

Similar to other social activities participation in a sporting pursuit whether for leisure or competition involves the body engaging in social practices that give new meaning beyond simply biological characteristics (Shilling 1993). The movement of the body in running and athletic coach training manuals, for an example see Noakes (2001), emphasises the body as a mechanistic hierarchical system where episodes of running or training are concerned with the continual improvement in the efficient function and form of the running body. The focus is on improving the cardio-vascular system, body strength, biomechanics and fuelling of the body. These texts often include chapters on the psychology of sport to improve and maximise performance, in particular for competition. This whole subject area is often referred to as Sport and Exercise Science, SES (Brackenridge et al. 2005), with its scientific knowledge and approach replicated in the popular press, sporting magazines and internet sites. The focus of the body on objectification and quantification suggests that while the sporting body can in principle be for leisure or play it is increasingly rationalised into a self- regulated work like form. Sport and Exercise Science (SES) has tended to give a limited consideration of the everyday social and natural environment in which the biological body functions. It is social practices that labour upon and transform the body, a process that Connell refers to as 'transcendence' (Shilling 1993: 110). Through this embodiment gendered bodies are both defined and transformed by existing social categories. As the work of Connell suggest these categories form women's and men's bodies that reinforce masculine and feminine images (Schilling 1993: 106). From a review of sociological research on women and sporting activities, Markula (2003) concluded that separating the dominant technologies of power from technologies of the self is problematic; and, recommended that women need to engage in a critical self-awareness of dominant technologies on their sport. In Foucault's concept of 'technologies of the self' the concern was with the actions and practices that an individual performs on their own body, sometimes with the help of others to:

> permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection or immortality (Foucault 1988: 18 cited in Markula 2003: 88).

In the review Markula concluded that the concept of technologies of the self had been interpreted slightly differently in the research projects of women in the different sporting activities analysed (these were gymnastics, rowers and body-builders). The review focused on research that examined the role of diet regimes of sports persons as dieting is used by individuals in many sports to achieve the ideal body image for premier performance. Markula concluded that it was difficult to separate the technology of the self from other power processes. Some research

concluded that the process of dieting, as a transforming practice, enable athletes to fulfil the sporting discourse of achievement as an act of personal freedom and choice, however other research concluded that personal dietary choices were made within the bio-medical discourses of sports science and gendered images of the ideal body.

One framework for understanding the growth in activities such as running is to consider how health and fitness have become intrinsically linked in everyday life. The idealised body that is lean, toned and 'visually' healthy is one that both men and women, particularly from the middle class, strive for. The self-regulation required to achieve such an aesthetic disciplined body also becomes the body image of someone who is able to demonstrate self discipline, healthy and virtuous behaviour lifestyle. The act of running as a highly self-regulated activity is one form of a fitness activity that seeks to uncover or reveal the 'fit' individual body through rationalised activity and to cope with a rapidly changing world (Glassnor 1989). In this context, Lupton (1995: 143) contends.

> This concept of exercise is strongly linked with the concept of health as a 'creation' or an accomplishment of the self. It is also related to broader contemporary notions of the 'ideal' body as one that is tightly controlled, contained in space, devoid of excess fat or flabby muscle.

The therapeutic benefits of exercise and sport have also been explored with research evidence to suggest an association between emotional well-being and regular physical exercise and health life style (Steptoe et al. 1997), and that aerobic exercise is an effective treatment over no treatment in mild to moderate depression (Martinsen 1994, Estivill 1995). Further evidence suggests that exercise can be one element of an effective therapeutic approach (Laitinen et al. 2006, 2007) and that the social support network surrounding exercise behaviour (Oman and Oman 2003) also contributes to well-being.

Gender and the Body

The earlier analysis of marathon statistics suggest that men and women marathon runners also engage differently across the lifecourse and comparative research on choices in sport participation have revealed differences in men's and women's participation. Patterns of sport participation are generally accepted as being established at a young age.

Research into participation in sporting activities suggests that men/boys have not only been encouraged to take part in sport but that they are directed to sport that is masculine in terms of its emphasis on strenuous and competitive activities. Women/girls have not been so encouraged; instead definitions of fitness are based around performing everyday tasks, less on taking part in sport or exercise for fun and more on body image. Historically women's participation in sport was

limited by biological determinism in order that they should fulfil their duties of motherhood. This approach advocated the less vigorous sports activities which were not built around competitiveness and muscular bodies. Exercise, health and morality became intertwined with sports appropriate for women, for example, croquet, stressing the cultured, gentle recreational leisure activity that was good for health and not the competitive sport of men (Hargreaves 1994).

Women are less likely to see themselves as 'sporty'(Choi 2000: 5) and research by Scratton (1996) suggests that this low participation rate, in the UK at least, can be located in the education system from secondary school onwards. Scratton's research found that the majority of young women in her study of UK schools lost interest in physical education from secondary school onwards. Reasons given include dislike of feminine sporting activities offered which are seen as low status, the school sports kit, getting sweaty and communal showering/changing. Where women do participate in sport/exercise there is a tendency for the emphasis to be on regulating the body to achieve an acceptable body image and shape built around a cultural slenderness which in order to achieve requires tight self-regulation (Bordo 1990). Deem's (1987) research on sport in women's leisure also highlights that participation or non-participation should be understood within the wider context of women's limited leisure time, due to structural and ideological factors such as the accessibility and location of organised sport, demands of women's gendered role in households, biology, physiology and sexuality. Fasting (1987) highlights that in Norwegian society women's participation in sporting organisations takes place on men's terms and Hargreaves (1999) notes that in women's organisations there is an under representation of women form all social backgrounds.

Organisations and Measurement

There has already been much research undertaken in exploring how individuals work on their bodies to bring about changes, for example, gym users (Crossley 2004, Sassatelli 1999), bodybuilding (Monaghan 1999) and aerobics (Markula 1995). Running can also be gym-based with fitness centres offering stationary running on treadmills. Like body builders and gym users the emphasis for runners is on individual engagement with a series of activities which are different from team-based events (e.g. football, netball) or sporting events that require a high level of skill (e.g. tennis, golf). The very nature and form that running can take also makes it a complex activity to research. While it is certainly true that running is a highly individualised action it can, should the individual chose, also involve the social and team elements of other sports. Individuals can chose to run as part of a running club organisation and take part in team based running events. Alternatively they may prefer to run alone or with friends. For example, a group of club runners may train together or attend a formal training event at a local track. Non-club runners may build a running network through friendships and work. Running clubs have their own rules and regulations. Some are formalised through the club constitution

and like other sporting activities are focussed on the avoidance of conflict and injury. Club organisations can bring people together in a positive environment, although Huizinga (1970) identified that they also serve to regulate and structure what was once a playful creative activity (cited in Cashmore 2000).

The standard measurements of performance in running are time, distance and race position. In the professional athletic world statistical data recording personal best performances, games records, national records, and world records are scrutinised and interpreted. 'They define achievement and progress – progress towards the record. They are also said to serve as universal athletic currency, enabling unambiguous comparisons to be made between places and regions.' (Bale 2005: 24). Within local running clubs this practice is also adopted to include the recording of individual performance times and club record holders, with local athletes using this running currency to provide a common language between individuals of different abilities and commitment to running. Even for those runners that do not take part in races or do not belong to a formal club, the completion of a recreational run is often personally measured in time and/or distance, as a means of logging performance and progression. Research undertaken by Smith (1998) suggests that both the general public and runners themselves sub-divided runners into different 'types' based upon the level of regulated activity that the individual participates in. In a study of road running and racing, three types of runner were identified, 'athletes', 'runners' and 'joggers'. Those individuals whose speed enabled them to win or come highly placed in road races were 'athletes', those who regularly entered races but would never be placed for prizes were 'runners' and finally, the group of runners who may enter races occasionally were fun runners or 'joggers'.

The Consuming Running Body

Professional sport is financially supported by an array of different consumer practices that engage individuals in the sport as a participator and/or as a supporting spectator. Over the past twenty-five years sport has become increasingly linked to the media and advertising. For many sports, particular the team-based sports such as American football, soccer or football, baseball and ice hockey, there is a branded market for sports goods and services that are advertised and endorsed by sports personalities. The commodification of sport has been extended to include celebrity where sport related products are endorsed by world leading professional sports stars (Horne 2006). Major sporting events such as matches or large city marathons are also televised and sponsored by sports related brands, for example sports drinks and equipment manufacturers. Sport is part of a wider lifestyle choice that places an intrinsic link between the product, individual choice and a healthy, fit, and, successful sporting body. Individual fitness is constructed as a consumer lifestyle that requires the individual to engage in a project of the body (Featherstone 1987), and perhaps it is not unsurprising that in this context consumer culture and

sporting activity have mapped together (Hargreaves 1987). The promotion of the healthy body is one that is linked to the healthy self of personal free choice and self-expression (Watson 2007). To aid the individual runner there is a plethora of running technologies available for consumption. For both men and women there is a wide variety of running clothing and equipment that is marketed as enhancing running experience, protecting/managing injury and maximising training benefits. The array of products available both aim to maintain the inner and outer body (Featherstone 1982) to both feel and look like a healthy runner. The inner body is concerned with the consumption of appropriate training regimes, nutrition and general maintenance against injury. Those activities from SES, discussed earlier, include training knowledge, dietary advice and use of sports therapists (physiotherapists, masseurs) can all contribute to the success of the visible outer body in terms of general body image and improved performance. In addition the outer body also requires the individual runner to undertake some identity work to acquire 'the look' of a runner and the mass consumption of appropriate running equipment, latest designs and technologies is driven by advertising that can be found in specialist running magazines. Smith Maguire (2002) undertook a textual analysis of fitness manuals in the US and concluded that the body of a fitness consumer was a body of consumption. This 'body of consumption' was able to calculate positive rewards for overall well-being and healthiness, to develop motivational techniques to overcome inertia and possible failure, and to undertake the physical exertion of training. The image of a runner in advertising is not just one that is thin, lean, athletic and healthy but also one that has the latest running clothing made of hi-tech wicking material, the correct shoe for their running style and terrain. There is information on dietary requirements for different distances and a range of supplements to be taken before, during and after training/race sessions. More advanced and costly technologies are available for recording individual fitness and progression storing data on time, distance and heart rate. Abbas (2004) undertook an analysis of the front cover and letters pages of a leading running magazine from 1979 to 1995 and found that the image portrayed of the successful runner was middle class. The image naturalised age and gender inequalities and promoted individual responsibility for their healthy running bodies.

While all of the discussion around sporting practices, sport and exercise science, the influence of consumerism and pursuit of health and fitness lifestyle we are still left to ponder a key questions in relation to non-elite running practices. What are the processes by which an individual, including myself, become involved in running? Are the running practices they engage in constraining or enabling, and how does running relate to wider lifestyle choices? In my autoethnography, it was these questions that I wished to consider in relation to my own reflections on my experiences.

Methods: Autoethnography

There has been a growing emergence of academic writers critically reflecting on their own autobiographical experiences to make sense of the complexities of social and political life. Critical reflection has been used by researchers in ethnographic research to make sense of research settings (May 1993), particularly those that involve particular difficulties and challenges (Lee-Treweek and Linkogle 2000), providing additional insights into the understanding of the specific focus of the research. The autoethnographic approach requires the author to engage in literary writings to clarify understanding for the reader, to engage in critical self-reflection and analysis. For Ellis (1999) autoethnography bridges the gap between the social sciences and arts; advocating a process of emotion recall to imagine being back in a social scene with both the physicality and emotions of the event. Autoethnography situates the individual writer as both the researcher subject and the researcher, to research and understand oneself. It is characterised by writing in the first person, situating the '*I*' in sociological understanding (Katz Rothman 2005, 2007, Stanley 1993, 1995) through which the researcher can critically understand his/her own experiences. The 'autobiographical I' is 'inquiring and analytical' (Stanley 1993: 49). Autoethnography has been used by many academics particularly around experiences of physical and emotional pain and illness (Sparkes 1996, 2000, Ettorre 2005, 2006, forthcoming a, forthcoming b). Ettorre (2006: 153) uses autoethnography in a reflexive process to understand a recent illness where the method of 'autoethnography presents particular embodied events with people in time, their social shaping and how these can be seen as emblematic of wider cultural meanings and social trends'. The autobiographical method has also been used to consider movement and emotions (Sutton 2009, Letherby and Reynolds 2009), while autoethnography with an emphasis on emotional recall has been employed to help others to mend wounds (Ettorre forthcoming b).

My motivations for using this approach emerge as part of my future research ideas to explore the leisure or non-elite based running community. Exploring my own reflections on personal experiences would provide critical understanding that would both help inform my research and also enable sensitivity to individual differences in how we negotiate the social and political. It would allow me to clarify the concepts and emerging issues that have presented through my running body. Furthermore, it would hopefully facilitate a personal awareness of the barriers between the researcher and the researched. My autoethnography is one that focuses on both the pain and pleasure of training and participating in races. From enjoying the freedom of movement of a running body, balanced against constraints and negotiation, of moving my running body through a landscape of technologies for improving my running body and jointing a local running community.

The data for my autoethnography is drawn from my running diaries which recorded training sessions, race results and some personal comments on how I felt at the time. These diaries were kept between 1999 to 2006, a period in my 'running career' that saw a significant changes in how I choose to run moving

from a causal solo jogger to joining a local running club in the UK. Detailed diary entries were kept between 2003 and 2006 as this period corresponds with a developing enthusiasm for longer distances up to and including the marathon. Prior to 1999, my last experiences of summer track running were as a teenager at school, reluctant, and always at the back running on a track disliking all aspects of the compulsory, physical education lesson. I have used the diary as the basis for remembering and re-remembering the past as an embodied narrative. Also, I have a photo album containing images of my participation in organised running events, with the images taken mostly midway and at the finish line. Depending on the specific event, there are accompanying memorabilia of medals and t-shirts. This process of revisiting textual and visual image data allows me to clarify the feelings, concepts and emerging issues that have confronted me through my running body; to critically reflect upon and to think about how my past experiences will potentially impact on my future research.

My Life and Running

It is May 2006 and I sit in my office with an open Word document ready to type a draft of my paper. Over the past three months, I have read about autoethnography, attended a mini-methods festival where the use of autoethnography was discussed by my colleague and friend, Betsy and I read some of the literature relating to the body, sociology of sport texts and feminist accounts of women and sport. My head is spinning with different ideas both about the content of this paper and the wider discussion of autoethnography in social research. Now as I come to start thinking and writing about my story, I have this fearful sense that what I have to write about is probably not that interesting to anyone but me. I also feel it is going to be hard to organise my reflections in a concise, meaningful way for the reader. Autoethnography feels a little like 'doing' English literature which was not my favourite subject at school. I then gaze out of my office window. It is a lovely sunny day. I could so easily stop at this point, get changed into my running gear and go for a run by the sea. You see running is so easy for me in comparison to academic writing. From the moment I step out of the front door, I can forget the struggles and hassles of everyday life and focus just on me, my feelings and my body.

Thinking Back in Time

Starting Out ... Summer and Autumn 1999

My story really begins in spring 1999. My mother had been diagnosed with breast cancer the year before. It had been a difficult time for her and our family. Cancer, like other serious illnesses, always brings the feeling of fear of death to families.

Working full-time and living 250 miles away from mum it was difficult to visit as much as I would have liked. I felt angry, worried and helpless as I watched her and my father deal with the endless rounds of cancer treatment and check-ups. Prior to this in 1998 I had watched my partner run the Plymouth Half marathon and I remembered feeling in awe of all of those runners, of all shapes, sizes and athletic ability who took part in this race. I distinctly remember the 'if only I could do that' thought that I quickly suppressed in my mind. 'Me and my body? Run? Never!' I recall that my participation in athletics as a child was restricted due to childhood asthma and the medical thinking of the day to minimise sporting exercise. For me, PE or physical education was not an enjoyable experience; particularly from secondary school onwards and in common with other young women I lost what little interest I had in any sporting activities. I had observed consistently that running was often used as a punishment by my PE teachers to control unruly pupils during lessons that served to heighten my personal fears of failure on the track.

While researching information on current medical breast cancer research and treatments on the internet, I found details of the Plymouth Race for Life. This is an annual women only 5km race series that is organised to raise funds for Cancer Research UK. I liked the idea of participating in this event, to do something positive in the face of all the negativity that surrounded my mother's cancer. With a group of friends, I ran the race. I enjoyed the togetherness of the run – women of all shapes, sizes and abilities. There was also a rewarding sense of having a personal challenge and of elation at crossing a finishing line. Here the finish line means accomplishment, success and feeling proud whereas at school it was a feeling of relief to simply survive the PE lesson. Afterwards I decide that I want to continue running and I am supported by my partner. I cannot really pick out any distinctive elements of running that encourage me to continue. Maybe it is the sense of doing 'something', channelling my anger about my mother... Maybe it is the fact that I am participating in a physical activity that was independent and individual, which gives me a sense of liberation and freedom. I can exercise when and where I want. While I cannot say I was particularly focussed on my overweight body, I never weighed myself back then, perhaps there was a motivation within me to lose weight, and transform myself from my 30-something-year-old, comfortable, sedentary lifestyle. At the same time, I feel a sense of guiltiness, as my mother's health deteriorated. Here I am using her illness to springboard my own improvement in physical health and well-being.

Thinking Forward to… Spring 2006

On a cold, windswept Tuesday evening I am with my friends in the car. We are laughing and half heartedly moaning about the cold weather conditions – it's about 2°C. We arrive at the running track. As usual, we warm-up before completing a session the athletic coach has planned for us; 400m at a slow marathon pace, 400m at fast 5km pace, repeated for 20 laps. We start with cold bodies, shivering until

our muscles warm up. It is a heartfelt warmness that extends to my general sense of well being as we chat and share stories of our recent news. We are endurance runners and share the track with faster track athletes. I run in lycra tights and a close fitting thermal top, still slightly self-conscious that in my view I am still a 'relatively heavy and slow runner' compared to others here, but the clothes are practical and appropriate for the conditions. I have my lightweight track shoes on and my multiple lap watch. I think back to my first attempt at running faster in 2003. Although I don't especially recall giving it much thought at the time, I wore baggy leg length trousers and a cotton T-shirt back then. I was no doubt covering up my larger, heavier body. When I first started running at the track, I remember the feeling of loneliness of belonging but not belonging to this group of runners; of being the outsider. Now these women are my friends and I am happy to at last be accepted as part of the group. As we continue to chatter in the car, I allow myself a contented smile. I've come a long way in almost 6 years. New friends, new knowledge about training regimes and a smaller, fitter body. I've completed 3 marathons, over 20 half marathons and numerous 10km and 5km races and 4 dress sizes smaller. And I am still improving my race times. I love running!

Summer 2006

I am thinking about how my running has progressed over the years as I do this I flick through my training diary kept in meticulously detail on a spreadsheet. It charts my progress from my initial charity jogging body as I continued becoming a social jogging body, before joining a running club where my body became a social running body.. and finally in the last 18 months the progressing of my moving body into a competitive running body where time and speed become prominent in my diary. I feel proud of my diary as it represents a point in my life when I made time to record and acknowledge those achievements; by me and for me.

Going Back in Time to 2002. I Re-remember my First Club Evening

I arrive and am warmly greeted by smiling faces. I am asked about my running speed, I say laughing 'slow, very slow' and I am placed with a group of women who laughed and confirmed that they are the 'slow group'. They like to have a chat on the run and we get to know each other. Over the weeks and months that followed we run in different environments, urban, rural, at different times of day, sometimes very slow to chat and at other times a little faster with less talking. We all run in the club tee shirts with the club name and logo. I notice that everyone sticks to their allotted groups. The faster runners, predominately, male receive the most attention as they win prizes or are highly placed at local road races. At first I am happy to remain anonymous but over time I become angry about this, I begin to feel that the slower runners, mainly women are invisible. There are occasionally sexist, racist and homophobic comments made by a few in the club; 'I should challenge this', I think.. But no one seems bothered and when I tentatively try

to approach these issues that annoy me with the women I run with they seem unwilling to discuss or see there is no issue to discuss. Of course in the world of academia, it is easier for me to say something but in 'the outside world' with local people from different backgrounds these issues are more difficult. Now I continue to flick through my training log to September 2003. The words track are listed; this was the transitional point at which I decided that I am no longer content to plod around in the slow group. I want to see if I could go faster. Emotionally I want to break out of the mould of my social jogging body that had been defined both by me and by the informal organisation of the club into well-defined running groups.

I read the training literature in magazines and on the World Wide Web about interval training, emphasised as 'essential' to improve performance. Organised weekly track sessions take place but few individuals in my club attend. The reasons given are 'too hard', 'only for the serious runners' and 'dominated by other running clubs who take themselves more seriously than we do'.

Re-remembering my First Track Session

I turn up 5 minutes early for the 18.00 hrs track session. There is no one on track-side so I sit down on the bench and wait. I look at the 400m track and think back to my school days at the summer sports day and remember how I dreaded the annual event. Almost 20 years later, I am back at a track, feeling nervous, with a sinking feeling in my stomach. 'Should I really be here?' I ask myself. A few other runners turn up, chattering and laughing amongst themselves. I am outside of this group, a stranger. They say 'hi' but not much else. It is difficult for me to start a conversation as I have serious doubts about whether I am worthy of being here. They appear to be older than me and I am reminded that this is completely different to the images of young track athletes that I see on TV. Although not young, they have lean, athletic bodies and they look like runners. I am conscious of how much bigger I am then they are. They have all the 'gear'. They have appropriate running shoes. They are wearing lycra shorts or runners shorts with well fitted wicking runners t-shirts or vests. They have proper running watches. Some have heart rate monitors that are bleeping. I still run in baggy trousers and a loose fitting cotton t-shirt to hide my flabby body. I think that they must be wondering why I am here too; I don't look or feel like a proper runner. This is the first time that I am offered advice from a UK Athletics qualified coach. I feel slightly embarrassed that he suggests some training sessions for me and seems to be saying that you can be a faster runner if you want. Yet, it is my desire is to be that faster runner. It is a wish that I want to keep as a private goal, not to be made public knowledge. I still harbour the fear of failure from school days.

At the end of the summer season formal track sessions cease as the track has no lighting facility. I now wear 'appropriate' running clothes and have bought sophisticated running watches to record my training. A small group of us decide to continue running informally using the track in darkness. We are breaking the track rules but these are happy times. My now new running friends are more 'serious'

as they not only train appropriately but also eat healthy, follow professional injury prevention and recovery advice.

News of my nocturnal track training soon filters back to my running club. My altering body appearance as I start to lose a considerable amount of weight and my increase speed and endurance are obvious to all including me when I see the official race photos. I am no longer invisible. I like the contrasting photos, it feels me with pride. My race results are read out followed by the words, ‘I guess that is another personal best, Carole?’ It was a nice feeling but I am also feeling sadness as the distance was growing between me and the woman I was running with. ‘Am I betraying the essence of their running group?’ I ask myself. One women says, ‘You’ve flown the nest’ and ‘Just remember that I trained you’. I can’t work out if she is angry or pleased for me. I start to feel isolated and this is further reinforced when I am subjected to a very public telling off from one of the male committee members for using the track during the winter months. I find myself, no longer able to keep quiet, and uncharacteristically shout back louder, ‘I am running at the track with a group of friends, without my club vest on, as a member of the public. I am not stupid and I am fully aware that I am running at my own risk’. I feel my face is red with anger. I am told that ‘be it on my own head and not to come crying when I get injured’. I smile and say ‘Fine’, and I stubbornly resolve to continue training with my friends at track. I am ignored by everyone for the rest of the evening and run alone. I feel like I have done wrong by answering back but deep down feel that I have done right for me.

In the weeks that followed I attend club nights less regularly. Partly because they did not fit in with my marathon training schedule, partly because I felt awkward and did not want any more confrontation. Looking back now I regret the course that I took, I should have continued to attend more regularly. I start to worry that my faster running may be seen as arrogance, particular when I start to develop a niggling injury. Eventually I leave and join another club; sadness is replaced with excitement of meeting new runners. Joining the new club I do not feel the same levels of anxiety and intimidation as I join as an established runner.

And Work and Leisure Time

My changing body image starts to be noticed at work. I am surprised when people stop to ask me if I am ‘okay’ and ‘not ill’. As I enthusiastically explain my marathon training, I receive responses. Many are supportive. They also vary but one theme remains constant – ‘What damage are you doing to your knees?’ ‘Do you not increase your risk of having a heart attack?’ Others colleagues ask, ‘Do you have the right body shape to be a runner?’

As I increase my training session’s time is becoming compressed. Life is becoming hectic as I try to juggle my workload which I notice increasingly I fit in around my running rather than letting work dictate. I slowly realise the amount of work that I have been doing in my out of work hours and the all consuming nature of academic work. Running has given me back that distinction of work

time and 'my time'. Now that I can run faster I am able to run with my partner, sharing news about our day and the experience of the run itself. My network of friends slowly drifts as I spend more time with my running friends and less time with other friends who are mainly based within the university. Leisure time is spent talking about running and not the latest work related issues or politics. My family also become interested in my running. My mother and I talk about my running regularly and her cousin tells me, 'You know your mum is very proud of her wheezing little girl'. I feel proud and happy too at my achievements.

Discussion

In this discussion I want to consider the key themes that emerge in relation to how I became involved in running, my engagement with the different technologies of running and how they relate to gender and running together in the context of the literature. As I ran alone initially and then with others, I felt my body move between private and public spheres. Running alone, I could be in my own private world, albeit amongst the public gaze, whereas running with others involved negotiation with their whims, feelings and perceptions of me and vice versa. Improvements in my running performance particularly as I moved to a competitive running body resulted from my engagement and adoption of training knowledge and technologies. I have summarised my progression in Figure 3.2. What is represented are the changes over time that I experienced as I started running more quickly and over longer distances. Longer distances were run at a slower pace, short distances much faster. However, for all distances time performance improved.

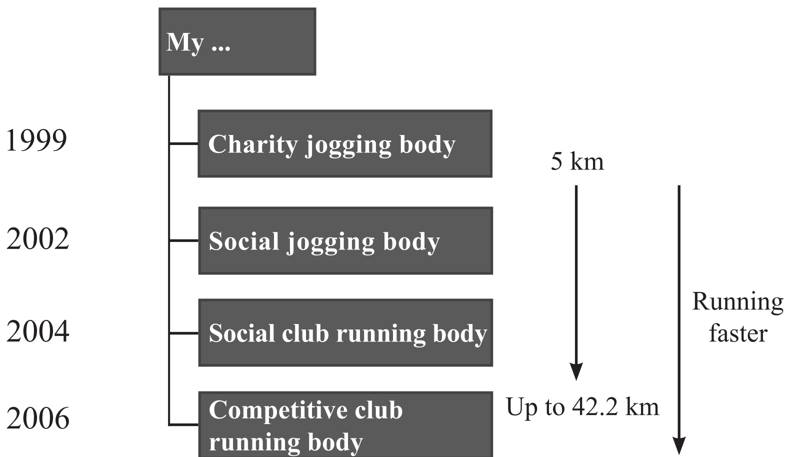

Figure 3.2 Summarising progression

The SES technologies of running situate the body as a place of regulated work, as formalised individual embodiment and modelled in part on the lifestyle of the professional, elite athlete. In a non-elite setting, I chose the degree to which I consumed these technologies within the confines of my everyday work, home and social life. As a lone runner, starting out, I gave little thought to a dedicated training regime, and yet the act of joining a club would suggest at least my understanding of training. The club training nights, while apparently gender neutral, and were in fact masculinised with the emphasis on competitive performance and improvement of the physical body. Within the club training sessions, decisions are determined by senior, predominately male club members. For me, there was a significant difference in the gender relations between my academic world and my social world; there was a greater degree of explicitness in the politics of the club and acceptance of knowing one's place. When my actions challenged this, I felt uncomfortable, lonely and these feelings were the initial trigger that led to my eventual departure.

My autoethnography has allowed me to consider how the expert knowledge of the sports sciences becomes public, everyday knowledge and language for both men and women runners. The running body is a consuming body that engages in social practices in the assimilation of technologies. Adoption of the technologies varies between individual runners depending on their particular circumstance. As my running developed the more engaged I became in the complexity of training practices designed to improve the running body and I modified these to fit my personal preferences and circumstances. The different running groups that I have belonged to represent how my acquisition and adoption of knowledge, and subsequent experiences, are situated temporally and spatially. I observed that not all women in the club follow strict training regimes; some runs were for fun and pleasure. My desire to run faster meant that I joined a different group of runners who followed the rules of sports and exercise science more rigorously. Here the importance of the social elements of engaging in a physical sporting activity is evident; as are the fun and friendships that emerged. However these are fragile relationships that within organised club sessions hinged most often on individual performance versus group collectiveness. At a personal level, my wish to improve was offset against a sense of loss of the running friends I was leaving. The unresolved tensions for me were a wish to be collegiate and run with other women while at the same time also improving my individual performance.

Joining a local running community changed the nature and way that I thought about my running body. I was no longer 'a jogging body'. I was wearing the technical clothing of the professionals. My changing body image was highly visible to both runners and non-runners, and the public gaze extended to open questioning about running as my sport and the state of my own health. Inquiries about my running were mixed with underlying fears of a risky behaviour with the potential for injury and ill-health. Reminders about the risk of injury were a powerful political tool both with the club organisation and more widely as the comments from non-runners about developing knee pain illustrate.

Conclusions

At the beginning of this chapter I stated that one of my motivations for undertaking this autoethnography was for me to gain an understanding of aspects of my own experiences and to consider these in relation to my future research plans. The importance of running with others emerges as a key theme that is negotiated against a framework of running technologies and the social and political dimensions of the social club organisation. I am currently researching the running histories and experiences of men and women runners, both club and non-club runners. The interviews are exploring the issues of training, racing, running environment and running with others. I am hoping to learn more about how others besides me 'embody a healthy running body'.

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PART II
Bodies and Representations

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Chapter 4
The Visible Body: Health Representations in a Consumer Society

Rui Machado Gomes

Introduction

Contemporaneity (i.e. the moment we are living in) appears as a new visual regime marked by the growing power of imaging technologies – particularly those used in medicine – to access the inner body and, hence, play a constitutive role in the formation of norms on the perfectibility and changeability of the human body. The notion of body visibility was devised to highlight the body's dual nature in contemporary culture. This new visual regime brings out the true cult of the body confirming, at any given moment, that *we do have a body.* Yet, and at the same time, it also underlines the ambiguities created by excessive discourses and transparency. Thus, the use of the notion of *transparency* (Dijk 2005) interplays with body presence/absence, one of the main hallmarks of the health and well-being oriented, consumer society. Transparency comes into play as medical information and technologies show an increasing trend to support inner body examination; plus, it is validated by increasing self-observation, self-diagnosis or self-medication as a way for the layman to access body signs and effectively act inside it. *A contrario*, however, the lack of transparency is reflected in how the *fleshy body* is being progressively withdrawn from our daily life, forced as it is to undergo hygienic purification before making its appearance in public spaces and images. This chapter argues that ambivalence is one of the signs of the present day body crisis, endured side by side the image of a perfectible body.

Contemporaneity has seen the dawn of a daily life fully permeated by body crisis. The general search for a current and immediate meaning for human life is one of its main symptoms. The fear of ageing, obsession with health and fitness, maintenance and dietary rituals, the search for autonomous therapies and the spread of self-medication are in themselves indicators of an unprecedented fascination with subject self-knowledge and self-fulfilment. Meanwhile, such reflexivity, impregnated with medical and psychological knowledge – typical of late modernity – doesn't always provide the subjects with increased ability to control the situations they find themselves in. On the contrary, such reflexivity often intimidates and inhibits the subject's range of options. Wider knowledge about social life doesn't translate into greater control over the subject's destiny. This incapacity, caused by excessive reflexivity in the information era, is also a

consequence of the social system's rigidity and immobility. Society appears to be immune to any change, whereas 'permanent changes' shift towards the inner individual and his/her body. The crisis of major narratives has transferred the final hope of utopian projects into each individual's body. As remarked by Bragança de Miranda (2002: 180):

> On the one hand, the 'world' has been replaced with the body, as an organising category of utopian images; on the other hand, this process develops hand in hand with the crisis of the 'body' itself. Something that should not be surprising, as the 'body' has to explode and dissipate in order to supersede the world.

We live in a time when the glamour of the body, the faithful trustee of each individual's identity, seems to be the only utopia we have been left with. And, yet, never in the past have doubts been so extreme regarding the knowledge we have of our bodies. On the one hand, we seem to believe in salvation through the body; on the other hand, we have grown deeply sceptic about the array of knowledge and technological devices made available to us to control or improve it. As a consequence of scientific and technological progress made in areas as diverse as biomedicine, genetic engineering, organ and tissue transplantation, reproduction, plastic surgery, implants or physical exercise physiology, the body was turned into the new territory where individual freedom should be exerted. Genetic engineering is not the only discipline offering us new body architecture; engineering, physics and surgery are also involved in the process of creating hybrid beings made of organic and electronic elements alike. The term, *cyborg* designates body shapes that no longer fit the 'former' notion of body as flesh. The body has gone from being nature's fixture to being progressively subject to consumer society's choices and options. Within the consumer society and in face of the current crisis of major narratives produced by ideological, political or religious entities, the body emerges as a final resource to controlling events and as a key element in identity building.

However, breakthroughs in knowledge and control over body options, seemingly within some people's reach, are not without a certain amount of scepticism. Indeed, the greater the possibility to overcome the limits imposed by the body, the greater the uncertainty about whatever remains *natural* in one's body. The anxiety for control, as much as scepticism, has shaped a cognitive and mental context favouring the evolution from medicine to techno-medicine, as a discipline increasingly dependent on sophisticated equipment to carry out both diagnosis and therapeutics. In this context, inner body imaging and simulation techniques have played a crucial role in developing a body transparency culture with obvious repercussions on how the body is presently represented.

This chapter examines body experiences as a product of medical-normative and moral discourses on the body. Understanding how body images like 'obesity' and 'slimness' are not only empirical characteristics of (un) regulated bodies, but rather the effect of discourses about bodies is the main aim of a content analysis of the media discourses in social identities construction. Social representations

of the body and body practices will be studied in relationship to the impact of consumer society, examining how lifestyle magazines emphasize the importance of body image and how they create a convincing link between health and body shape. Nowadays the body seems to be gaining in both dignity and valorization, as the individual is expected to care for its good performance. Meanwhile, medicine develops a technical-scientific complex that presents predictive medicine, based upon genetic knowledge, as the perfect platform for health. Thus, the discourses about the body cannot be understood as dissociated from progress and human perfection ideology that has been leading to the progressive medicalization of society.

A documental corpus of two international magazines edited in Portugal in 2007/8 (*Men's Health* and *Happy Woman*) is used, from which 345 relevant articles concerning the body, dietary and health management are selected. We proceed to the discursive analysis using categories like metaphors, values and body images. We also look at the attribution of the social responsibility for health to the proactive citizen.

Body Transparency: From the Objective Body to the Subjective Body

The identification of the body with the *individual* who owns it is basically a modern invention. Nevertheless, the body is a long-lasting mental category, as reassured by the entire western metaphysics based on the relations between the inside and the outside, between the visible corporeal and the invisible incorporeal, or by Hobbes's reference to the political community as *body politic*. The *body* is a general assumption of the modern order, built on its legal definition as a synonym of property and freedom. In spite of that, the body as the property of an autonomous subject has also justified an increased number of interventions on its architecture, perpetrated by either its owner or others. It is from here the augmented perception of the body at risk and in crisis is derived.

The crisis of the body has also amplified its fragmentation in quite diverse directions, visible on both the objective and subjective traditions of body representation. The two main currents are deeply rooted in the Western world's intellectual tradition and both of them originated primarily in modernity and individualism. On the one hand, the realistic body, the anatomic body and the body-object has been given pride of place by the objective body tradition; on the other hand, the subjective body tradition reveals the fictionalized body, the psychological body and the body-subject. To a certain extent, we are in debt to both traditions which, although contradictory, form the common *humus* (i.e. organic basis) of the contemporary images of the body.

The first tradition is well represented in the work of anatomist Andreas Vesalius. The illustrations from Vesalius's *Corporis Fabrica*, dated 1543, unveil a mental change with numerous and meaningful consequences. The anatomist and the author of the so called Vesalius's musclemen or *écorchés* have the ambition of

representing the inside of the body in an objective manner. However, the attempt to transpose natural body thickness to the two-dimension plane of a sheet of paper made it a goal that was altogether impossible to achieve. As Le Breton (1993) recalls, the artist has to be seen as part of a convention and a style. Therefore, the intention to achieve truthfulness and accuracy is really symbolically transposed to the representation of desire, death and anguish. The prints of *Corporis Fabrica* as well as those of numerous other anatomy studies up to the 18th century show tortured bodies and images of anguish and quiet horror. However, as Canguilhem pointed out, Vesalius's man remained a subject responsible for his attitudes., although the social and cultural 'tissue' of his time is still present, with all the prohibitions and the anguish inherent to the dissections and the violation of human integrity, Vesalius's anatomic observations have also introduced for the first time a perspective in which man (sic.) is methodologically separated from his body, a separation that was certainly easier than expected as the corpses dissected by Vesalius were unlawfully collected at the cemeteries and gibbets of Paris. The former insertion of man as a figure in the universe is not displayed, except for its reverse form, in the pictures of the anatomy study. Reduced to scalped skeletons, Vesalius's *écorchés* are nothing but bodies. The anatomist is thus announcing the birth of the modern body concept, by presenting a spectre of man. 'Man' is no longer himself, but rather his shadow. From this moment onwards, conditions are present for the genesis of the modern man: the ontological cleavage between body and man is now the mental horizon of a body that is self-sustaining for its own ends.

The second tradition is depicted by the images of Picasso's *monsters*. In the 1925–1932 period, Picasso produced a large number of works centred on the deformation and distortion of the human figure and body. These works were brought together under the *monsters* designation, adopted by some art historians (Caldas 1987). Paintings such as *The Dance* (1925), *The Acrobat* (1929) or *Bather With Beach Ball* (1932) reveal the deformation effect the human body has been subjected to in the first half of the century and this continued in other visual arts such as photography, sculpture, cinema, etc. The 20th century shall be remembered as an unhappy century. Early on, World War I turned the battlefields into graveyards of mutilated and limbless bodies. The war horror would repeat once again on a global scale and several times at regional ones. The objective body as seen by the 16th-century's anatomist has been replaced with the deformed body where the represented figures cannot be immediately perceived. The illusion of body transparency, provided by the enlightenment and the ontological separation between man and body, presents us with a sort of historical leftover, extended in time and leading us to believe the hypothesis of an individualized, yet identical, body. Picasso opened deep breaches in that regime of 'the identical', by rendering a representation of the human body based on deformation and illegibility. The representation of the body is no longer the mirrored image of the world but rather seen as the world's theatre. The episteme of similarity had previously given place to the episteme of representation, as demonstrated by Cervantes's *Don Quixote*

or Velasquez's *Las Meninas*. The analysis made of Picasso's paintings and sculptures from the 1925–1932 periods within formalist art is impregnated with notions of violence, thus underlining the *excess* applied by Picasso to the nearly unrecognizable forms of the human body. As in other art expressions of the same period, a hysterical investment in the body appears to be present. Picasso's bodies are not defined by their shapes or their figurative representation, but rather by the deliberate act to disorganize shape as a means to access the body. The body ceases to be anything in particular, and unfolds in many simultaneous and contradictory narratives. The figures glimpsed in Picasso's paintings, or in Kertesz's photographic distortions, allow and promote the psychological projection of the human figure, leading us to attribute certain characteristics and qualities to this figure.

This subjective body, open to different interpretations, has been largely responsible for an outbreak of body-related discourses. While the 20th century may have been born as an unhappy century, it has struggled along its course to be a happy century in its closure. The happiness of the 20th century coincides to a great extent with the search for body happiness, that is, the search for the promise of an illness-free life, a body with extended longevity and an always-retrievable beauty. The 20th century opened and closed with the announcement that two rather different codes had been deciphered, either of them quite promising for future unforeseeable discoveries: the mind code and the genetic code, respectively. In 1900, Freud published *The Interpretation of Dreams*, an attempt to decipher the mental origin of some human suffering through language; 2000 has seen the discovery of the human genome with the promised ability to delve into the unfathomable universe of the causes for diseases. These two symbolic moments are highly expressive of the existing ambivalence in the century of the body. On the one hand, we relish the promise of a 'new man' with super-human capabilities; but, on the other hand, we feel ever more apprehensive in face of the great dangers caused by our interfering with Nature, including human nature.

The history of scientific medicine is made of increasingly more hybrid and efficient attempts to combine both traditions of body representation, turning the opaque content of body volume into a crystal-clear surface. To be able to see the inner matter enclosed by body surfaces has been the continuous struggle of medicine, in its pursuit to reveal the pathologic arena. Since the 16th century, with Vesalius's anatomy, medicine has tried to pinpoint pathologies inside an objective anatomic cartography detached from the patient as a person. Medicine's view over and inside the body has become a sort of exploration of new wild landscapes and power has been acquired to reveal the newly found territories. As underlined by Heidegger's concept of *aletheia* (understood as the truth of the being through unveiling), the power of revelation rewards its agents with a sacred status that is today leveraged by the ever growing scope of technosciences, especially when bodily imaging has become the core output.

The imaging of the inner body has evolved similar to medicine, in all its aspects, drawing a path from molar to molecular. Since the X-Ray was discovered by Röntgen in 1895, the opaque body has become a transparent body, through

the use of prodigious medical imaging technologies. mammographies, ultrasound scans, computerized tomographies, fetal imaging and magnetic resonance have made it possible to visualize internal organs and systems. In the case of the brain, the imaging techniques evolved similarly: EEG (Electroencephalogram), PET (Positron Emission Tomography), fMRI (Functional Magnetic Resonance Imaging), SPECT (Single Photon Emission Computer Tomography) and many more. For some of them, digital simulation is a *modus operandi*; others depart from the molecular level to reconstruct molar reality, using algorithms to manipulate digital information. In any case, the mimetic realism these images are intended to attain sets off contradictory effects among both experts and laymen. Physicians tend to regard them as an amplification of their diagnosis and specialization capabilities; laymen appear to have developed greater eagerness for information in the networked society.

Information-induced anxiety makes the laymen's identity dependent on health research and data available to the general public from various information networks – Internet, television and the general and trade press. Medical knowledge is now largely accessible to the laymen, thanks to the networked society. In late modernity, the dream of social progress through knowledge was converted into the fantasy of perfect health through information.

The health versus illness issue is no longer confined to the hospital environment and the medical centres nor is it confined to the traditional doctor-patient relationship. This issue has spread to other social and commercial arenas. The promotion of health has been brought to contemporary households by TV campaigns. 'Health' is showcased in supermarkets and shopping malls; catches our eye in cosmetics advertising, is displayed in leisure sports arenas, and flows freely within cybernetic space. Nowadays, we witness the demolishing of the final frontiers, ones that have long resisted the differentiation between health production and health consumption. Today, we all appear as consumers in the great healthcare industry marketplace.

This cultural trend amplifies the risk-safety paradox, as demonstrated by the dissemination of self-diagnosis and the self-visualization practices. According to Mintel market research group (see: www.mintel.com), the self-diagnosis market is currently growing in the United Kingdom at the pace of approximately £100 million per year. The so called DIY (Do-It-Yourself) tests have broadened a quite profitable market, feeding on anxiety and uncertainty, and democratizing access to self-diagnosis devices made available by both the pharmaceutical companies and public health policies. Besides being offered osteoporosis, diabetes, cholesterol, or bowel cancer diagnosis kits, people may now go to virtual kiosks and nearby diagnosis centres to check and control their health, based on a vast array of indicators such as blood pressure, Body Mass Index, etc. Another sign of the uncertainty and anxiety market is clear in the public fascination with TV series featuring surgeons carrying out realistic procedures, documentaries displaying simulations of the blood stream, images showing the inside of internal organs and exhibitions of plastinized corpses providing a contemporary three-dimension

version of the Vesalius's *muscle-men*. Magazines, radio programmes, TV thematic channels, newspapers, advertising and public medical debates disclose specialized information about nutrition and physical exercise, and put forward solutions promising physical and psychological health or body makeover. However, instead of reducing uncertainty, this complex of body-related information has turned into a source of uncertainty. This is primarily due to scientific knowledge's 'intrinsic' nature, based on assumptions of inductive and probabilistic knowledge.

Subjectivation: The Body as a Place of Discourses

In face of this, it is fair to say that our current representations of the body are the result of a complex historical process. Scientific, cultural and technical constraints contribute to shape the way in which we perceive and use the body. Mauss (1973) proposed the notion of *body techniques* to stress the social nature of body practices, a sort of variable bodily *habitus* according to social factors such as education, wealth, fashion and prestige. Mauss (1979) argues that the modern notion of person is a symbol resulting from a certain personality development, as well as a model to confer subjectivity to the individuals. This is the consequence of subjectivity technologies (Foucault 1988), leading individuals to think of themselves as the subjects of their own behaviours and capabilities. Both Mauss and Foucault deny the notion of original subjectivity as each individual's ontological essence. Subjects fail to exist when deprived of social processes, mainly those of a discursive nature that produce them as free and autonomous beings. That is precisely the meaning of the term *subjectivity technologies*: a set of ethical techniques to be imposed on one's self and whose main outputs include the very notion of subjectivity.

Within this vision, the perspective of the body as the enclosure of a unitary being should be abandoned. Instead of referring to a body-intrinsic entity, it is suggested that the 'self-identity body' may be the result of a specific body regime promoting a relationship between the body and its owner. In different terms, agency is in itself an effect, the result of self technologies invoking human beings as bodily realities. Therefore, a need is acknowledged to reflect on the historical conditions that made it possible for man (*sic*) to construe himself as a reflexive object. This self-over-the-self dominion relationship or self-knowledge has been established in quite a variety of ways. Confession, devotion, body care, and self-esteem are some of the procedures proposed or prescribed to the individuals in order to establish their identity. In any case, the self-identity body is presented as the property of a subjectivity ruling over life and death.

Today, the body seems to have been dignified and more highly valued, for it is assumed it will be well taken care of. Medicine has developed a technical and scientific complex where molecular and genetic knowledge based predictive medicine are presented as the platform for perfect health. Thus, discourses about the healthy body cannot be understood in any way other than within this ideology of human progress and perfection that has drawn society to increasing

medicalization. These messages promote the myths of moral strength and will as forms of constructing contemporary subjectivities.

Moral perfection is the counterpoint of biological perfection. Yet, perfectionist ambitions conceal contradictory body practices and representations: on the one hand, overtraining (*vigorexia*) and the refuse to eat (*anorexia*) and on the other hand, 'orgiac' bodies, revelling in excessive eating (*bulimia*) and unwilling to do any physical exercise (*apathy*). The former suggest great tolerance to body pain and exhaustion. Eating disorders tend to proliferate in a cultural environment where low-calorie diets are encouraged (Bordo 1993). The latter refuse to accept body standardisation and suggest excess: excessive eating and excessive risk exposure, drifting increasingly apart from cautious behaviours, regular physical exercise and maintenance of adequate body weight. As Turner (1996) recalls, we come face to face with a swinging pendulum travelling to-and-fro between the opposite forces of Dionysius and Apollo. The cultural background of Western Christian civilization may be reasonably synthesized using the two opposing ends of orgy and fast. Orgy is rooted deeply in the Dionysian cult with its denial of rules, marginality and the protest of unprivileged social groups. Fast, in turn, is the legacy of the Apollo cult, a display of rational control, restraint and self-dominion. It is certainly not by chance that most studies carried out to analyse the effects of social and economic status on physical activity and health prevalence in different social groups show a notorious social asymmetry regarding the levels of practice and its consequences for physical capital and health (Gomes 2002).

Underlying this new healthy ideology is the rhetoric of free choice and personal autonomy. In this context, two types of discourse may be identified, with apparently contradictory values:

a. *The defence of an ascetic lifestyle*, devoted to hard working, self-denial and discipline. Conditioned by the representation of a thin and muscled body, middle and upper classes seek forms of body distinction based on the ability to live a healthy life. Resorting to self-control, enrolment in regular training and fitness programmes, often with personal trainers, they attempt to demonstrate their moral and physical superiority, as opposed to low-class groups.
b. The proliferation of practices rooted in the new prudentialism-based ethical regime (O'Malley 1992), *but also in the pleasure of body consumption*. Through sales and marketing techniques, the individual and collective anxiety about the future of each one's body is magnified, and people are encouraged to invest in improving their quality of life and health. The ethics advising lifestyle maximization, associated with the new lifestyle management technologies (what and how to eat and drink; what type of physical exercise to adopt and where to go for training; what healthcare procedures should be followed and which associated products should be taken, etc.) generates an relentless self-governance imperative.

Whatever the case may be, the effects produced by these two contradictory trends converge into the same idea of self-centring and self-dominion techniques, a phenomenon some have referred to as a return to narcissism. Narcissism may be understood as the neurotic version of a new lifestyle centred on jogging, healthy diets, weight control and physical maintenance. *Anorexia*, as an extreme version of narcissism (Turner 1996) presents some interesting elements for reflection in a sports context. Data on the prevalence of eating disorders among athletes is quite illustrative of the normative power of self-restraint techniques applied to eating habits. The American College of Sports Medicine estimates that 65 per cent of women competitors in figure skating, synchronized swimming and endurance sports suffer from eating disorders. The relationship between food, health and physical appearance is particularly important for women, especially in a society where self-representation is so highly valued. Within such a perspective, women's social value is associated with their body and is today expressed through the ideal of slimness. Being slim or *elegant* has become not only a seductive and attractive image, but also a symbol of self-control, moral integrity and high social status (Marzano-Parisoli 2001). This orthodoxy tends to produce an ascetic approach to sports and the body, and persuades a growing number of people that every individual's body can be modified and constructed to meet the intended requirements.

The Role of the New Health Brokers: A Portuguese Study and its Methodology[1]

In the 21st century western high-tech societies, the media, as new social brokers, affirm themselves as a privileged means for the transformation and dissemination of values, ideals and standards, particularly when related with body management. Relying on an average audience of 24.6 per cent of the total number of readers in the Portuguese written press (Marktest 2008), men's and women's lifestyle magazines are now in a singular position to disseminate and reinforce those values, ideals and standards.

Social representations of the body and body practices were studied in relationship to the impact of consumer society, examining how lifestyle magazines emphasize the importance of body image and how they create a convincing link between health and body shape. A documental corpus of two international magazines edited in Portugal in 2007/8 (*Men's Health* and *Happy Woman*)[2] is used, from which 345 relevant articles concerning the body, dietary management and health are selected.

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1 Data processing and presentation in this empirical study is the responsibility of Nuno Gustavo, PhD student in *Tourism, Leisure and Culture,* University of Coimbra.

2 *MH* Magazine – issues 76 to 87. *HW* Magazine – issues 14 to 29 (except issues 20 to 22 – out of print).

The methodological work is based on a Foucauldian discourse analysis and we use categories such as metaphors, values and body images.

The two magazines were selected based on two criteria: print run and editorial style. As to print run, both magazines stand out in their respective *rankings*, with *HW* ranking first in the universe of monthly women's magazines published in Portugal. Additionally, among the existing lifestyle magazines, these are the ones showing an editorial trend that is markedly centred on body management. Data resulting from the thematic content analysis of the selected articles were statistically processed using a SPSS database and Microsoft Excel.

Reader Profile for Womens's and Men's Magazines

Women's and men's magazines have become a fixture in the daily life of about 2 million Portuguese. According to the latest data published in Marktest's Media and Advertising Yearbook (2008 edition), the public's interest in thematic women's and men's magazines runs across the entire Portuguese society, and features a whole set of particular traits.

Readers are mostly aged 18–44 years old in the case of women's magazines (81.6 per cent monthly and 75.6 per cent weekly magazines), and 18–34 for men's magazines (68.1 per cent). The readers' gender was also in line with the magazine's target group: men's magazines are predominantly read by men (76.9 per cent) while women's magazines are mainly bought by women (77.5 per cent).

Although there is a predominance of readers from the middle lower and lower classes, it is noteworthy that a public recruited in the middle class (64.8 per cent) and in the middle upper and upper classes (55.9 per cent) remains loyal to monthly published magazines. Indeed, that fact is clear in the occupational variable, where the following occupational groups stand out:

a. Top/middle management professionals – 14 per cent for men's and 15 per cent for women's monthly magazines;
b. Qualified professionals/experts – 20 per cent for men's and 7 per cent for women's monthly magazines;
c. Professionals from services, trade and administration – 16 per cent for men's and 19 per cent for women's monthly magazines;
d. Students – 25 per cent for men's and 19 per cent for women's monthly magazines.

The Media and the Body's New Social Notoriety

While in the past, family and religion were considered to be the main references available to the individual, today, self-image and self-consciousness are constructed and based on predominantly commercial references, a reflection of the social, cultural, economic and political contexts that characterize 21st-century societies. The contemporary subject is no longer an heir of traditions. Instead, the

contemporary subject perceives himself as playing a determinant role in his/her own condition. In the new social regulation model, the body arises as a central element in both action and communication. That reality is expressed by tattoos used nowadays to produce identity and design the bodies of famous public figures:

> I've got tattoos with the names of the people I love best. It's my way of expressing myself, Angelina Jolie explained. (*HW*, no. 19)

In such a scenario, the body has acquired greater interest and notoriety. The *media* recognize and sustain the body's new social exposure. Out of a total 24 analysed issues, 841 articles were listed, from which 41 per cent tackled body and self-care related subjects in a range of different approaches. The average number of articles on the body subject can be set at approximately 53 per cent per issue in the case of the men's magazine and 31 per cent in women's magazine *HW*.

Set within a framework of perfectionist, naive speech and graphics where youth and the ability to manipulate the body are deemed endless and eternal, dreams, stereotypes and promises are sold. The offer is made of *quick tips to improve your life*, ranging from *three exercises to grow muscle mass in a few weeks* to *formulas to relieve stress in only 40 minutes* (*MH*, no. 85).

Sex – From Invisibility to Dominant Theme

In the group of analysed articles on the body subject, sexuality stands out, to reach an impressive 20 per cent of the sample. The most intimate parts of the body are unveiled under the form of disclosed secrets – *11 fantastic sexual secrets* (*MH*, no. 82) and unprejudiced exposure – *With no Taboos* (*HW*, no. 28), thus reshaping the form of how the body is socially seen and managed. Based on a sexual argument, men's and women's magazines reveal and teach how to manage the body physically and emotionally, presenting the body as a source of communication and attraction. In issue no. 80 of *MH*, on the *MH Sex* section, a six-page article highlights *what they [women] really think,* and promises *more and better sex as of today.*

A New Body and Health Approach for Everyone

From the sample of themes addressed by these magazines for which the body subject is a common denominator, the following subjects stand out: *physical exercise* (16 per cent), *behavioural factors* (14 per cent), *nutrition* (14 per cent), *beauty care and treatments* (14 per cent), *alternative medicines* (6 per cent), *body and mind* (6 per cent), *medical advice* (5 per cent), *health self-diagnosis* (5 per cent) and *medical surgery* (2 per cent).

In this range of themes, one can realize that the traditional players in the clinical arena are now relegated to the background. Headings as in *MH* no. 81 – *Heal yourself without seeing the doctor*- are quite common. Body management appears to have been taken over by a set of new health brokers, operating independently

from the traditional healthcare players. Lifestyle magazines clearly undertake that role as they suggest *the best homemade exercises*, *the best health secrets for Man* (*MH*, no. 85).

New health brokers make a point in detaching themselves from the medical language. Instead, they deliver adjective-filled messages: *simple*, *instantaneous*, *fast* and *successful,* which are the notions making up a health narrative based on each subject's autonomy, efficiency and responsibility. Being a key issue, healthy nutrition and eating is repeatedly present: *eat this and never get sick* (*MH*, no. 79), *the 16 worst things you can eat* (*MH*, no. 84).

In women's magazines, the association between health, well-being and beauty is continuously linked with beauty care and treatments; the idea is created that body appearance can be changed instantaneously: *breast size boosting in 30 minutes* (*HW*, no. 29), or that a new body shape is achievable over a two-month period: *stop cellulite – get a new body in two months* (*HW*, no. 14). In turn, headlines targeting men emphasize body volume, strength and physical exercise as health signs: *more muscle in less time – only 30 minutes a day* (*MH*, no. 78) and *strong shoulders with no effort at all* (*MH*, no. 76), are a few examples of headlines aimed at building a social body image that is within everyone's reach.

Articles with numerous recipes and prescriptions, particularly, *anti-cellulite recipes* (*HW*, no. 27), plans and scripts presented under the common form of tips and hints – *1,073 new health, fitness and sex tips* (*MH*, no. 79), contribute to demystify the idea of an inaccessible body as much as to promote body condition and management through a *self-care* and *self-management* philosophy. The editorial line of *Men's Health* magazine is the expression of a self-help version focused on will power and self-care. Data from the latest scientific studies presented in a simple and understandable language is used to pass on the idea that proper body care requires some strength of will (*quit-smoking programs are not enough)* (*MH*, no. 79).

A Body Image Tailored to Consumer Societies

This type of magazine values *the latest news*, *the things you cannot do without*, *the must-haves*, *what's in* and *what's out*, and *tips*, thus building a relationship with the body where the economy of ephemeral well-being is constantly present. In light of these statements, *feeling well in your own body* is a concept that, additionally to being symbolic and functional, must be understood as the raw material to be shaped to external imperatives. *A 12-week plan to get your body ready for a bikini* (*HW*, no. 24) or *5 simple exercises to have this kind of body [young and muscled]* (*MH*, no. 81), are the primary assumptions of the new *Visible Body*, one that cannot be built detached from a vast set of *gadgets*, ranging from the simplest, such as clothes – *reduce thigh volume with straight fit dark-coloured trousers* (*HW*, no. 25) – to the most sophisticated ones, such as the car, *fancy, attractive, safe and comfortable*, a string of adjectives associated with the driver (*MH*, no. 78).

More than a question of looks, this is a new ideal, a new form of being in the world and living one's life. It is presented as within anyone's reach, through simple self-diagnosis and self-management processes devised to comply with certain standards and stereotypes, where aesthetic and hedonist *clichés* set the tone. Here, once again, the individual's body is seen as the key element to that materialization.

Being Self-responsible

In this new game of *Self* construction, individuals are assigned with, made aware of, and held morally responsible for the need to construct a concept of themselves, which is nothing more than the expression of how they perceive themselves in relation to the surrounding reality. The responsibility to manage one's body in a functional way has fallen short in the light of the new Self. Presently, this is also and essentially a challenge with a symbolic dimension. For instance, here is one of the challenges presented in *HW*, no. 28: *combine the season's trends with your own body features to pick your new bikini.*

The individual pursuit of health has moved forward since the healthism of the early 1970s when themes of individual effort, discipline and will came together with the deregulation of public health programs. Experts have indicated how to be healthy by means of exercise and prudent behaviour. The normalizing ethical power of the model is proposed by a rhetoric of free choice and personal autonomy. Such thinking is typical in countries which are attempting to replace old models of regulating health. These messages promote the myths of moral strength and will as a way of building the contemporaneous subjectivities.

By manipulating the body's biological nature, the body itself becomes a place of discourses, dialogues and significances, that is to say that it becomes the most elementary object in communication and identification. In this way, the passage from the biological body to the physical, psychological and self-conscious body is carried out in a reflexive way. Socially dominant stereotypes are the reference adopted, and they form and spread on the basis of a symbolic language, where the image, the signs and the visual dimension affirm themselves as the engine of the new dominant culture. Today, people live to meet challenges like *Flatten your belly forever. Do as actor Paulo Rocha* (*MH*, no. 82).

The fashionable and consumer body. Besides its scientific dimensions, the concept of health also entails relevant assertions of aesthetic, environmental and social nature. These new dimensions and interpretations of the health concept arise as: on the one hand, the reflex of the new healthist (Crawford 1980) and positivist health model, where well-being is the prime motto; and, on the other, a consequence of new discourses and novel interpretations of well-being endorsed by the new health players.

Taking the advertising indicators as a reference for different modes of health social management, an analysis of the advertising sample of the two magazines shows the following highlights: advertisements about health management-related

products, particularly nutrition (e.g.: food supplements, energy supplements in the case of the men's magazine, and *light* food products in the particular case of women's magazine), and to beauty and dietary products (particularly in women's magazines). As an example, issue no. 29 of *HW* magazine had 26 per cent of pages filled with advertising (51 pages). The figure went down to 15 per cent in the case of *MH* magazine, issue no. 77 (19 pages).

Resorting to the most persuasive marketing practices, to which advertising and trademarks are faithful allies, the *media* make a massive use of images depicting the body as the central element in communication, to establish a new self-identity and self-image construction process. This would require no more than, for example, *to renew your image* using *89 style tips*. These tips, tailored to the holistic essence of the *Self*, include topics as: *personal care, travel, restaurants, engine, universe, practical fashion* and *events* (*MH*, no. 88).

In this process, magazines rely also on public figures to create common and universal language and references. This way, and by means of a reflexive dynamic, these standard ideals are set as the dominant reference, as the individual engages in the construction of his/her new *Self*. The *life of a übermodel – Gisele Bündchen* (*HW*, no. 17), the *sexy naivety of Scarlett Johansson* (*HW*, no. 23), *eat this – grow muscle – the tricks of our cover model! [Gregg Avedon]* (*MH*, no. 85) are some examples of worldwide references that help shaping the individuals' physical and symbolic *Self*.

A high-tech body perspective. As the body is established as a reference and an object of cult, the individual is now burdened with the need to make a continuous investment on his/her body, the materialization of which is so called *Self-health*. In this new vision, the individual's focus and objective as far as one's own body and health are concerned, are now the search for optimum well-being, as this will determine the individual's entire performance in all aspects of his/her life. The need for monitoring required by the *self-health* model translates into a search for information on references, mechanisms and *self-scrutiny* practices, – *don't fall victim to heart attack [...] know how your eating habits impact on your blood pressure and be on the safe side.* (*MH*, no. 80), which currently include the most sophisticated technological equipment (e.g. Heart rate or cholesterol self-measurement devices).

However, being such a new topic, the use of technology (either by invasive or non-invasive techniques) is still seen as suspicious, and therefore, the sharing of experiences by anonymous citizens who have already undergone those procedures is crucial to attest those treatments' efficiency and immediate results:

> Before going on VelaSmooth [radiofrequency treatment], I wasn't happy with my body, because I had accumulated fat, cellulite and loss of firmness. I've had 17 sessions now and I'm very happy with this treatment because results are already visible (Cláudia, 35 years-old, in *HW*, no. 19).

Resorting to new technologies favours the development of a new relationship between the visibility of the body's inside and outside. If, on the one hand, the external environment is the reference to be taken into account, resorting to technology grants one the power to manage the body, by monitoring and manipulating it on the inside. Treatments such as *endermologie* where *the client wears a specific suit and, through the operation of a machine – LPG – lumps are defragmented* restoring *skin's tonus and in-depth tissue firmness* or *radiofrequency*, a treatment in which *heat is induced to increase intercellular oxygen rate, producing a metabolic reaction of the fat cells and reducing them*, ensuring *immediate lifting effect* and *smooth firm skin* (*HW*, no. 29), are examples of the new technological arsenal managing the body from the inside, while producing the intended external effects.

Risk and Body Transparency

In recent years, the public sphere has strongly fed upon the safety-risk paradox. Safety is a symptom of bio-power which has been present ever since the 17th century. Turning death into an object of apprehension, this disciplinary power is concerned with survival, the extension of life and public hygiene protection. Now supported by new body political technologies, bio-power has been extended to the whole population in areas such as birth rate, fecundity, old age and epidemic control. Foucault uses the concept of bio-power in volume one of *The History of Sexuality*. He sets a double perspective in how power over life is seen. On the one hand, bio-power aims at maximizing the body's anatomic forces, by integrating them in efficient systems. On the other hand, bio-politics requires formulas to regulate and control diseases, mortality and longevity. In contemporary societies, this distinction between these two different poles of bio-power, referred to as discipline and regulation, respectively, has been overcome. Today, the issue of safety runs across quite diverse spheres of life, and there seems to be a consensus around key ideas of anticipation, prevention and self-responsibility for everyday life events. On the safety side, solutions are presented which promise physical and psychological health, including: magazines, radio and TV programmes, newspapers, advertising and public medical debates with more or less specialized information about how body-related risks can be mitigated. The food and agricultural industry invades all aspects of our lives, including our private life, with the wide-spread of the nutrition information labelling and its behavioural indications. On the risk side, offers are increasingly present of lifestyles encouraging alcohol and stimulants intake, leisure drugs and sedentary life. Very often, the risk is deliberately sought through adventure activities in the wild, use of motorized technologies, intense and extreme physical activities or survival contests in severe conditions.

Side by side the safety provided by the new technologies which appear to reduce fears that not long ago characterized our body existence are uncertainties as to our future risks. These are also amplified. The notion of risk becomes central

in a somatized society (Turner 1992), where the notion of body preservation is highly valued in public space. The seductive promise of life with no illness and super-human longevity, has also produced menacing visions of excessive cloning or bodies incorporated by electromagnetic components. The obsession with risk presents: a sort of victory over whatever aggression may come our way. But, this is almost always haunted by the possibility of a new risk arising from newly-discovered technological solutions.

Risk presents itself in quite contradictory and paradoxical versions. On the one hand, there is an attempt to minimize risk in all areas. As a result of increasing social reflexivity, social practices of the prudential type are constantly examined and adjusted in light of the information acquired about their consequences, in such a way that *thought and action are continuously refracted one through the other* (Giddens 1992: 29). In this deeply reflexive context, bodies are subject to unprecedented risk monitoring. The health imperative is reflected also in the amount and contents of the information conveyed by the information society's networks. Insurance companies, experts and politicians introduce the idea of insurance into a growing number of areas: measurement of blood pressure, cholesterol, body mass index, sexually transmissible diseases, smoking habits, family diseases, etc. Other sets of potential risk evaluation parameters are used as forms of actuarial control or, simply, as indicators to be taken as guidelines to primary prevention policies and lay education programmes. Statistics manage to broaden the effects of those control policies. Car accident risks, occupational accidents, domestic accidents, children's accidents, stroke or cancer incidence are the object of statistical studies aimed at establishing threshold values and defining which populations are at risk, in order to anticipate and identify the most dangerous 'places', considering average values and standards. Populations as a whole are put under administrative control while, at the same time, statistics introduce individualized thought over risk and individual responsibility for its control in social reflexivity. Risk prevention and mitigation now fall under the realm of individual responsibility.

The vocabulary used by experts and by state administrators has also instilled in the most private thoughts the need to monitor and decipher one's experiences, developing a new *therapeutic sensibility* (Lipovetsky 1989). Knowledge linked with the health sciences, sexuality or physical activity has made its way into everyday routine which helps describe and provide references to one's social life. Nutrition and body weight control, the awareness of blood pressure reference values and the need to control it, cholesterol monitoring and control, moderation of sexual activity and its relation with sexually transmissible diseases, regularity and intensity of physical activity and the role it plays in health are considered to be testimonies of individual options, lifestyles and physical appearance. Under these circumstances, one's eating habits, physical activity, body monitoring and adopted sexual behaviours express a personal choice allegedly expected to constitute one's narrative. Therefore, illness has also become associated with one's insufficient ability to take good care of him/herself. Not doing any exercise, not being able to quit smoking, not eating in an adequate and moderate way are perceived as moral

and volitional deficits and hold each individual responsible for his/her own well-being. Ill people are more frequently blamed for their condition (Shilling 1993): failure to actively monitor one's health is often deemed as a deviation (Crawford 1980) and obesity is almost always explained by a lack of will.

The search for and the escape from death are the faces of a society coping with the crisis of major narratives and the loss of meaning. The other side of risk is communitarism, the protection of traditional cultural references, the fight against social and individual precariousness. As individuals become more fearful of ageing and death, they tend to take good care of proper body functioning. The notion of a healthy body also reveals an eagerness to control body image: workout and controlled eating habits cannot be dissociated from the efforts to recover body control. Well-being and health are the linguistic operators used to justify free time spent in physical activities, and provide the grounds for using physical condition and appearance as one of the worker's productive force. Marx's compulsion of work interplays with Baudrillard's compulsion of consumption. In the past, the worker struggled to use his/her free time in a manner as different as possible from his/her working time. Contemporaneity has witnessed the dawn of a daily time totally contaminated by the general reproduction of human life. Health self-management has brought the subject to the need of managing the economy of his own body.

The Contamination of the Other and the Transparency of Different Bodies: Final Comments

The recent focus on health is largely supported by the metaphor of body *contamination*. The body is now subject to a vast range of aggressions and contaminations that may be caused by pollution, contagion or sexually transmissible diseases. This has brought along the spread of new images of the 'subjects' subjectivity', such as increased monitoring of the biological effects of what we eat, sunbathing, intake of air and water, or the sexual intercourse one enters into. Simultaneously, susceptibility and aversion to body decay increases. Sick people, the elderly and all of those who show body marks of physical decay are excluded or ignored under the trivialization of urban interaction. They become transparent to others. The same kind of voiding is present in the picture offered by advertising, by the cinema and by the inflated use of body photography in the public scene:

> The growing interest for magazines with photo illustrations (especially in those areas where the body was the dominant theme) has made body images a constant centre of interest in everyday life. People got used to having photographs of half naked (although idealised) bodies around the house, on their dining tables or on their bedside tables: young, tanned, smiling and vigorous bodies, embodying a promise of health, wealth and happiness as long as they are properly taken care of, obviously, with the right products (Ewing 1999).

However, under the shameless exposure of intimacy, advertising has at the same time pushed aside the *fleshy* signs of man. Anything that conjures up the organ-made body is banned from sight in leisure industries. Ageing, fatigue, sweat, wrinkles and all the signs of time passing are put away, out of the social actors' sight. Alternatively, those same signs are shamelessly shown in humorous contexts. The threshold of aversion to the decaying body is altered in the new visual regime. Displaying the body seems to imply also the responsibility to do so in accordance with certain dominant physical standards of appearance. Through the body, the subject is judged for his social and professional performance. Success is dependant on the subject's ability to shape his body in line with new emerging requirements. The advertising campaign of *Clinique Formule Homme* is a good example of the relationship between body appearance, identity and performance:

> Man thinks about himself (that's not new), he also thinks about his skin (something he doesn't want people to know about). Times have changed: those times are long gone. Just like a suffragist, man discovers, affirms and claims his identity as he looks at the bathroom mirror. He finally dares to speak aloud of whatever he used to do silently, when he secretly used his wife's cream, her mask or her exfoliating scrub. Virility is no longer an obstacle, man changed criteria and he has also adopted new icons in terms of looks. Today, clean is good, from head to toe. Being successful means, more than anything else, feeling good in your skin.

The rituals linked with body transparency are also visible in the attempt to eliminate from sight everything that emanates from the body. There is a promise to clean away anything that may stain one's appearance, to have us decontaminated from whatever may prevent wealth, to scrub away everything that drags us away from happiness. After surgery, the true identity is reborn. The body arises as a place of redemption and judgement of how successful one has been; men's skin is today seen as a symbolic sign and an erotic value. Just like women became entitled to muscles and virility, so have men become entitled to *skin-deep* sensibility. In many professions, the vital reproduction time

> is indeed a second shift of productive work, and is filled with jogging, gym, massages, workout, etc. (Santos 1994).

The individuals' will to dominate their own body and whatever flows in it has been present, to a greater or lesser extent, throughout history. Changes in body ideal and health-related moral values are associated with illness-induced anxiety and, especially, anxiety caused by the presence of the *dangerous others* and the risk of being contaminated with their diseases (Gilman 1988, 1995). The body, through its visual traits, exposes the identity of the subject in relation to 'himself', but also in relation to the society and the group he wants to be recognized in. Determining what is identical and excluding what is different is part of an historical process

by which identity and alterity have consistently been constructed. The deviator may be the foreigner, who comes from beyond the borders, but he can also be the insane, the criminal, the ill person or the aberration for whom special areas are defined intended to confine them as much as make them noticeable. The asylum, the hospital and the prison, as disciplinary spaces, are a part of this power-knowledge complex and play a didactic role. Just as diabolic images were used in the Middle Ages, body images used in advertising establish what is to be feared and rejected, and are seen as a warning of what human *nature* shouldn't be. This was the role of the disciplinary spaces that helped construct the notions of insanity, illness and delinquency. Contemporary control societies have replaced the confinement of disciplinary spaces with an appealing operation put in place by the media, with a view to typifying and dividing human activities into allowed and illicit, public and private, individual and collective, producing a simultaneously individualizing and totalizing power. Present day control societies have shaken the disciplinary boundaries based on public/private differentiation, and made them permeable and subject to inter-contamination. Between maximum intimacy involving the private exploration of sensations, and maximum public exposure where the individual is compelled to reveal him/herself, a new notion of public space is emerging, tainted with slight traces of incivility and dissolution of public roles (Lipovetsky 1989, Sennett 2002).

Indifference towards the moral standards ruling other people's life comes hand in hand with maximum exposure of each one's body, emotions and feelings, even if it takes place in new protected architectural or symbolic spaces. That is the case of the new body leisure activities based on a particular therapeutic sensibility. Certain physical activities are highly illustrative of the modern obsession with the self, expressed in one's desire for self-knowledge and knowledge of one's own limits, as well as for the intimate revelation of the true authentic being. Activities such as body expression, yoga, tai-chi, bio-energy or relaxation techniques became a space where the psychological body takes over the objective body. Bringing the body into existence for one's self and re-conquering body innerness are the staging grounds where one's self representations are produced today. More than narcissistic representations, which they unquestionably are, the new representations express a normative narcissism, because self-knowledge technologies have managed to replicate restrictions imposed by the new body brokers within everyone's innermost sphere. In a system personalised by this *movement of consciousness*, where everyone is the ultimate one responsible for his/her condition, the individual seems to be left with the sole goals of improving his/her body's reliability, remaining young and being actively committed to self-preservation.

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Chapter 5
The Internet and Medicalization: Reshaping the Global Body and Illness

Peter Conrad and Ashley Rondini[1]

Sociologists have studied medicalization for more than three decades, especially in North America (Zola 1972, Conrad and Schneider 1992, Conrad 2007). By medicalization we mean defining and/or treating a social problem or human condition as a medical problem. This includes a range of conditions including attention deficit hyperactivity disorder (ADHD), alcoholism, anorexia, post traumatic stress disorder (PTSD), premenstrual syndrome (PMS), menopause, social anxiety disorder, and obesity, among many others (see Conrad 2007). One manifestation of this has been the expansion of diagnoses in the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association; the number of diagnostic categories grew from 106 in DSM-1 in 1952 to 297 diagnoses in DSM-IV in 1994 (Mayes and Horwitz 2005). Over the past decade, medicalization scholars have noted that the 'engines of medicalization' have shifted from the medical profession and social movements to biotechnology, managed care, and consumers (Conrad 2005). It has long been noted that medicalization can be bi-directional, including demedicalization and new medicalization. Despite the important cases of demedicalization (e.g. homosexuality and masturbation), there is strong evidence that medicalization has been expanding, with a considerable concern about 'over-medicalization'.

In recent years, the Internet has become a vehicle for promoting or criticizing medicalized approaches to human problems. The global reach of the Internet has expanded medicalization debates to a more worldwide scale. This chapter examines two cases of 'problems' of the body that have utilized the Internet to promote their views and state their claims; one of the cases is seeking a form of demedicalization while the other is making claims for medicalization. The first case consists of what have been called 'pro-ana' websites, which began in the US, promoting the view that anorexia is a legitimate way of life rather than an illness. Here we see the emergence of an international 'counter narrative' to the medical views that are available worldwide. The second case is what Carl Eliott has depicted as 'wannabe amputees'; these are individuals who communicate with one another on websites and discuss how they wish to obtain their amputee status.

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Recently, they have increasingly desired to have their disorder recognized as a medical problem, Body Integrity Identity Disorder or BIID.

Coming of the Internet

The browser enabled worldwide web began in the 1990s. The Internet has grown enormously in the past fifteen years, as have the number of users. The number of Internet users keeps growing, with roughly 360 million users in 2000 and an estimated 1.5 billion users in 2007 (http: //www.internetworldstats.com/stats.htm). The greatest penetration of usage is of course in the developed world, but China has pulled ahead of the US as the largest number of Internet users (Barboza 2008). According to recent statistics, North America has roughly 250 million Internet users. Sophisticated search engines, like Google, make accessing relevant information quick and simple. Virtually everything about the Internet is growing or increasing. The Internet revolution has affected health information and communication as well; nearly 100 million Americans regularly access the Internet for health information, with most focusing on specific diseases (see Conrad and Stults 2010). The Internet has become a global marketplace for health related information.

One of the most interesting and widespread aspects concerning health on the Internet are the thousands of interactive or participatory websites, bulletin boards, discussion groups, social network groups and other forums for virtually any illness or disorder one could imagine. These often become online communities, where many members participate regularly while some just visit occasionally and others 'lurk', by reading the posts without actively contributing. While the Internet has helped individuals become more active consumers, it has also transformed them into *producers* of knowledge. In this Web 2.0 (more interactive) era, individuals now have the ability to construct their own websites, 'home pages' or develop blogs about their health issues, transforming them from consumers of health information to producers of health information and care (Hardey 1999). The Internet is truly an interactive marketplace of communication about specific illnesses as well as discussions about health and treatments. Thus the Internet has become a repository of lay knowledge, as well as a medium for promoting alternative and challenging perspectives about particular problems and disorders. It has become a place where lay viewpoints exist alongside professional perspectives, at times supporting, questioning, or challenging medical knowledge.

There are now thousands of electronic support groups (ESGs) available online. Prior to the Internet, illness was a private affair for most people. Now, given the virtual online worlds, illness can be more of a shared and public experience. As Barker notes, 'the process of understanding one's embodied distress has been transformed from an essentially private affair between doctor and patient to an increasingly public accomplishment among sufferers in cyberspace' (Barker 2008: 21). On occasion these interactive Internet groups (or sets of web-based groups)

develop distinctive and challenging perspectives to the dominant medical view. In the cases we examine here, one web group is seeking demedicalization while the other is seeking greater medicalization. By examining these here, we hope to develop some insight into the role of the Internet in increasing or reducing categories of medicalized conditions.

Pro-Ana Websites: Anorexia is a Lifestyle Choice, not a Disease

The dominant perspective on anorexia is that it is an eating disorder and a psychiatric illness marked by extremely low body weight, body image distortion, and an obsessive fear of gaining weight. Anorectics control their body weight by extremely limiting their food intake, excessive exercise, or diet pills or diuretics. Bulimia is a related eating disorder characterized by binge eating and subsequent purging. Contrasting and challenging medical definitions, so-called pro-ana websites and online communities present a view that rejects the medical perspective and offers an alternative stance on extreme dieting and thinness.

'Pro-ana' and 'pro-mia' websites and online discussion boards emerged on the Internet in the late 1990s. 'Ana' and 'Mia' are the community's nicknames for 'anorexia' and 'bulimia', respectively, and the early forums advocated for an understanding of eating disorders that was not negatively slanted. For simplicity sake we will refer to them all as pro-ana websites here. Internet websites for anorexics provide a forum that enables individuals living with an eating disorder to share experiences. Pro-ana websites, however, go beyond merely creating a forum for interaction and discussion but also developing a community with a strong point-of-view about anorexia. They attempt to present a 'positive' and non-medicalized view of anorexia. Individuals with eating disorders who participated in these communities could recontextualize and reframe their own understandings of anorexia and bulimia within an online sub-cultural framework that counters dominant medical paradigms. (McLorb and Taub 1987, Pascoe and Boero 2009) Some websites self-consciously see themselves as part of a pro-ana movement, selling pro-ana and pro-mia identity bracelets (Miah and Rich 2008).

It is difficult to reconstruct the content of the original pro-ana sites now, since the sites became very controversial (i.e. they were accused of proselytizing young girls to become anorexic) and many have been shut down or reconfigured in response to negative publicity. Similarly, a number of the interactive forums currently on pro-ana websites or social networking web pages now have become more restrictive requiring administrator approval, limiting access to 'outsiders.' Current 'pro-ana/pro-mia' websites reference the original sites as 'first wave Pro-Ana', from the current offerings of 'second wave-' or even 'third wave' pro-ana spaces. Our interest here is primarily in the early and pioneering pro-ana websites, with some reflection on the evolution of the more recent sites.

One of the hallmarks of the early pro-ana websites was the clear assertion that anorexia was *not* a disease, but rather a 'lifestyle choice' which should be

respected as a matter of individual autonomy concerning one's body. Pro-ana sites actively rejected the medical label; some stating directly, 'Anorexia is a lifestyle not a disease.' The 'lifestyle choice' assertion squarely contradicted the dominant medical view that saw anorexic behavior and bodies as distinct pathology, by advocating for the demedicalization of extreme ultra thin bodies and extreme dieting and exercise. Articulations of collective identity and 'community' were centered around adherence to this doctrine of anorexia as lifestyle, and pro-ana as the movement which advocates the celebration of this lifestyle (Boero and Pascoe 2009). Implicit here is both resistance to medicalized definitions of what it means to be anorexic, as well as a movement toward a positive, idealistic view of anorexic eating and bodies. In a sense the attempt was to normalize, destigmatize, and, at times, valorize anorexia. As one site posits,

> If people are allowed to smoke, drink, box, and do other things that may harm themselves just as much or even worse than anorexia, and the media and people allow commercials and websites that encourage such destructive behaviors, why not Pro-Ana? (http: //www.freewebs.com/thinnest/whynotproana.htm)

Many of these sites displayed galleries of photos labeled 'Thinspiration', or 'Thinspo', which includes pictures and montages of incredibly thin, even emaciated looking, people, reinforcing a cultural ideal of extreme thinness. These include celebrities, advertisements from magazines, and images from members of the website community. These photos were both meant to be a form of positive inspiration for thinness and a graphic depiction of the 'normalness' of extreme thin. While 'Thinspo' photos were displayed to celebrate the idealization of this body type, 'reverse trigger' galleries depicted photographs of extremely obese people in an effort to remind viewers of what they should desire to avoid. Early pro-ana sites demonstrated contempt for body fat, and inadvertently, for individuals who had obese bodies. Obesity was juxtaposed with anorexia and framed as the 'real' health risk to be wary of; the two were constructed as polar opposites; fat was unhealthy and unattractive and thin was ideal and beautiful. In this sense, thinness (and, in this case, extreme thinness) was thereby framed as a more 'natural' body state, as was demonstrated by 'inspirational quotes' on the sites such as the following:

> One day I will be thin enough. Just the bones, no disfiguring flesh. Just the pure clear shape of me, bones. That is what we all are, what we're made up of and everything else is just storage, deposit, waste. Strip it away, use it up…In the body, as in sculpture, perfection is attained not when there is nothing left to add, but when there is nothing left to take away. (http: //www.freewebs.com/thinnest/.htm)

The notion that anorexia is a medical condition from which one should 'recover' was anathema to the core principles around which these original pro-ana communities advocated. Early pro-ana sites, then, were not usually a space

wherein 'recovery' from anorexia was characterized as a desirable outcome. The medical view saw anorectics as deviant, while early pro-ana sites inverted this ideology by claiming that anorexic bodies are in fact 'ideal', 'pure', and 'natural', citing 'common-sense' understandings of hegemonic beauty standards as evidence to this claim. Consistent with this desire to reject the dominant medical discourse regarding anorexia, these sites also offered advice regarding how to undermine the unwanted imposition of medical interventions in one's anorexic 'lifestyle'. This included 'tips' about how to avoid detection of weight loss, such as, 'Wear nail polish to hide the discoloring in your nails from lack of nutrients' ('Big n' quick 257 tips'), or use 'fishing weights' to fool one's parents or doctors about actual body weight.

In contrast to these sites, a number of slightly different sites emerged after 2005 at least partly the result of the negative publicity and repression of the original pro-ana sites. The creators of the new pro-ana sites, in an attempt to differentiate themselves from what they called the first wave of the pro-ana 'movement,' developed second wave sites that were markedly different from earlier ones. These sites often had warnings like; 'Pro-Ana Nation does not encourage distorted eating or reinforce ideals of physical perfection. Anorexia is not a lifestyle choice, but a serous mental disorder.' It is likely these warnings reflect an attempt to protect the website from the kinds of pressure and harassment that closed down most first wave websites. While these new sites still supported demedicalization of anorexia, they did it in a less challenging and more subtle fashion. These new sites were still lifestyle-oriented, but they now included spaces wherein the discussion of recovery could take place, albeit in a value-neutral way. These sites neither rejected nor promoted recovery, but instead acknowledged the desire to pursue recovery as one possibility within an anorexic community. As one site, Blue Dragonfly announced:

> We do not promote disordered eating or the mentality that causes it, but we won't attack you if you have not recovered yet, or if you don't ever plan to recover, or if you are in limbo between the two. Already recovered? Come on in… (http: //blue-dragonfly.org/)

Many of these sites now contained advice about how to safely be an anorexic, sometimes even citing the principle of 'harm reduction.' Harm reduction is a public health term for strategies that reduce harmful effects that may result as a consequence of certain forms of deviant behavior. This is a common in the world of addiction and drugs, especially in Europe. Examples include developing needle exchange programs to reduction HIV infection risk or offering medical heroin maintenance to reduce the criminal behavior necessary to maintain one's drug habit (see Inciardi and Harrison 2000). While these websites didn't cite harm reduction, in a sense they offered advice about how to be a better anorexic. They gave advice about how to be safe with anorexia, e.g. to survive on minimal calories, get enough calcium, or to bulimics 'drink a ton of water when binging.' Such advice can

contribute to demedicalization by helping individuals manage their disorder better and avoiding the perception of an acute need for medical treatment. At the same time, there is evidence of a collective distrust towards recovery programs and treatments administered by medical institutions and mental health practitioners (also referred to as 'the pros') who were not themselves anorexic. This was illustrated by a number of allusions to the ways that 'the pros' treated anorexics, juxtaposed with the ways that the online communities regarded 'their own' members. Help from the former was seen as inherently dehumanizing, stigmatizing, and generally suspect, while support from the latter was characterized as loving, non-judgmental, and genuine. One example of this kind of differentiation from the website 'House of Thin' (http: //www.houseofthin.com/entrance/mission.php) is found below:

> What we do is make a safe place for others to come to and be themselves. Some say we promote the eating disorder, but again, not true. We do say that there is no shame in being eating disordered, the only bad thing is what causes the eating disorder. That is how pro-ana is different. The pro-recovery sites make you feel like trash for having an eating disorder and make you feel like you are in competition to recover and no matter how well you're doing with it, it's not as good as everyone else who go around preaching the gospel of recovery and making you feel even worse. On pro-ana sites, you will recover when you are ready for it and at your own pace.

The conclusion that these contrasts would seem to point to is that participants in the pro-ana online communities are making an authenticity claim to the 'real' knowledge and understanding of their experiences. This dynamic is mirrored in the findings of Pascoe and Boero (2009: 17), in their analysis of pro-ana and pro-mia discussion forums, as they note, '…knowledge is used to establish authenticity'. These claims of access to 'real' (i.e. first hand) knowledge are constructed in opposition to the views of those who espouse medicalized understandings of anorexia as a disease that invariably constitutes an immediate need for treatment and eradication.

The second-wave pro-ana sites reflect an ambivalent relationship with medicalization. On the one hand, diagnostic criteria is effectively cut and pasted from medical texts to describe the effects of eating disorders on the body, while moving away from the fervent 'lifestyle' language of the first wave sites. On the other hand, these criteria are listed as 'signs' rather than 'symptoms' of eating disorders, and the notion of extreme dieting and thinness as deviant is still contested. These sites resist explanatory frameworks for disordered eating which are focused on individual level pathology. In contrast to their first wave predecessors, these sites attribute responsibility for the 'problem' of eating disorders to a variety of contextual factors which can damage individuals' self esteem, including society, family structure, the media, and so on. In contrast to first-wave pro-ana sites, second wave sites do not depict loathing for, or rejection of, either body fat, or fat bodies. Rather, the sites claiming to be part of the 'evolution' of pro-

ana introduce what could be called a politic of more universal body-acceptance. While earlier sites rejected the stigma associated with anorexia by positing that anorexic bodies were ideal, with obesity as the enemy, later sites espoused a more inclusive ideological stance, whereby it is asserted that *no individual*—neither the extremely thin anorexic nor the extremely obese—should be stigmatized, or discriminated against for any kind of body type. This shift is also significant to medicalization in that contrasting anorexic bodies to obese bodies was previously used as a mechanism through which the former were idealized and the latter were held up as the 'real' deviant bodies vis a vis their apparent 'unhealthiness'. The rhetoric of second wave pro-ana sites recognized potential harm but still rejected medical diagnoses and treatments. In a sense, these sites now extolled a form of body acceptance rather than a pathological model of deviant bodies.

The medical profession and the eating disorders treatment community continue to oppose the pro-ana sites, arguing that they encourage severe dieting and eating disorders, discourage people from seeking necessary treatment, and normalize dangerous anorexic behaviors. The 'eating disorder treatment establishment' and related anorexia and eating disorder organizations view the pro-ana sites with distain and have done what they can to challenge and contradict the Pro-Ana message and, when possible, work to close down the websites.

While the first wave pro-ana groups were seeking a demedicalization of anorexia by challenging medical categories and treatments, the second wave groups, while still committed to demedicalization, do it more by advising how to live safely as an anorectic (harm reduction) and with a broader acceptance of a range of body sizes and shapes. While there is still 'thinspiration' here it is less shrill and exclusive, although still affirmed as beautiful.

Wannabes: Amputees by Choice

In the December 2000 issue of *The Atlantic* magazine Carl Elliott published an article 'A new way to be mad.' In this article Elliott described individuals who, while normally able-bodied, had long-standing and firmly held belief they should be amputees. Paradoxically, they feel their body is incomplete with their four limbs and the desire for amputation can become a central feature of their lives or even an obsession. As one individual noted:

> It has been precisely in these last years that the desire has gotten so strong, so strong that I can no longer control it but I am completely controlled by it. (quoted in Elliott 2003: 221).

Another individual typified these feelings when he said 'two legs made him incomplete' and, paradoxically, amputation would make him whole (First 2004: 2).

Many of these individuals become obsessed with finding a way to become an amputee, even by doing great damage to their limbs with shotguns, chain saws, dry ice or putting their legs in the way of an oncoming train, in an attempt to create a situation where they would receive an amputation. While most recognize that there are currently no doctors who will amputate a healthy limb, some still search for surgeons who would be willing to undertake amputation surgery. One Scottish surgeon, Dr. Robert Smith, performed surgery on two individuals in 1997, but the negative medical reaction to these procedures was so strong he quickly discontinued this practice. As of now no doctors are willing to perform amputations on healthy limbs (Bayne and Levy 2005). To the best of our knowledge, the Elliott article was the first time individuals with these unusual proclivities had received such public exposure.

For the most part, the body location of the desired amputation is quite specific; e.g., the left leg two inches above the knee. These individuals say very explicitly that this specific amputation is what they seek and without it their body will not feel whole. Over the years, various clinicians have described this disorder and called it by various names: Apotemnophilia, Amputee Identity Disorder, Amputee by Choice, Body Dysmorphic Disorder, or Body Integrity Identity Disorder. Despite the proliferation of names, none of these names has become an 'official' medical diagnosis, but rather remain descriptors of individuals who strongly desire limb amputation. There are variations in emphasis: one of these terms assume a connection with sexuality (Apotemnophilia), body identity (Amputee Identity Disorder, Body Dysmorphic Disorder) or that this is a chosen state (Amputees by Choice). For the purposes of our analysis we will use the indigenous term wannabes (as in wannabe an amputee), a term individuals have come to use to describe themselves, since it doesn't assume any disorder or medical etiology.

Many wannabes keep their amputation desires secret from families, partners and friends. They recognize that others would see these wishes as unusual or even bizarre. But for many years, these wannabes have been connecting with one another through Internet list serves, discussion sites, blogs, and websites. What might seem like a strange or even idiosyncratic desire—to have a healthy limb amputated—to most people, now had a medium where others with the same desires could contact and communicate with each other. Elliott reports one list serve with 3,200 subscribers (2003: 209), and there are now numerous websites and discussion groups where wannabes and others can share information, get support and, as we will see, promote their condition as a medical disorder in need of medical treatment.

Michael First, a psychiatrist at Columbia University, has conducted the most developed research on wannabes (First 2004). He has interviewed 52 individuals who were self-identifed as desiring the amputation of a limb. Sixty-five percent were recruited from Internet sites; seventeen percent (n=9) of these had an arm or leg amputated, two-thirds using high risk self-inflicted techniques with the other third engaging surgeons in the amputation. The most common explanation for desiring an amputation (85 percent of the sample) was a mismatch between

the individual's anatomy and their true identity as an amputee. Overwhelmingly, the individuals focused on a specific limb they wished to have amputated. First found that none of his interviewees were delusional, and that although some had sought treatment for their desires, neither psychotherapy nor medications had reduced the intensity of their of their desire for amputation. These respondents who had been able to secure the amputation reported feeling better than ever, more whole and complete. First (2004: 1) concluded that this an 'extremely unusual clinically distinct condition characterized by a lifelong desire to have an amputation of a particular limb.' He compares it to Gender Identity Disorder and suggests the name as Body Identity Integrity Disorder (BIID). First (2004: 9) notes this *could* be a medical clinical disorder:

> If additional research replicates and expands this study's results, could a case be made to include this condition in future DSMs, on the grounds that, although rare, it is a distinct condition associated with distress, impairment and risk of death (e.g., due to botched amputation)…

First was the editor for DSM-IV, so he speaks with authority about the potential of BIID to be included in the next DSM. However, First has also been quoted as saying that people with BIID are basically normal.

> They have families. They have all kinds of jobs, doctors, lawyers, and professors. They are not screwed up apart from this. You could spend the evening with them and not have the slightest clue (Quoted in Henig 2005).

There are numerous websites created by and for wannabes providing a medium for connection and information. Given the rarity and potentially stigmatized nature of their desires, the Internet presents a unique venue for wannabe interaction. Without these sites, an individual might well believe he or she was the only one that harbored the desire to be an amputee. But with the Internet, there are now communities of wannabes that can communicate with each other, exchange information and give one another support. In a real sense these sites have been able to unite individuals who had previously felt alienated or alone. As one man noted:

> For a long time I thought I was alone in the world with this bizarre wish. I collected information about amputation and amputees and and several time I threw it all away. I wanted this wish to go away… Although [eventually] I knew there were others I had no idea how to get in touch with them. Or where to turn for help….Later on I learned the potential of the Internet. Most information was on devotees (people sexually attracted to amputees) but I also found some concerning wannabes. The quality of information varied a lot…Finally I had mustered enough courage to contact other wannabes and I have not regretted If for a fraction of a moment. It was a great relief as well as a bit scary finding out how similar the experiences were despite the dissimilarities in personalities…

> This [experience on the Internet] has made me feel much better about myself. (http: //www.geocities.com/starstranger_2000/)

These Internet websites and discussion group provide social support, a collective legitimation for the longings for amputation, a forum to search for doctors who will help them, and discussion of 'safer' ways to achieve self-amputation. There has been some concern that these sites might lead to more risky attempts at self-amputation, but others have suggested that the information on the sites and the quest for medicalization provides the potential for harm reduction (Berger et al. 2005).

In recent years, there has been more discussion on the wannabe websites about the 'disorder', the potential for treatment (surgery), and especially advocacy among some parts of the community for the inclusion of BIID in the next edition of the DSM (which will be published in 2012). It is common to hear comparisons to 'transsexual' or 'transgendered' individuals; that they are 'trapped in the wrong body,' are mismatched with their body and self-identity, and that medical treatment is available to treat an individual's difficulties and suffering. Individuals with diagnoses such as 'Gender Dysphoria' and 'Gender Identity Disorder', can receive 'treatment' in terms of sex reassignment surgery, so why not wannabes (who are now are beginning to refer to themselves with a related designation, 'transabled')? If BIID could be included in the next DSM, this would make those with the disorder eligible for reimbursement by health insurance. This of course brackets the question of whether there would be surgeons who would be willing to perform amputations on a healthy leg, hand or arm. As one site explains:

> And if BIID does become a recognized mental illness, then we are more likely to be accepted by the medical community. just as transsexuals started to see accepted avenues of treatment when their condition was accepted as a mental illness, we believe that it will take us being formally labeled as mentally ill before we see treatment options open to us. And we don't necessarily mean to have a 'cure' for BIID (BIID-Info.org).

Another site echoes the view that BIID is a mental illness and that is OK:

> There are those people who are transabled that will argue thatBIID is not a mental illness. I think part of that reaction is dueto the generally negative view of society over mental illnesses.For me, I don't care about being labeled with a mental illness, oneway or the other. If it takes BIID 'achieving' mental illness status,and be included (sic) in the next edition of the DSM for us to have doorsopening on avenues of treatment that fit our needs, then I embracethe idea that I have a mental illness. For me it's a means toward anend. But this is also a reality. It is something that affects my mental health (Transabled.org).

While not all wannabes/transabled individuals believe that the acceptance of BIID as a medical diagnosis in the DSM-V would be a key to treatment and acceptance, many do. For those who do advocate the medicalization of persistent desires for amputation do so with the hope for greater acceptance of their condition, especially by the medical community, and the firm belief that the only kind of treatment would be some kind of body realignment surgery that would essentially be an amputation. If BIID were accepted it could be argued that surgical amputation was a safe form of harm reduction compared to the highly dangerous attempts at self-amputation and could affect an example of patient autonomy (Bayne and Levy 2005: 79–82). Several researchers and advocates alike believe that medicalized amputation would have therapeutic affects on the obsessions and mental health of the individual (First 2004, Bayne and Levy 2005, Furth and Smith 2002). This raises the question about what kind of status is voluntary disability would have under the Americans with Disability Act and other entitlements for people with disabilities.

Leaving aside whether persistent desires for amputation and the related identity discomforts should be defined as BIID and included in the DSM, it is very clear that many of the wannabe websites and their participants are using the Internet sites in part to actively advocate for the medicalization of Body Identity Integrity Disorder as a medical/psychiatric illness which merits medical intervention

Concluding Remarks

Pro-ana and wannabe websites have become active vehicles for sharing information, creating community, and advocating particular positions. With the pro-ana sites the overall message is that anorexia is an acceptable (sometimes even valorous) condition and that medical interventions may not be necessary because anorexia is not an illness. The wannabes, on the other hand, aspire to both legitimation and medical recognition, especially those who advocate for the inclusion of BIID in the DSM. Thus one group is pursuing a strategy of non-medicalization if not always demedicalization, while the other seeks medicalization and what they perceive to be its benefits. While these websites act as a 'refuge' for these socially defined deviants, in a real sense each of these groups is also something of a fledgling social movement, promoting their vision of reform. It is interesting that each web-based movement extols that acceptance of their position would be a way of reducing harmful or risky aspects of living with the condition (one by medicalizing, the other as part of demedicalizing).

The Internet shapes the formation and strategies of each group. It is our belief that wannabes would not (indeed probably could not) have a collective presence without the Internet. Given the rarity of the condition, its invisibility, and the potential stigma from revealing one's desires publicly, the accessibility, anonymity, and wide reach of the Internet are critical to the creation of wannabes as any kind of community or activist group. This raises the question when does an

idiosyncratic desire become a social movement? Anorexics are both more common since anorexia is not rare among adolescent girls (the National Institute for Mental Health estimates that up to 3.7 percent of females suffer from anorexia, while up to 4.2 percent suffer from bulimia) and more visible, since anorexia actually affects the body in ways others can see. So anorexics could probably find each other in real life if they so desired. What makes the pro-ana sites unique is that they have become a locale where numerous anorexics can virtually gather and share and develop strategies that either reinforce anorexia as a valorous condition or provide a venue where girls can coach each other about how to become a better anorexic, sharing anorexic strategies for maintaining their condition. In short, pro-ana sites allow for the development of a counter narrative of anorexia challenging the dominant medical treatment narrative. In each case, the Internet is critical to the formation and sustenance of the group's ideology and purpose.

Participating in these website groups can profoundly impact individuals as well. While it seems doubtful that individuals are recruited to the disorders by these websites, those inclined toward the obsession with thinness or with becoming an amputee are certainly likely to be attracted to the sites, especially in a world that would stigmatize or attempt to alter their desires. At first wannabes may be completely confused by their desires, and anorexics, while recognizing their desire in more common cultural terms, try to hide their desires from family and others who they believe would disapprove. The existence of a community of individuals with similar desires and outlook on the Internet is very attractive to the individuals and reassuring that there are others like them out there. Hearing about others' experiences and exposure to the viewpoints on the websites may alter participants own experience of their condition (First 2004: 9). Using Ian Hacking's (1995) conception of 'looping' effect, the perspectives promoted on these websites create material for participants to construct or modify their identities and shift or reinforce their take on medical views of their condition. In short, individuals' participation in the websites creates the possibility of new identities about themselves and their bodies.

What makes these websites and related online communities so intriguing is that they become nascent social movements as they promote alternative perspectives to the standard medical viewpoints of their condition. The Internet has a global reach and is expanding rapidly, so whatever happens online can resonate throughout the world. Whether these web groups become a significant force and harbinger for change in the medicalization-demedicalization process, or whether they will be relegated to an interesting footnote in social and medical history is yet to be determined.

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Chapter 6

The Ageing Body: From Bio-Medical Fatalism to Understanding Gender and Biographical Sensitivity

Jason L. Powell

The significance of the ageing body is important for the discipline of gerontology. For example, illness can limit the functioning of the body and this can have psychological, political and social consequences. Recent debates on 'healthy ageing' (Gilleard and Higgs 2001) is conceptualized in terms of body maintenance and such activities form a central feature of consumer societies (Featherstone and Wernick 1995). At the same time, biomedical models of ageing have devised the means to foster intellectual respectability to a range of 'scientific' ideas about the body. The bio-medical model suggests it can reconstruct the biology of bodies through plastic surgery; it can interfere with genetic structures; and it can move internal organs from one body to another. There is an irony: the more we know about bodies and the more were are able to control, intervene and modify them, the more uncertain we become as to what 'the body' actually is. The boundaries between the physical body and consumer society are becoming increasingly blurred. In this context, the body represents an important issue for gerontology in particular and social science disciplines in general. The chapter addresses the question as to how the biological ageing body acquires meaning, and also how the meaningful body itself, relates to such signifying processes and social efforts as to understand gender and the ageing body. In particular, we assess the relevance of the ageing body, and ageing identity for pointing toward a Feminist theory that can be defined as interconnecting gender and ageing. To add insights to gendered ageing, the chapter will conclude arguing for a biography of ageing. Part of the context for realizing the potential of biography is its dissection of meaning, not as fixed, but as fluid as found in the context of everyday life. Biography provides a significant contribution to un-locking an understanding of what is means to be a human person situated within and across the lifecourse. Biography can be used to reveal critical consciousness, understanding of personal identity and social meanings.

Despite this, there are ambivalent representations of the ageing body in western culture. There has long been an occidental tendency, in matters of ageing and old age, to reduce the social dimension of ageing to a fixed set of life 'stages' which are said to determine the experience of old age. Accordingly, being old

would primarily be a private experience of social adaptation to inevitable physical and mental decline and of preparation for death. This of course was the main viewpoint of disengagement theory which suggested that people of retirement age should adapt themselves for the ultimate disengagement of death. This was not only a dominant functionalist narrative in American gerontology, but also such arguments played a key positional role in shaping negative societal representations of ageing.

The representations of what it is to be old have been shown to structure the ways in which individuals and social groups alike recognize old age in others and in themselves. In their content analysis of retirement magazines, Featherstone and Hepworth (1993) suggest that the types of images of old people presented in specialist magazines are consonant with attempts at focusing on the positive side of being old. This is usually linked to the 'Third Age', those in early retirement and the continuation of a full round of leisure and other activities. The message here is that there now exist opportunities for consumption. Betty Friedan (1993) argues that consumer culture promotes a concern of 'active ageing' and then exploits it. Morris (1998) agrees, asserting that consumer culture is pre-occupied with perfect bodies, spread through glamorized representations of advertising. The visual image is increasingly dominant in western culture. Thus, consumer society reinforces and creates negative language and images of later life. There seems to be an inverse relationship between images of old age and the participation in social life (Bytheway 1993). Further, Morris (1998) suggests that consumer culture emphases youthfulness as the ultimate aspiration of social identity – 'the body beautiful' – it is increasingly marginalizing the identities of older people in later life.

Literary evidence of the sudden realization that old age has caught up with the young self is plentiful – see for instance Bytheway's (1993) account of Bernard and Mary Berenson's encounters with their aged bodies or J.B. Priestley's description of the sudden realization that he had become old. The visible physical manifestations of senescence therefore constitute a disguise that conceals the real, unchanged, self (Featherstone and Hepworth 1993). Bytheway and Johnson (1998) assert that we need a well-constituted image of what old looks like before we could recognize the signs in our own images.

Social gerontologists can study persons of a certain age, but their reality seldom reflects that of the subjects they study when their bodies are ignored, because becoming, and being, old are embodied processes. In those parts of the bio-medical establishment where care is most emphasized, rather than regimen and control, particularly in nursing, there seems to be a deeper focus on the provision of care based on a rigorous emphasis on the patient's subjective experience (Benner 1995). In these patient care contexts, substantial attention has been devoted to the ethical implications of various disease definitions. Specifically, the discussion also focuses on how language shapes the response to illness, and to how disease definitions and paradigmatic models impact communication between health professionals and patients (Rosenberg and Golden 1992). Significant work on social understanding

of disability has demonstrated how the *lived body* is experienced in altered form and how taken for granted routines are disrupted, invoking new action recipes (Toombs 1995). Nonconventional healing practices have also been examined. In this context, embodiment and the actor's subjective orientation reflexively interrelate with cultural imagery and discourse to transfigure the self (Csordas 1997). Even emotions are best analysed as interpretive processes embedded within experiential contexts (May and Powell 2008). Hence, simultaneously, becoming, and being, old are about the corporeality of being old, the embodiment experience of holding on to physical/mental integrity and reasonable health (Baltes and Carsterson 1996).

Yet it has only been in the past two decades has there been any sustained attempt to fuse together postmodern concerns about ageing bodies in order to foster a deeper understanding of ageing identity (Gubrium and Holstein 1995). Gubrium (1992) has investigated how ageing is constituted in the consciousness of persons. The struggle for meaning when accompanied by chronic pain may be facilitated or impaired by constructs that permit the smoother processing of the experiences. Biggs (1999) makes the point that postmodern ideas of embodiment encourages care-givers of older people to gain empathic appreciation of their clients' lifeworlds and enhanced affiliation with them through the use of biographical narratives that highlight their individuality and humanity. It is therefore important to focus on the construction of identity that is imposed upon the discourses of exteriority and interiority that impinge upon the body.

Bio-medicine and the 'Truth' Stories about Bodies

In this discussion the biomedical model is understood to have four components. 1) The mind and body are essentially different and medicine is restricted to considerations related to the body. 2) The body can be understood as analogous to a machine. 3) Medical answers are thought to be more reliable when they are founded on the basic sciences. 4) And thus biophysical answers are preferred to all others (Longino and Murphy 1995). This model is reductionistic and by focusing almost entirely on the body, it ignores the person that animates the body, and the lifeworld that contextualizes the person.

The bio-medical model has dominated the perceptions of old age in gerontology. As Powell and Longino (2002) pointed out, the medicalization of old age is not an objective scientific process, but rather a series of policy struggles at local, national and international levels. These struggles to define the nature of ageing are between several *provinces of meaning* such as old and potentially old people, their network of informal care-givers, the helping professionals of different types, entrepreneurs from family run care homes through to pharmaceutical companies of global reach, and finally the institutions of the state and the organization and distribution of resources through policy spaces (Biggs and Powell 2001).

Michel Foucault (1977) has shown important insights for gerontological theorizing. He attempts to analyse the extent to which institutional medicine objectifies the 'sick' body, once it has been medicalized. For Foucault (1977) the body is not natural but created and reproduced through discourse. Foucault maps out how medical power became a disciplinary strategy which extended 'control over minutiae of the conditions of life and conduct' (Cousins and Hussain 1984: 146) of individual bodies. Arguably, the medical profession became an institution in which the advice and expertise of professionals was geared to articulating 'truths' about bodies (Armstrong 1983). Medical domination through observation and scientific discourses objectified 'sick' bodies as 'diagnoses began to be made of normality and abnormality and of the appropriate procedures to achieve the norm' (Smart 1985: 43). In this way examining the body of older people was central to the development of power relationships in social situations:

> The examination is at the center of the procedures that constitute the individual as effect and object of power, as effect and object of knowledge. It is the examination which by combining hierarchical surveillance and normalizing judgement, assures the great disciplinary functions of distribution and classification (Smart 1985: 49).

Arthur Frank (1990: 135–6) has suggested that the medical model occupies a privileged position in contemporary culture and society:

> Medicine does occupy a paramount place among those institutions and practices by which the body is conceptualized, represented and responded to. At present our capacity to experience the body directly, or theorize it indirectly, is inextricably medicalized.

The way in which biomedical models of ageing have interacted with older people is a subtle aspect of control and power (Katz 1996). This interaction legitimizes the search within the individual body, for signs, for example, that s/he 'requires' forms of surveillance and processes of medicalization (Powell and Biggs 2000). This legitimation permeates an intervention into older people's lives, because professional practices of surveillance are said to befit older people – because of the discourse of pathological ageing (Powell and Biggs 2000). Biomedicine, hence, constructs the identities of older people as objects of power and knowledge:

> This form of power applies itself to immediate everyday life which categorises the individual, marks him by his own individuality, attaches him to his own identity, imposes a law of truth on him which he must recognise and which others have to recognise in him. It is a form of power which makes individuals subjects (Foucault 1982: 212).

Unfortunately, the medical model perceived old age, in particular, as related to physical, psychological and biological problems of the 'body' (Longino and Powell 2009). Such 'problems' of the ageing body were tied to narrow individualistic explanations such as that ageing bodies 'decay' and 'deteriorate'. In western culture, therefore, the ageing body has been perceived as the 'bottom line' – subject to relentless growth and decay and 'body betrayals' (Biggs and Powell 2001). Insofar as there is a history of ageing, there is also a history of medical discourses of power which have attempted to 'colonize' narratives that would understand the body (Powell, Biggs and Wahidin 2006). According to Katz (1996), the effects of the decline analogy can be seen in the hegemonic dominance of medico-technical solutions to the 'problems' of ageing that bear on the 'body'. As Biggs and Powell (2001: 95) point out:

> This has led to a skewing of gerontological theorizing and research towards geriatric medicine and the relative failure of more broadly based social and life-course approaches to impinge upon thinking about old age.

The dominance of the medical model and its understanding of the ageing body has colonized definitions of old age. However, there is also ambivalence. It has also sought to re-invent itself as the 'saviour' of ageing via the bio-technological advancements that foster re-construction of the 'body' and to prevent the ageing process (Twigg 2004). It appears:

> established and emerging master narratives of biological decline on the one hand and consumer agelessness on the other co-exist, talking to different populations and promoting contradictory, yet interrelated, narratives by which to age. They are contradictory in their relation to notions of autonomy, independence and dependency on others, yet linked through the importance of techniques for maintenance, either via medicalised bodily control or through the adoption of 'golden-age' lifestyles (Biggs and Powell 2001, 97).

The medical model also has tended to disembody older patients by ignoring their 'lived bodies.' Research by Twigg (2004) indicates that medical discourses of power play a key interventionist role in societal relations and in the management of social arrangements. That is, medical 'experts' pursue a daunting power to classify, which has serious consequences for the reproduction of knowledge. The power to classify also serves to maintain power relations (Powell and Biggs 2000).

Schrag also (1980: 252) powerfully illustrates that the medical model provides a:

> subtle and erosive process [to individual identity]. Almost every agency of education, social welfare and mental health talks the seductive language of prevention, diagnosis and treatment; and almost every client is held hostage to

> an exchange which trades momentary comfort and institutional peace for an indefinite future of maintenance and control.

'Lived bodies' play not only a crucial part in the identity formation of older people via medical discourses but also, of equal importance, in the social constructions and representations of the body between older men and women. While the naturalization of the body has been pointed out and contested its 'objective' stance via the appropriation of social constructivist insights, gender is a key identity variable identified and evaluated, a dividing practice between men and women. Gender, therefore, is important and significant for the further gerontological study of ageing, identity, and embodiment.

Gender and the Ageing Body

Feminism has focused on the ways women's bodies were controlled and dominated within patriarchy. A series of social institutions – medicine, the law and family – were implicated in the control of women through the control of their bodies. According to Twigg (2000) feminism drew our attention as to how women are represented in culture as more embodied than men, as representing the body itself.

The 'body' within social gerontology pays insufficient attention to the ways in which gendered bodies have always enjoyed varying degrees of absence or presence in old age – in the guise of 'female corporeality' and 'male embodiment' (Gittens 1997). Indeed, there are discursive strategies whereby 'the body' and 'the social' are dissociated in the first place. In this framework, woman is saturated with, while man is divested of, corporeality. Older women have higher rates of chronic illnesses than do men, and their bodies outlast those of men (Estes 2001). In clinical settings, in old age, women outnumber men in nearly all waiting rooms (Moody 2001). Yet she is divested while he is invested with sociality. The absent women in social gerontology were the women in the body excluded from the social. It is male bodies that animate the social – they appear for a fleeting moment, only to disappear immediately, in the space between 'corporeality' and 'sociality'. Thus, it is not simply a case of recuperating bodies into the social, but of excavating the gendered discourses whereby gendered bodies are differently inscribed into and out of the social in the first place. As a needed qualification, Harper (1997: 169), reminds us that because women are always embodied and men are not, 'men become embodied as they age' through the experience of the experiential and constructed body.' So the gap between women and men may narrow, in some ways, as they age.

Indeed, Feminists have underlined the limits of Cartesian thought which considered the subject as disembodied and, above all, a-sexual (Braidotti 1994). In the representation of the female body, the dichotomy between body and mind has been used to emphasize sexual difference. On the one hand, we have masculinity

which is defined in relation to the mind and the 'logos,' while the feminine is defined in relation to the body and its procreative functions, an essentialist construction, par excellence (Twigg 2000). As Adrienne Rich (1976: 184) reminds us, women have had to deconstruct the patriarchal stereotype which links the female body with its procreative function: 'I am really asking whether women cannot begin, at last, to think through the body, to connect what has been so cruelly disorganized.

Rich stresses that women have to overcome the damning dichotomy between soul and body, in order to re-appropriate their bodies and to create a female subject, in which the two entities are complementary. Contrary to andro-centric and Euro-centric philosophical tradition, feminist philosophical studies have emphasized that the body is a symbolic construct, located in a specific historical and cultural context: in other words its conceptualization can no longer ignore the close nexus between sex, class and race (Blaikie 1999). Women often find themselves defined as 'the other' (the residual category).

Contemporary cultural representations of ageing focus on the body because this provides the clearest evidence of the historical inequality between gender differentiation: the body of women is inscribed with oppressive ideological mystifications (Friedan 1993, Sontag 1991). Western literature and iconography are full of anthropomorphic discursive representations of old age as a woman with 'grey hair', 'withered', 'faded', 'pale and wan face', 'foul and obscene' (Friedan 1993). The old woman becomes a symbol of 'evil' and an allegory of time which completely corrupts everything. In Portrait of an Old Woman by Giorgione (1508–1510), the devastation impressed on the curved figure, balding with few teeth and deep lines on her face, her eyes pervaded by sadness, acts as a reminder of the transience of beauty. It provides a terrible warning of what is to come, hence the scroll laid on one of her hands reads: 'with time' (Greenblatt 1980).

The notion of 'intertextuality' can be used as it is a mechanism by which the social world is fabricated and this explains why cultural 'ideologies' continually perpetuate perceptions of ageing and gender. Postmodern perspectives can facilitate an understanding of how older people can intertextually re-construct cultural narratives to explain their representations of identity and self-identity. Such a strategy involves a challenge to the homogeneity of the social category 'elderly' as an embodiment of the 'times up' medical narrative. When the issue of social identity in later life is analysed Foucault's (1977) contention seems powerful in articulating that there has been a growth in the localities of power and knowledge that seek to inscribe physical and social bodies with discourses of normality and self-government. In the search for a stable identity not dominated by both professional and cultural discourses of power, older people must 'achieve' it through 'ontological reflexivity' (Giddens 1991). Accordingly, the self-identity needs to be consciously constructed and maintained. The ageing self has a new pathway to follow, stepping outside dominant discourses of medical and patriarchal reason, to include a process of safety, self-exploration, self-struggle and self-discovery, it is anything but given. This allows the inner and outer space to reflect on the self but more specifically a 'biography of the self'.

Towards a Biographically Sensitive Approach?

The notion of biography is central to gendered older people's meanings and experiences of mind and body relevant to the lifecourse. Older women make their own biographical histories across the lifecourse. From earliest age to old age, individuals create biographical narratives to create a sense of coherence and self-identity (Biggs 1999). The social worlds that older people create are put together by categorized experiences. Categories take on an existence of their own for interpreting and constructing meaning. The interior mental processes of individuals and their self-identities dynamically collide and interact with social forces to produce and reproduce the forms of experience.

Alfred Schutz's notion of 'biographical work' (Starr 1983) is the means of embracing this dynamic interplay of subjective and objective social processes. By tracing an individual's life career trajectory over the lifecourse, the concept of biography allows us to document the development of their unique configuration of personal powers, skills and emotional-cognitive capacities as they emerge out of the interplay of social involvements and constraints. This is because biography refers to the comparative development of variable powers between older people, while tracing specific individual's experiential trajectories of across the lifecourse and the unique social configurations in which they are enmeshed.

One could apply this example just as well to the other end of the lifecourse; old age. According to Encandela, when we look at ageing and the social construction of 'pain' we can see the use of a postmodern perspective. Encandela (1997) investigated the interrelationship of ageing and trauma and found it was constituted in the consciousness of members and helping agents. The struggle for meaning accompanied by chronic pain may be facilitated or constrained by the availability of constructs that permit the processing of the experiences. Members of cultures that stock recipes for skillfully manageing pain may well be more likely than others to construct beneficial interpretations in the face of these challenges (Encandela 1997). Postmodern gerontology in this content encourages the professionals who work in the field of pain management with older people to gain an empathic appreciation of their clients' lifeworlds and enhanced affiliation with them through the use of biographical narratives that highlight their individuality and subjective sense of self (Biggs 1999).

Subjective experience, in this sense, is an amalgam of several, often seemingly diverse, sensitivities and operations. Settersten (1999) suggests that the study of the lifecourse teaches us that it is open to historical contingency. Distinctive changes for older people cannot be understood without reference to biographical contexts. At the same time, Settersten (1999) claims that there has been scarce study of inter and intra cohort variation in the ways that socio-historical circumstances relate to particular lives. Members of cohort groups react in unpredictable ways to historical contexts. The timing into expectable social roles can influence the ways in which they are experienced and alter expectable role entrances and exits in life zones such as work and employment. Similarly, sub-groups of individuals may

hold basic values of their generational cohort but hold a different outlook to their larger cohort; a process of 'self-identity'. To understand the ageing self in such terms enables us to appreciate the power and control dimensions of human conduct as they apply to individual self-identity of older people and how they are linked to the social world. Because older people vary in terms of their biographically produced personal powers and capacities across age and gendered cohorts it is important to recognize how these feed into, and in turn are influenced by, other social domains such as 'situated activity' or the arena of interpersonal relations and social settings, gender and contextual resources and as such are reproduced social positions, relations and discourses.

Conclusion

It would seem that the ageing body is yet another mode of embodied subjectivity for gerontologists to unravel. The re-territorialization of the ageing body by society, and paradigmatically by social gerontology, is a strategy, which parallels the denial of subjectivity within the main traditions of scientific medical and social practice. The concept of the 'body' itself may take on particular sets of gendered meanings for older people, both men and women, whose subjectivity of identity formation conflicts with the objectified scientific definition. In terms of the latter, the explanatory frameworks derived from bio-medicine help to reinforce stereotypes that late life is synonymous with and indeed caused by being old. Medical narratives of the body, far from totalizing knowledge about bodies, obscure the social construction of identity and practice. The body like parchment is written upon, inscribed by variables such as gender, age, sexual orientation and ethnicity and by a series of inscriptions, which are dependent on types of spaces and places. We have questioned gender with ageing in highlighting how gendered and ageist discourses serve to confine and define, old bodies. What has been attempted to bring to the fore, are the different ways medical and gendered knowledge of ageing are socially constructed in western society that animate opportunities for biographical development. To realize biography, is to re-cast gerontology around a more reflexive framework, a movement in social science that illuminates an understanding of the relationship between states of individual consciousness and social life. As an approach within social gerontology, postmodernism seeks to reveal how human ageing awareness is implicated in the production of social action, social situations and social worlds. Postmodern ideas asks of us to note the misleading substantiality of social products and to avoid the pitfalls of reification. It is inadequate for gerontologists to view older people only as 'objects'. Older people are 'subjects' with sentient experience and as such, we should focus on the investigation of social products as humanly meaningful acts. The 'meaning contexts' applied by the social gerontologist explicates the points of view of older actors based on gender and ageing. It also expresses their lifeworld. A reflexive gerontology strives to reveal how older men and older women construe themselves,

all the while recognizing that they themselves are actors construing their subjects and themselves.

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PART III
Abject Bodies

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Chapter 7

'Where the Excess Grows': Demarcating 'Normal' and 'Pathologically' Obese Bodies

Shirlene Badger

Obesity is a public disease, both in discourse and in physical expression. Despite complex understandings across disciplines as to the causation of obesity, the obese body is commonly seen to be somewhat self-evident revolving around a simple equation of input and output. Beyond discussions of causation, descriptions of the obese body hold an increasingly significant political, public health, scientific and personal power. How actors engage with this description varies from the moral and self-evident, to scientific curiosity, through to personal experience. That is to say, the multiplicity of norms that can be attributed to the obese body to define some parts as normal and other parts as beyond normalcy cross a broad range of public and private structures and experiences.

In this chapter I draw on data collected as part of an ethnographic study that crosses the various locales and experiential perspectives of actors in a 'genetics of obesity' study. My research involves observation within and recruiting through a genetic research team to explore the impact of undergoing investigation for a genetic cause for obesity in severely obese children and their families. While, my research specifically seeks to explore the obese body within genetics of obesity research, it will be clear that the obese child or adult must cross and navigate an ever increasing array of terrains and care pathways of which recruitment to a genetics study is unsurprisingly perhaps, only one, of many layers. To illustrate this, I will focus on the stories of bodies of children and the roles they play within different contexts, evoking realities and categorisations both surreal and mundane. I provide a series of snapshots from across my ethnographic engagements and I plot them amid two stories: the fictional story of *Charlie and the Chocolate Factory* and the political story of a child who acted as a 'poster girl' for the obesity epidemic in Britain. As such, these act as moments that highlight the *situation* of the classificatory act of obesity and more importantly, the political and fictional moments act as further evidence of the generalisability and assumed knowingness that is inferred on the fat body. They highlight themes of moral identity and how particular bodies are seen to threaten the 'natural' order of things. Drawn together, they allow me to begin to tell about obesity (see Mol 2002: 53). Perhaps I can illustrate how bodies move between different categorisations according to the specificities of context by recounting the ethnographic moment from my research that I have come to refer to as *The Bridget Jones moment.*

The Bridget Jones Moment: Distorting Categorisations of Time and Identity

It was my second visit to Samantha and her family. Near the end of a long day that had involved interviews with her two daughters aged 12 and 8 and a family visit (including interview) with the girls paternal grandparents, Samantha, her daughters and I were all in the living room chatting and drawing, having afternoon tea against the background noise from the music MTV channel on television. It had been a day full of moving accounts of bullying and hospital encounters, followed by rather different interpretations of fat by the grandparents. In a joint interview with a rather slim tall grandfather and his much bigger wife, I had been told of their open affection for each other: of Ron's view that 'once you've been with a big woman there's no going back', of the sexuality of fat bums and the intimacy of their relationship where fat was not pathologised but was celebrated, where their granddaughter Nerali 'fitted' both in physical expression and their future hopes for her. In the next moment Geri Halliwell's cover of the song *It's Raining Men* came on the MTV channel and the volume was immediately turned up. Samantha, her daughters and I started dancing around the room singing with Geri: 'It's raining men, Hallelujah! It's raining men, Amen … God bless Mother Nature, She's a natural (sic) woman too…'[1] The song had been used in the sound track to the first *Bridget Jones' Diary* movie. The movie is a dramatisation of the book by Helen Fielding where thirty-something Bridget records her life and modern preoccupation with her weight, alcohol, cigarette and food consumption alongside the complications of trying to be a modern independent woman desperate for a boyfriend. There is a moment in the movie when Bridget Jones is dressing for a date and she systematically goes through her selection of underwear, famously choosing the unattractive 'big knickers' that work their magic refining the figure under clothing. The scene of Bridget holding up the 'big knickers' flashed onto the television between shots of Geri singing. At this moment, Samantha's youngest daughter Juliette yells out 'Ha! Nerali wears knickers that big doesn't she Mum!' Nerali quickly retorts: 'No I don't, I wear knickers my own age size now don't I Mum?' More singing: 'It's raining men!' In a momentary culmination of the interviews of that day with grandparents and granddaughters and talk of family relationships and expectations, the concluding credit clips from the movie flashed through my mind. Bridget Jones eventual boyfriend is Mark Darcy and his parents are interviewed about the news that Bridget and Mark are together. In the movie, Mr Darcy responds using language and sentiment not too dissimilar to Ron earlier in the day. He says: 'Oh Marvellous, marvellous! Yes. Nice, healthy, well-built girl. Can't be doing with a girl who's just skin and bone. I like a woman with a backside you can park your bike in and rest a pint on. Hmm.'

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1 While the original lyrics to the song are 'She's a single woman too', the prominent chorus from the family members during this moment was 'She's a natural woman too'.

For me, this moment, in both real and surreal ways, merges both fiction and reality to highlight the various categorisations of the body that can be enacted at a given time. I began to see what could happen when the classifications of human time as measured through a child body meet what could be classified as a disease of space. Generationally speaking, distinctly normalised and valued views of the larger body and of the potential normal life narrative for a grand-daughters body clashed with the current preoccupations of the modern body project. For the grandparents, there was nothing *ab*-normal about Neralis' body. However in the context of her peers, the schoolyard and her sister, the measures of normal were somewhat differently applied. The most everyday expression of this throughout my research was how the model of normal human development and a mundane example of a variation on Quetelet's 'average man' is captured in the size = age assumptions of children's clothing. In this ethnographic moment, big underwear served as a signal of weight out of context on the one hand, and potential sexuality on the other. These mundane measures of normality serve an interesting ordering function in society. In this research, the talk of time and its passing is frequently measured by children's bodies alongside and in comparison with other children. It is captured in the cry of parents that their child's growth seems boundless and 'when will it stop?' It is also captured in the temporal distortion of clothing where produced according to the above mentioned age = size equation.

Knowing Through Fictional Worlds

Roald Dahl's story *Charlie and the Chocolate Factory* is a popular children's novel that has been adapted into theatrical productions and movies, most recently starring Johnny Depp as the bizarre owner of the Chocolate Factory – Willy Wonka. The story revolves around the announcement that Willy Wonka has hidden five golden tickets in chocolate bars shipped throughout the world for sale. The finder of a golden ticket will 'win' a visit to Willy Wonka's chocolate factory. With the final ticket discovered by Charlie (the only child depicted as deserving of the find), Willy Wonka opens his gates to the group of 'winners' and their accompanying adult family members. Through each themed moment a child eliminates themselves, firstly from the tour and secondly, we find out, from the ultimate reward of the chocolate factory itself. Each elimination occurs by virtue of the expression of a moral mark on the child; whether that be the over indulgence of Veruca Salt, the consumerist addictions of Mike Teavee or the greed of Augustus Gloop so evident in his 'enormity'. As each child's flaw brings about their own downfall, their exit is accompanied by the singing of those exotic little people that inhabit and staff the chocolate factory – the Oompa-Loompa's. Their songs tell of the obvious distaste and intolerance for 'selfish brat's' and 'greedy nincompoops' and the quite awful endings they inevitably cause for themselves. According to the narrator, it is only the innocent and generous Charlie who is not immune to the fearsome implications of the Oompa Loompas' songs and whose story continues.

Where children's bodies are represented, they seem to serve a particular ordering function in society. Stories, whether they take the form of fairytales, legends, fables, political discourses or personal narratives, act as reminders of the boundaries within which social action occurs (Plummer 1995; see also Christensen, James and Jenks 2001). Bettleheim has noted that:

> Fairy tales, unlike any other form of literature, direct the child to discover his (*sic*) identity and calling … Fairy tales intimate that a rewarding, good life is within one's reach despite adversity-but only if one does not shy away from the hazardous struggles without which one can never achieve true identity…The stories also warn that those who are too timorous and narrow-minded to risk themselves in finding themselves must settle down to a humdrum existence if an even worse fate does not befall them (1976: 24).

In Dahl's world, parents and children are either good or bad. Distinguishing between these virtues is easy because those who are bad visibly embody their vices. For example, Augustus is greedy, eats all the time and is fat. Juxtapose this against the small-ness of the 'good' characters – Charlie and Willy Wonka: Charlie is pitied by the crowds gathered outside the factory for his visible frailty and poverty and Willy Wonka's 'loneliness' and lack of family is similarly captured in descriptions of his smallness and squirrel-like actions. As a moral tale a number of deeply embedded tropes are evoked through the bodies of specific children and their virtues. There is a clear narration of the moves of good behaviour against bad and reward against punishment that despite specificity imply a generalisability to other children. Goodman (1978: 105) has argued that '[f]ictional worlds are metaphors for real worlds, metaphors that may themselves become literal descriptions. Fictional worlds make, unmake, and remake real worlds in …ways that may be recognised as real'.

The Spectacle of Childhood Obesity

Through various media we are increasingly seeing the spectacular display and representation of fat bodies, especially those belonging to children. Reality television shows such as *Fat Camp* or *Can Fat Teens Hunt?* follow a group of children or teenagers who are said to be embarking 'on a journey that could save their lives'. Other documentaries follow a single child like eight-year-old *Connor McCreaddie* or the *34 Stone Teenager* providing spectacular representations of a body that fills the screen, enormous in the mundane tasks of walking or finding a seat on the bus.

This increasing fascination with the fat pre-adult body runs parallel with a renewed portrayal of children with rare deforming disorders. In the British media we have seen documentaries in recent times about the Peruvian case of the Mermaid girl, the story of Lakshmi, the little Indian girl born with four arms and four legs

and named after the four armed Indian deity, or the Indonesian boy with a tumour for a face. Such spectacular displays of course have a long history in both their clinical and social forms. Michel Foucault (1963) has written extensively on the clinical 'gaze' and the development of modern clinical experiences. Indeed, in the case of the genetics of obesity team I studied, the role of the image was an inherent method for displaying the self-evidence of biological error and of the expertise of various team members to identify causative syndromes. Kemp and Wallace (2000) have outlined a history of the spectacular and its' various representations from fine-art anatomical drawings and dissections through to modern imaging technologies. The fascination with abnormal appearances for the public and indeed medical imagination has been well documented by the developmental biologist Leroi (2003). He highlights the extremes of human mutation in order to explain how we become what we are, reflecting a long held belief that somehow the physical evidence of the body tells us something about the inner (*cf*. Featherstone et al. 2005).

Many of the family members in this study recounted moments when they felt that their size was read as a moral mark on their identity, specifically where others were believed over them. For example, Glenda and Nerali recounted incidences at school:

> *Glenda*: Like this girl in class one day, I'll always remember it, she called me a fat ugly cow and she put me over the teachers desk and the teacher weren't there and I don't know if you remember the skulls that we used to have well she was hitting me over the head with it and it was my mate actually who came and dragged her off and we all had to go to the head mistress and we was all going to get caned for it and she was going to get away with it because she came off worse because my mate hit her and I said 'No look here' I said 'it didn't happen like this' and they said 'well she's given us a different story' and I said 'well who are you going to believe?' and they believed her. When you're big it isn't just being fat – they don't believe – that they don't believe it isn't your fault, they believe it is your fault. But anything else you tell them they don't believe you anyway.

> *Nerali*: One of the teachers shouted at me because she wouldn't like listen they never told the kids to stop. Bullying. Calling me names and wouldn't let me join them and going to. There was this one girl and she was called Erin and the teachers thought she couldn't do nothing wrong cos her Mum worked in the school and she thought she were everything … I didn't like her at all. This one time, this other girl and Erin we were supposed to go on this trip out to the museum and I bought this river thing and Caragh said that I'd stolen it from her so my head teacher said to me, 'Well if its Caragh's I'm taking it off you. Anyway, Caragh says its hers and you're not allowed to have it cos its Caraghs' and she said she was going to phone the police because if it was Caragh's then it would have her fingerprints on it and if it was mine she said it would have my

> fingerprints on it and she wouldn't give it back, she gave it to Caragh. It made me feel unwanted, horrible.

The learned association between the visibly excessive body and moral traits is deeply pervasive. There is increasing empirical evidence that suggests that discrimination of fat adults as lazy and incompetent in current Western societies (Puhl and Brownell 2001), is also expressed from early childhood toward fat children (Latner and Stunkard 2003). In *Charlie and the Chocolate Factory* when Augustus Gloop is spotted drinking from the chocolate river, Willy Wonka shouts urging him to stop: 'You will dirty my river'. The ability of the moral mark to pervade, indeed infect other objects and characters has been repeatedly referred to in literatures on fat (see Murray 2005). In an interesting study, Klaczynski (2008) has shown how children believe and operate as if obesity is contagious and how contact with objects or people so infected is avoided. Hence, the body is a visible sign that can be read.

Embodying the tensions outlined so far in this chapter, the body of the child (especially the child monster) is also believed to carry some sort of diagnostic power that tells us something about society. The proliferation of 'fat stories' relies on a certain need to tell and a need to consume (*cf* Plummer 1995). The need to tell the modern personal story becomes a means by which an explanation can be built to describe what is going on and who one is in the scheme of things. During my own research, I became aware of the various resources that participants relied on to construct their stories and explain their (parents and children) appearance in a medical space as opposed to another space such as the diet clinic or the gym. Sometimes the stories told the progression through all logical spaces to this point. Many expressed that they had never had the opportunity to tell anyone 'the whole story' and that in the telling they experienced a firming of the boundaries of their identity.

The consumption of fat stories poses interesting questions. For example Lucy Mangan (2007) who writes a blog on the *Guardian.co.uk* website talks of the TV reality show *Can Fat Teens Hunt*? She writes:

> Sometimes there is a title so brilliantly appalling, or appallingly brilliant, that it exerts a hypnotic fascination. Though one's rational mind fights against the urge, the primitive, reptile brain, which alas is the part that controls the hand that controls the remote control, is helpless before it.

Another online review of the same show reported:

> TV is the theatre of cruelty. Most programmes seem to be about misery or, the impending misery of people…I realised this during *Can Fat Teens Hunt?* when I agreed with my girlfriend who flatly stated 'We'll have to watch this every week you understand.. I want to see these people break..'. Instead of being appalled, I agreed wholeheartedly (Gimmers 2007).

The gothic fascination with those liminal bodies that transgress the boundaries of the 'natural' or of the modern 'body project' (Shilling, 1993) is revealed in the idea of 'breaking the body' – of pushing those bodies to their limits until they 'crack'. In a similar vein to that which Plummer (1995: 49) describes about the proliferation of modern sexual stories, a major pattern is discernable in the telling and consuming of fat stories: these are the stories of suffering, surviving and overcoming.[2] As Plummer notes, this is a particular story telling form of our time.

Who does this Body Belong to? A Case Study of Responsibility

Early on in my data collection period, a particular media and political moment immediately exposed the central questions of this research. The death of a three-year-old girl from obesity related causes became 'the poster girl' for a political report and media furore that seemed both a public and private altercation of the adult conundrum 'How did we come to be who we are?' that has been expressed by Henrietta Moore (2004: 736). At this time, I had spent two days observing other members of the girl's family in the clinical research facility at the hospital during which nothing was said of the loss of a sister or daughter. Any grief expressed was on the part of staff who both enjoyed the childlike qualities that were perfectly performed against staff suggestions of a backdrop of relative economic disadvantage. With great degrees of patience in-between tests, I was taught to play the Playstation game *Snowboarder*: the essential goal being that somehow I produce a higher score than the medical staff. The children drew pictures, were cheeky to the nurses, and asked inquisitive questions to the extent that I frequently overheard nurses comment to each other 'They're such nice children' or 'They're so good'. These observations preface the story I am about to tell of the House of Commons Health Committee's Report on Obesity (2004) as an attempt to recognise the criticism that the sociology of childhood has relied heavily on descriptions and the analysis of the socially constructed child. While critical social constructionism undoubtedly challenges the dualisms of modernity and asks under what conditions and how is the child produced, it also privileges discourse over materiality (Prout 2005: 63). In the remainder of this chapter I want to follow Wallace (1994) who in exploring the issues raised by the child 'everywhere in representation' (294) asks: 'Are there significant points of coincidence between discourses of 'the child' and the lives of children?' (Wallace 1994: 298).

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2 See Monaghan (2006, 2007) for the ways that fat and morality are narrated in regards masculinity and Throsby (2007) for the importance of stories in accounts about gastric bypass surgery.

The House of Commons Health Select Committee Report on Obesity 2004

During May 2004, I had noted during fieldwork that those academics and practitioners I was coming into contact with had some sort of mental note of expectation that a report from the Health Select Committee's Inquiry into Obesity was due to be released. This would be the resulting document from a much-publicised enquiry launched in 2003. Conducted by one of those investigative committees comprising members of all political parties equipped with the task to inform and justify policy decisions confronted in the House of Commons,[3] the publicity surrounding the Report claimed widespread evidence collection through visits to the USA, Brussels, Finland and Denmark in order to glean from best practice. In contrast I encountered many ambivalent murmurs as to the level and routes in which evidence had been sought, with some specialists in the field making it clear that they had not given evidence or had made written submissions but not been invited to provide supporting evidence. Thus, the validity and impact of the report was not held high in expectations or in regards implementation. Perhaps this was not peculiar to obesity or to this report, nor was it a matter of simple disciplinary positioning and ownership of the field. Rather, it was situated within a wider discontent with such political outputs in the UK at the time as was borne out in responses to the delays and eventual release of a similarly timed government white paper on public health and the jostling between John Reid (then Secretary of State for Health) and Tessa Jowell (then Secretary of State for Culture).

The Report was due for official publication on May 27th 2004. A press release issued on 26th May and embargoed until publication, highlighted rising rates of obesity, potential health consequences, the need to increase physical activity and a focus on preventing obesity in children. At about 6.30am on the morning before the official release, in between the sports news and statements by Colin Powell regarding the political status of American troops in Iraq, Roger Harrabin told the BBC Radio 4 *Today* programme of key points in the contents of 'a late draft'. He told presenter John Humphrys 'It is very strong meat. It starts with a reference to a case at the Royal London Hospital where an obese child died of heart failure aged just three. Now that's a rare case but it is, they say, a portent of things to come.'

The focus on 'premature loss of life' was made explicit in the first paragraph of the introduction. The future scenario of obesity soon surpassing 'smoking as the greatest cause of premature loss of life' was situated firmly within the borders of the British nation. National statistical evidence was given to qualify the use of the descriptor 'epidemic' to 'what has happened'. It also situated the problem as being population wide and hence, beyond personal BMI scores with the potential to impact on structures relied on by citizens and representing the health of the nation. 'It (obesity) will bring levels of sickness that will put enormous strains on the health service, perhaps even making a publicly funded health service

3 See http: //www.parliament.uk/parliamentary_committees/health_committee.cfm.

unsustainable' (HOC 2004: 7). But it is the second paragraph that prompted many of the resulting media headlines and on which this case study will focus.

> 2. Dr Sheila McKenzie, a consultant at the Royal London Hospital which recently opened an obesity service for children, offered a powerful insight into the crisis posed to the nation's health. Despite only being in existence for three years, her service had an eleven-month waiting list. Over the last two years, she had witnessed a child of three dying from heart failure where extreme obesity was a contributory factor. Four of the children in the care of her unit were being managed at home with non-invasive ventilatory assistance for sleep apnoea: as she put it, 'in other words, they are choking on their own fat' (HOC 2004: 7).[4]

Predictably perhaps, the dying 'child of three' became the reference point and marker for both the report and the obesity crisis in England. A member of the committee, Dr Taylor, reported: 'We had a lot of evidence throughout the Inquiry that obesity in children is a huge huge increasing problem. As it is children we have to get at more than anybody else, it was felt that this was a way of emphasising the danger for children' (Boseley et al. 2004: 4). Thus, the death of a child became some sort of modern moral fairy tale. Although the child was never named or pictured, many reports suggested a knowingness of the child. This was reflected in conversations I later had with people about the case where they would state 'Oh yes, I remember the pictures of her.' It is perhaps useful to stress that there were no pictures and no naming of the girl or her family. Generally speaking, pictures of fat people in newspaper reports tend to be headless with a focus on the torso and from below in a manner referred to as 'headless fatties' (Cooper 2007). The three-year-old body was evoked discursively in an attempt to evoke public recognition of a pathological threat. A single child became the vector of national destinies touching both the individual and the family and representing the risk inherent in every body as illustrated in the following excerpt: '[t]heir report into obesity, published last

4 The original evidence referred to in this paragraph was submitted as a brief letter from Dr Sheila MacKenzie for the Childhood Obesity Service, Royal London Hospital and also bore the names of Dr Nigel Meadows (Consultant Paediatrician in Children's Nutrition) Sophie Aubrey (Children's Dietician) Kat Blakely (Clinical Psychologist) Dr Siobhan Carr (Consultant Respiratory Paediatrician) and Alison Franklin (Children's Nurse for Sleep Disordered Breathing). It is the second paragraph in the letter that is cited in the Report. It reads: 'My role is to identify medical problems associated with obesity. In the last two years one child at the age of three has died of heart failure secondary to extreme obesity. Four other children also with severe obesity are managed at home with non-invasive ventilatory assistance because they have severe obstructive sleep apnoea (OSA) because of their obesity. In other words they are being choked by their fat. Were we able to study all severely obese children, I'm confident that we would identify many more children with OSA. In addition, many of these children have abnormally high insulin levels, a prelude to Type II diabetes.'

week, paints a picture of a Britain so gluttonous that we are choking on our own fat' (*The Sunday Telegraph* 2004: 2).

Newspaper articles following the release of the Report played on the sensationalist introduction with headlines such as 'Choking our children on their fat, 'Fat and dead at 3' and 'Now obesity kills child aged three'. The flurry of media activity developed a culpability argument not just of national interest but of particular parental responsibility. One journalist wrote: 'When a three-year-old girl who weighs 40 kilograms dies of heart failure brought on by obesity, you know her parents are guilty of gross child abuse' (Devine 2004). Similarly, in a letter to the editor of the Evening Times (Glasgow) on May 31 2004, Agnes Barton of Scotstoun wrote: 'Surely her parents, despite their grief, should be charged with child abuse … If people treated animals in such a manner they would find themselves before the courts'. While the family remained anonymous, the culpability argument directed toward the parents flourished. Almost two weeks later a 'corrective' story emerged reporting interviews with Professor Stephen O'Rahilly and Dr Sadaf Farooqi. Prior to her death the Cambridge GOOS team had identified a mutation in the leptin appetite pathway. They were quoted as saying:

> When a child is exposed on the front page of The Sun as the poster child for the obesity problem it seemed to us rather cruel that this was being presented as an example of how parents were stuffing their children. It seemed a terrible indictment on the parents when we knew there was a genetic defect in this child and we knew 100 per cent that was the cause of her obesity (O'Rahilly quoted in Laurance 2004: 19).

> The death has become part of the discussion about what children eat when in fact it was the result of something else entirely ... We are mixing up children's weight issues with distinct medical problems … It is an incontrovertible fact that a genetic defect was the cause of this child's problem (Farooqi quoted in Laurance 2004: 19).

Following these corrective statements, media excerpts talked about 'apologetic science' or referred to the genetic condition as Prader Willi Syndrome including interviews with parents of children with Prader Willi Syndrome. Further incorrect statements within 'corrective' reports concluded that 'siblings of the girl who died are understood to be of normal weight, indicating that the fault did not lie with the parents' (Laurence 2004: 19). The response from the Chairman of the Committee Dr David Hinchcliffe was:

> What's really annoyed me about this is that the two people who were quoted on the Today programme appear to have drawn conclusions about our report from the tabloid treatment of part of our report. They don't appear to have read the report. When you've got a consultant pediatrician in a unit dealing with serious obesity saying that she's got children choking on their own fat, quite frankly it

> is pretty serious stuff. Had we not referred to her letter, which we do respecting in its entirety they way she put this, I think we would have been accused of suppressing some very important evidence … My suspicion is that there is more than a whiff of medical politics between the two groups of doctors concerned (Hinchcliffe quoted in Boseley et al. 2004).

In this sense, the three year old thus became a symbol of both medical/scientific and political disputes over legitimacy in regards evidence. The body of the child that had previously been evidence of a threat to the nation, became further victim and scapegoat in the adult world of political pollution. Headers in the Report reflect these ideas of obesity and pollution further. The heading *Obesity: Gluttony or Sloth?* caused both Stephen O'Rahilly and Sadaf Farooqi to respond:

> 'What a disgusting way to talk about a medical condition,' she says. 'If someone has a tumor in their throat you wouldn't say, I hope, that they were choking on their own dirt or something' (Farooqi cited in O'Neill 2004).

> Imagine that someone had written a report 'Cervical cancer – promiscuity or poor hygiene?' People would be outraged. These are sick people, yet they are being vilified (O'Rahilly in Parry 2004: 6).

Here I wish to acknowledge that while the Report clearly belongs to a specific political genre of outputs, and subscription to, and participation in the process bears a level of consent and awareness of this, it could be argued that the intentionalities with which the evidence was given and then used could bear a mark of dissidence between the paediatrician and the committee. It is often the case that when paediatricians are quoted in the media there is strong emotion expressed. The regular workplace confrontation with tragedy could arguably produce a particularly extreme view of the world. While there is a great deal to unpack in this political and public story, I wish to limit further discussion to elaborate on the idea of the dangerous liminal space occupied by the body of this girl (although never visually represented). Her death dominates the story and is taken up to pose questions of the natural and the social, of human and animal, of public and private and of being and becoming in the question of how does a child of three die of obesity? Most strikingly is the re-discovery of the threat of child mortality in a western society.

The Re-discovery of Child Mortality

Some commentators have suggested that the most striking part of the Report is that which reads: 'This will be the first generation in which children die before their parents as a consequence of obesity'. For many, obesity is a 'soft' threat to health as it is overcome by the management of the social body and bears no real pathological threat to life as a disease that kills. Like earlier threats to infant

mortality such as diarrhoea, obesity is a disease entity in classification, but in medical theory the dominant view is that it is a symptom of disease. In this section I want to explore the re-entry of the Victorian threat of death in discourses about children and the redistribution of the causes of death and illness in this context. As such, I am influenced by the work of Scheper-Hughes (1992) and Das (1997), whose ethnographies on suffering and everyday violence may, at first glance, seem removed from the topic of childhood obesity in Britain. I use these references, not to make light of the human suffering of those impoverished communities that the ethnographies above write of, but rather, to illuminate the various ways that certain discourses are being inscribed on the bulging bodies of children and how those children get gobbled up in these stories.

The death of a child in much of the Western world is not something that we would expect or consider normal. In fact the only way an encounter between death and infancy or childhood enters our worlds is generally through some tragedy – whether that be incurable illness, accident or criminal activity. However, it was not so long ago (and remains in many countries in which people live on the margins) that infant death was considered a mundane inescapable fact of nature or simply a biological function ensuring the survival of the fittest (*cf* Wright 1988). In short, infant death was historically treated as part of the 'natural order' of things. Both Armstrong and Wright have provided fascinating analyses of the discovery or 'invention' of child mortality and of the move to no longer see the infant as ' one of death's natural habitats, but rather as a terrain in which death was an obscene intrusion' (Wright 1988: 306). They map the development of a certain type of moralisation about child rearing as it came to be replaced by fundamental medical and hence, a resolvable policy problem. This involved the development of birth and death records based on medical classifications. But perhaps more pertinent for this discussion, that two of the greatest killers for children (diarrhoea and malnutrition) were not regarded as paediatric illnesses and, as mentioned above, were believed to be trivial. Thus many of the deaths recorded during this time bore no distinction between the young or old and were categorised under 'diseases of growth, nutrition and decay' (Armstrong 1986: 221).

It is ironic then to consider that when infant and child mortality have come to signify an important indicator of a nation's general status and well-being, that obesity (a pseudo-signifier of wealth historically) comes to feature as the new or 'modern' child mortality. For many of us in the world, as Scheper-Hughes puts it, 'the dialectic between fertility and mortality has lost its edge and is buried in the back of consciousness. For most Europeans and North Americans each birth signifies new life, not the threat of premature death' (1992: 273). And while this remains true for childbirth statistics, obesity is being put on the political agenda as a threat to childhood, where an extreme example of one child becomes the potential path for a nation branded as 'loving their children to death'. The further irony is contained within a juxtaposition of two seemingly contradictory epidemiological profiles: that infant mortality is connected with diseases of malnutrition and 'wasting' and the current threat of premature loss of life is from

obesity. Juxtaposed yet again, against frequent discussion of an aging population, the threat of premature death from obesity seems to defy the current improvements in standards of living that have produced this longevity. Against a backdrop of epidemics of infectious diseases such as measles, smallpox and pneumonia – we have obesity. Scheper-Hughes talks of the modernisation of child mortality in Brazil and highlights its uneven distribution and containment to one strata of society. Furthermore, she talks about an 'old' and 'new' pattern of child mortality where the 'old' diseases are controlled by immunisation only to be replaced by the 'new' killers related to bottle feeding. She says that in Brazil 'under the new childhood mortality pattern, death comes to children at an even earlier age' (1992: 280). Babies, importantly, come to be described as born into a power struggle. Poor infants are already disadvantaged in the womb and are born 'already thirsty and starving'. Whereas 'the babies of the rich were described as coming into the world fat and fair and 'greedy' for life ….fat, resilient babies were described as having *forca*, an innate charismatic power and strength' (Scheper-Hughes 1992: 315–16). Interestingly in western and developed societies, obesity has been problematised in terms of power and class issues. It is a signal of lower socio-economic status within supposed meritocratic and egalitarian societies (see Sobal and Stunkard 1989). Furthermore, the childhood mortality threatened by obesity seems to pose a boundless age limit: the risk level compounded with age.

The high rates of obesity in childhood in the Western world bear echoes of the explanations we have heard account for demographic transitions in the past. These rely on discourses of economic and social underdevelopment and so pose fundamental questions about taken-for-granted assumptions about social order. Berger and Luckmann (1971) have argued that death is the ultimate marginal situation. They argue that:

> death also posits the most terrifying threat to the taken-for-granted realities of everyday life. The integration of death within the paramount reality of social existence is, therefore, of the greatest importance for any institutional order. This legitimation of death is, consequently, one of the most important fruits of symbolic universes (Berger and Luckmann 1971: 119).

Within this research, the threat of premature death was never far from the narratives of identity work that family members told me. For example, Kelly talks of her fears as a 17 year old. She talks about her desire for gastric bypass surgery as being beyond a desire for a reconstructed body – this was a need that was based on life and death:

> *Kelly*: Yeah I just want to have the operation really bad. I don't want to wait for it. I just want it to happen. I've never wanted something so much in my life. It's the only thing that I want. But I'm worried I need it. I want it as well but I need it more than I want it. Because I'm scared by it. Whether I'm going to be like twenty or so and I'm going to have a heart attack or something. But I can't play

> like football or anything like my friends because I get out of breath so much. And I don't like eating in front of people because they're like 'Oh she's eating. Look at her she's going to put on more weight'.

Similarly, Carol talked about the potential threat of obesity to her 12 year old son's life:

> *Carol*: It's not only that you're fat, it's the fact of the other illness that come with that, with the obesity related um.
>
> *SB* So that concerns you?
>
> *Carol*: Yeah definitely. I worry to death about the weight on Dean um. I know his heart takes a lot of his weight but some days I go through and I sit and think God, I'm frightened to death I'm going to get a phone call about a pain in his chest or something'. I don't know. I'm really frightened for him.

The spectacle of parents burying their children has, throughout history, symbolised a challenge to the natural order of things. In this sense, the three year old held up as an example of the impending epidemic in Britain becomes an image-laden metaphor. The confrontation with death evokes a number of cultural codes in order to reflect the liminal space of both specificity and generalisability across generations. Perhaps I can explain this further by contrasting this with the encounter 17-year-old Joel had with discourses of mortality and obesity:

> *Joel*: I keep trying to lose weight because, something, I mean there was a bloke I was reading about in the paper yesterday. There was a guy in the paper I was reading about yesterday and he's trying to lose weight. He's about 18 stone and he's about my age and he wants to lose weight because his father dropped dead of a heart attack at 45 and he weighed 28 stone. So I thought to myself, that ain't giving me long to live like that. I mean if I only live to be 45 that's not very good. Not today. But I know it will happen because your body just can't stand it.
>
> *SB*: It must be quite a scarey thought.
>
> *Joel*: Oh yeah. I keep thinking to myself I'll be retired when I'm 60 and my Dad said yesterday 'if you make it'. I've got to lose some weight.
>
> *SB*: Just a hard think to think about though isn't it?
>
> *Joel*: Yeah I work in the cemetery and I see a lot of things you know. We had one when my Dad first started there when I was quite young and I remember him saying about it when he come home. This woman she was so heavy they had to lower her coffin into the grave with a digger. I mean, I'm 27 stone, four of my mates tried to pick me up in the wheelbarrow at college and they couldn't. So

> like they said if you fall over we can't help you. We can't pick you up and carry you. That's part of the problem – if anything ever did happen to me, they'd need a crane to get me out the house.

This is an extraordinary account of all the things that particular family members in this study live with and hold within their consciousness. In this excerpt Joel has seen and participated in burials. He remembers the spectacle of the burial of an extremely obese local woman. He considers his own death and burial. The spectacle of childhood obesity and the spectacle of burial culminate in Joel's account to reveal much more than a challenge to the natural order of things. Although Joel is a young adult and in that sense falls beyond the categorisation of confronting child mortality as it is commonly categorised, the threat of premature loss of life through obesity related causes was of great concern for him as it was for many others in this study. Firstly, it is interesting to note that the story Joel read of the death of a 45-year-old man from obesity related causes did not receive as much mainstream media attention as the death of the three year old. Secondly, if we consider the following quote from Das, we are confronted by the performance of death and its associated rituals that distinguish between a good death and a bad death. She says:

> In a sense, every death, except that of a very old person, introduces disorder in personal and social life. But in the flow of everyday life this is understood to be caused by events beyond the control of the living community. Indeed, one of the underlying tensions of mourning rituals is to absolve the living of responsibility for the death that has occurred. A common refrain in the mourning laments is to say that the ostensible cause of the death (for instance a particular disease) is only the pretext for death to do its appointed job (Das 1997: 81–2).

The performance of mourning rituals, whether that be the burial as Joel indicates, or the very public witnessing to the death of the three year old, serve to articulate what sort of death this is in social terms. What is interesting is that in these two stories of deaths, obesity as a cause of death does not seem to serve as an appropriate categorisation to either absolve the living or normalise the death. The mourning wail is transformed into a moral tale of spectacle. The stories of these deaths highlight questions not only of causation, and of the impact of illness, but also of what does it mean to be human and at what stage does illness signal a degeneracy of identity (*cf* Lawton 2000)?

Discussion

In this chapter I have highlighted some of the dualities that the child body has come to represent and embody and that the sociology of medicine has exposed. I have explored a selection of moments in which the child body enacts these

categorisations and yet challenges them. In using the fictional and political tales I attempt to illustrate the very potent moral tales and discourses that the child body embodies when it comes to beliefs within a general population. As we saw, a story of *a* child is quickly able to enter the imagination as representing a generalised view of reality and a potential for *all* actors. In this sense we can see how the body of a child can become the vector of, indeed embody, a range of moral messages.

I have moved through a vast literary, narrative, theoretical and analytical landscape in this chapter and I am fully aware that it raises a good deal of issues about which a great deal could be said. Much of the data I have collected is extreme and I have taken much care to try not to exaggerate this. But, in some moments there is a sense of unreality about the narrations family members provide. In a similar way that Bowker and Star (1999: 178) mobilise two classic texts around tuberculosis, time and hospitalisation and describe how on the arrival at Mann's Magic Mountain 'everything that was normal appears to change, and the whole place seems macabre and oddly humorous', we find that in the case of children's bodies and obesity, the flows of time and 'the insides and outsides of people become mixed up in almost monstrous ways' (p. 185). The movement between inside and outside and between various contexts for the families in my research comes to occupy a surreal landscape where the story may seem at once comical in its extremity, and for others deeply tragic. Where the child body measures time and the passage along the line of normal human development, disruptions to this are monstrous. Following Mary Douglas (1966) I have endeavoured to show the importance of acknowledging the public categories of which a body is a part or representative. The public categories of child as being and becoming are confounded further by the visible expression of obesity and the ways in which fat can be normalised (again within different contexts) or presented as an anomaly.

In this chapter we have seen that the obesity 'epidemic' resides in single children, in individual bodies. It is made alarming and public by the examples of these bodies in governmental inquiries and made knowable by the pervasive moral characters attributed to the fictional comparative caricatures of Charlie against Augustus. While knowledge of the general, be that obesity or childhood, is arguably valuable in its ordering function for morals and politics, it also clearly delineates and 'brackets' subjects and actions. Interestingly, if we are to believe the hype and subscribe to views about the primacy of the gene and concepts such as geneticisation, then surely we would have expected to see a great deal more media attention given to the death of the three year old in light of her genetic diagnosis. Attributing the child's obesity to a genetic cause instead closed down all discussions of morality (apart from political morality) and the hopes placed in medical science. Perhaps this indicates even more that there is something about children, and indeed obesity, that occupies an 'in-between' space (Bhabha 1994), or borderland of complexity.

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Chapter 8
Bodies, Drugs and Reproductive Regimes

Elizabeth Ettorre

Inscribing Disorder on Pregnant Drug Using Bodies: Cyborg Trumps Biopower?

Over the past decades indeed centuries, scientific and biomedical discourses on the body have become rooted in contemporary culture while bodies have become more flexible, ambiguous and 'socially produced' (Lorber and Moore 2007). As social scientists position bodies centrally in their approaches to society and culture (Martin 1992, Turner 1996, Frank 1995, Shilling 2005, Featherstone 1982, Davis 1997, Bordo 1993a; 1993b), natural scientists and biomedical experts continue to persist with creating techniques to alter the boundaries of these bodies and endeavour to close up the spaces between them. Often times, this has meant that social issues and cultural problems are not only allowed but also forced to emigrate to our bodies. At times, the troubling social and cultural issue of drug use emigrates in this way alongside the drug addict as a 'transgressive figure unable to speak his/her own truth' (Keane 2005: 91). In effect, we have all become unwittingly members of a captive audience to the cultural spectacle of drug use. Of course for drug using women this spectacle has damaging consequences.

Until recently, accounts of women offered in the drugs field have been uncritical and ahistorical. A systematic enquiry into this issue must highlight key individual and social factors which offer full accounts of the day-to-day experiences of women drug users. We need to be able to explain comprehensibly the structural roots of power and for women, the issue of power whether cultural, social, political or economic is most important. In contemporary theory, power is a contested concept. However, with regards embodiment theory, power has a specific pivotal point: the body is the product of power relationships. Turner (1996: 63) contends that an excursion into these sorts of power issues can be considered a materialist enquiry: this material body as an object of power is produced in order to be controlled, acknowledged and reproduced. For Turner, power manifests itself through bodily disciplines or technologies of the self and regulatory regimes targeting particular bodies as well as entire populations. Since the Enlightenment, the embodied subject has been the focal point of practices and techniques of rational scientific domination. According to Foucault, this body has been at the core of productive control that marks the command of discourse in modernity and the concurrent sexualization and medicalization of the body in a new power configuration, biopower (Braidotti 1994: 58).

Modernity is the era of biopower – of constant normativity. Biopower is about the power of normativity over living organisms; the force producing and normalizing bodies to serve prevailing relations of dominance and subordination and total control over human living matter (Braidoti 1994: 58). In this era, the body has not only exploded into a network of social practices but also imploded into a fetishized and obsessive object of care and concern (Braidotti 2002: 229). In this complex process, the body, constructed by biopower, is many layered and situated over multiple and opposing factors. Clearly, bodies are encircled by many disciplinary regimes and strategies of attention in a relentless, incessant endeavour to normalize them.

On the other hand, contemporary power may be seen to work by networking, communication redesigns and multiple interconnections rather than normalized heterogeneity (Braidotti 2002: 242). Donna Haraway (1991: 155) argues that in our fast moving technological and scientized societies, techno-bodies or cyborgs emerge as a type of political identity, resistance or antagonist consciousness. This identity accentuates issues of race, gender, sexual and class difference within a broad remit for survival and social justice (Braidotti 2002: 243). This is because this cyborg identity is embodied by those refused stable race, sex and/or class membership who have proficiency in reading 'webs of power' (Haraway 1991: 155).

If the body is not already always there to be constructed by discourses nor its existence permanently postponed behind the meaning imposed by discourse (Shilling 2003: 70), the body can be envisaged as Haraway's cyborg – embedded and embodied, seeking for connections and expressions in a non-gendered and non-ethnocentric perspective (Braidotti 2002: 243). In this sense, the cyborg trumps the body confronting biopower because the cyborg is not subject to biopolitics, rather it replicates politics. The cyborg is crucial to confronting the 'informatics of domination', these frightening new networks of a world system of production, reproduction and communication (Haraway 1991: 161–3). The cyborg is a kind of disassembled and reassembled, postmodern collective and personal self – a self, which Haraway argues, feminists must code.

Whether or not we embraces Haraway's cyborg, her ideas are instructive. They teach us that women's position is deeply related to their assimilation or manipulation in this global system. Thus, for feminists, that bodies really do matter in this assimilation or manipulation is about recognizing that beliefs in, discourses about and tools of modern technologies impose and embody novel social relations for women on a global scale. Most importantly, the drug field can not escape this type of coding, that is to say, technologies and scientific discourses about drugs and drug use can be tools for imposed, compulsory meanings and continued exploitation on the basis of race, gender and class. While drug users will be pressed into constant normativity, those with ability to read 'webs of power' may champion their own survival and social justice and exhibit forms of 'resistance consciousness'.

This chapter examines the intersections between the biological and social dimensions of gender and health with special reference to bodies, drugs and reproduction. Thus, I turn attention to a type of embodiment that is on offer to drug using women – the reproducing body. In this chapter, I aim to trace the cultural representations of pregnancy and drug use with regards to our 'bodily obsessed' society, examine the regulatory regime of reproduction with special reference to pregnancy and drugs and look closely at the 'real' material sites or gendered bodies upon which the chaos and disorder of drug use are inscribed.

Given the above, I discuss five inter-related issues related to drug reproducing bodies. First, I look at what is meant by reproductive regimes. Second, I look at reproductive bodies, both drug using and non-drug using, within 'the somatic society'. Third, I look at how 'normal' or 'deviant' and non-drug using or drug using pregnant bodies become visible and indeed visualised through the 'scopic drive', a characteristic of this somatic society. Fourth, related to the somatic society with its scopic drive is the regulatory regime of reproduction which I explore with regards its disciplinary practices directed towards drug using pregnant bodies. Last, I present and analyse ideas on women, drugs and pregnancy and look specifically at pregnant drug using bodies as 'material sites' related to the notion, 'disordered body'. Here, the idea of resistance to the dominant ideology of reproduction emerges.

My assumption in this chapter is that the pregnant drug using body is constructed as a deviant body, a discursive construct which is separated from other female bodies and deciphered by experts as being immoral, inferior, disgusting and 'out of order'. This process generates a controlling response and has devastating intended and unintended consequences for these gendered, drug using bodies.

Defining Reproductive Regimes: The Governance of Pregnant Bodies

Similar to gender (Lorber 1994), reproduction as a component of culture is exhibiting signs of a social institution. As reproduction ascends as a social institution, it develops into a system of governance further surrounded by attendant regulatory regimes, focused on the replication of bodies which must exemplify completeness, health, well being, individual and social potential and the future welfare of society (Ettorre 2002). Reproduction is socially organized around a set of values, norms, activities and social relations that symbolize notions of able-bodiness, human survival, progress and individual promise. At the same time, reproductive bodies, especially female reproductive bodies, become more valorized than ever before through reproductive regimes and the surveillance of their pregnant wombs in and through biomedicine.

There is a array of practices guiding pregnant bodies as they are gathered together in a systematic way under the flag of reproduction. The symbol of reproduction as an emergent social institution (and regulatory regime) is the pregnant body; the body of a woman producing a baby, as well as the chemicals, hormones, eggs,

cells, genes, blood, fetal tissues – all gathered, drawn, scraped, tested, examined, and at times, discarded within reproductive medicine. Women are reproductive containers and science's (mis)representation of the female body shapes our whole understanding of how reproduction 'works', has been and continues to be gendered throughout the life course from conception onwards. An assortment of disciplinary strategies (i.e. biomedical knowledge, technologies, public health discourses, etc.) attends to the pregnant body to construct and normalize it. This process is carried out under the supposedly munificent gaze of the physician. Here, reproductive regimes exist as systems and processes structured around regulating reproductive bodies whether pregnant or not. They include the complex methods of governance linking, submerging and sometimes fusing women's reproductive bodies with assortments of medical technologies and biomedical discourses, defining what are 'normal' and 'deviant' pregnant bodies as well as 'tried and tested' procedures.

For the purposes of this chapter, the term reproductive regimes affirms the sociality of reproduction; directs attention to governmentality through which pregnant women play an active role in their own pregnancies; highlights power dynamics, the organized practices (mentalities, rationalities, and techniques) through which pregnant women are governed; establishes material bodies; recognizes the 'conflictual' nature of reproduction and makes links with both micro and macro levels.

Drugs, Reproductive Bodies and the Somatic Society

Reproduction is an important aspect of social and cultural corporeality in the somatic society defined by Turner (1992: 12–13) 'as a social system in which the body, as simultaneously constraint and resistance, is the principle field of cultural and political activity – a system which is structured around regulating bodies'. For Turner, the body in the somatic society becomes the dominant means by which the crises and tensions of societies are thematized. The body makes available the material for our political ruminations as we learn that our cultures are obsessed with bodies.

For example, experts frequently ask the questions: How do bodies move?; What do bodies consume?; How do bodies get sick?; How do bodies stay healthy?; How healthy or how sick are bodies?; What do bodies look like?; How do bodies differ from the 'norm'?; What is the body 'norm'?; What colours or race are bodies?; How do bodies appear?; When?, How? and With whom do bodies have sex or not have sex?; How old or young are bodies?; How do bodies change?; What do bodies ingest?; Do bodies decorate or mark themselves?; How do bodies die?; etc. These sorts of questions are asked in the somatic society with one overriding aim – to regulate and control bodies. In this way, the clout of staking cultural and political claims through the body rests on the assumption that bodies like property are real material objects whose dispositions are of great concern to society as a whole (Urla and Terry 1995: 6). The feminist adage, 'the personal is political' rings true

today, given that material, gendered bodies are political targets and extend our feminist ontological and political concerns to cultures of resistance. Furthermore, it is important to note that from a feminist point of view an inherently political agenda includes an intense interest in the 'effects that new paradigms of thought have upon material bodies' (Shildrick and Price 1998: 15). For me, some of these new paradigms relate to the discourse and application of biomedicine.

In the somatic society, women's bodies and specifically, their prenatal, reproductive spaces or wombs became construed over time as the battlefield for the social body's survival (Stormer 2000: 118). These reproductive bodies become the substance of our ideological reflections on human life in a world of risk, insecurity and disorder. In the 19th century, women's reproductive organs began to coincide with colonial nation states' perception that their material landscapes were apparently lacking sufficient White populations (Stormer 2000: 118). Today, the White majority's heterosexual, able-bodied, young, female wombs perform a functional role by normalizing prenatal space in a society obsessed with regulating reproductive bodies. In the contemporary drugs field, when poor, pregnant, African-American women produce 'crack babies' (Humphries 1999) or 'infant addicts', these deviant bodies are able to connect institutionalized racism and sexism to biological reproduction, while being increasingly targeted and oppressed in the battleground for the social body's 'war against drugs'.

The biopolitics and concerns of somatic society revolve around controlling reproduction (rather than increasing production) and regulating the spaces between bodies – to monitor the interfaces between bodies, societies and culture as well as to legislate the tensions between habitus (i.e. life world of actors or cultural codes) and the body (Turner 1992: 12). Turner contends that we want to close up bodies by promoting safe sex, using clean needles, etc. In this context, the pregnant drug user becomes a visible feature, if not potent symbol of the somatic society. A 'using woman' (Campbell 2000) exposes how the personal and public problem of 'drug addiction' during pregnancy reflects simultaneously embodied desires for an unfettered womb and an open ingesting body as well as the cultural need for bodily restriction, control and regulation. Of course, her race, class and age will govern both the formulation of her desires and the way culture controls these seemingly 'uncontrollable' desires.

In the somatic society, treating women as mere uterine environments that can be invaded or punished involves the kind of blaming the victim mentality that can only seem proper when one completely ignores the complex social conditions surrounding prenatal harm to future persons (Callahan and Knight 1992: 235). Blaming pregnant drug users is all about wanting to close up these 'deviant' female bodies and regulate them physically and psychologically, while, at the same time denying that self-surveillance within the context of a desire for a positive fetal outcome (Irwin 1995) may exist for many, if not all of these women. From a feminist point of view, a series of significant suspicions are raised in this context, given that the disciplinary power of the drug treatment system often operates to adjust these pregnant drug users to dominant gender, race and class

structures as well as depoliticizes and individualizes their situations (Young 1994: 33–4). One can rightly ask, 'Who really benefits from this type of drug treatment system? Surely, it is not pregnant women. Related to this issue of benefiting from treatment, previous research (Pursley-Crotteau and Stern 1996) has shown that pregnant women in treatment who are going through the developmental process of achieving a 'maternal identity', found that their psychological and biological needs often conflicted with the treatment philosophy that was offered to them.

As implied above, the ideal body in the somatic society is a conforming body not a deviant one. Thus, a drug using body, particularly a female pregnant one, falls short of this conforming body ideal. In general, the pregnant body is constructed both as a docile subject, submitting to invasive medical scrutiny and as an active agent, responsible for optimizing fetal health (Lee and Jackson 2002: 126). On the other hand, for the pregnant drug using body, her docility and active agency appear as questionable, if not vigorously denied by society. This denial may be one reason why attempts are made in the drug treatment system to give pregnant drug users treatment priority (Arfken et al. 2002, Carter 2002, Curet and Hsi 2002, Nishimoto and Roberts 2001, Greberman and Jasinski 2001, Rosenbaum and Irwin 2000): these women are constructed as being wild, out of control bodies. This cultural denial of these women's agency and normality implies that their bodies as well as their fetuses are worthless.

Ironically in the somatic society, bodies become more conforming, compliant or obedient when they become healthier and less ill as well as more ill and less healthy. Either way, they are drawn into some form of self and cultural governance. Both conceptions, health and illness, are culturally and socially constructed and all cultures have known disciplinary practices and regulatory regimes surrounding the notions, health and illness. That the notions, health and illness, can be embodied and furthermore, are able to be translated into notions of 'good' or 'bad' and 'normal' or 'deviant' bodies, reflects the fact that morality is deeply embedded in the discourses of health, wellbeing and disease. Of course, a similar process is visible with regards the discourse of drugs use, as drug using bodies are constructed as 'bad'/'deviant' bodies. Drug users are perceived as socially, physically and mentally diseased individuals. Given that the somatic society is concerned with regulating reproductive bodies as a fundamental activity of social, cultural and political life, women's drug using bodies are centrally located and become represented as 'bad'/'deviant'/'diseased' bodies in need of, regulation, restraint and control.

Becoming Visible: Visualization Through the Scopic Drive

The disciplinary practices and regulatory regimes surrounding health and illness in the somatic society can be seen to mirror those surrounding the drugs discourse. These practices and regimes vary from culture to culture according to how ill or healthy, 'good' or 'bad' and 'normal' or 'deviant' bodies become

visible and, as we shall see, are visualized. Importantly, these practices and regimes differ according to the extent and range of the scopic drive (Braidotti 1994: 64) in science and medicine. The scopic drive is a powerful cultural force which categorizes 'normal' or 'deviant' bodies and achieves biomedical aims by making embodied subjects observable and comprehensible according to the ideology of scientific representation. Here, it is interesting to consider what addiction specialists refer to as the molecular basis of addiction (de Belleroche 2002) when pleasure centres and reinforcement centres in neurons as well as adaptive responses to cell signalling are visualized. These scientific representations disembody the drug user (e.g. her body is absent), while at the same time expose how troublesome addictions can be represented visually on a cellular level. This unique process involves the commodification of the scopic and the triumph of vision over all other senses (Braidotti 2002: 246). In effect, for the biomedical expert, seeing is believing. Braidotti (2002: 246) is concerned with this vision centred approach to thought, knowledge and science, characterized by this scopic drive which turns visualization into a crucial form of governance. This indomitable, scopic drive not only breaks the connection between seeing and the mind but also denies embodiment, by visualising what's in bodies through seeing technologies or strategies such as ultrasound, MRI scanners, high power microscopes, or more traditional pictorial representation of cellular processes.

In our era, we experience the omnipresence of the visual – visualization has been turned into the ultimate form of control. The triumph of this scopic drive or what I call, 'disembodied vision', is that it is a clear gesture of science's epistemological domination and control to make visible the invisible and to visualize the secrets of nature (Braidotti 1994: 64). Pregnant bodies may be the objects of medical scrutiny and surveillance as what's in their wombs become more visible, but these bodies are also sources of discomfort and disgust in popular culture (Stabile 1994: 84).

Furthermore, it is difficult to conceptualize pregnant embodiment given that there are striking taboos surrounding representations of the pregnant body in visual culture (Tyler 2001: 74). Nevertheless, visualization can be an important means of controlling pregnant drug users in a variety of settings – on the street dealing or buying, with her partner, at home, in work, in treatment, in prison, etc. If and when her pregnancy is visible, she is likely to be more vulnerable to the vagaries of her social situation.

While cultural representations of pregnant women depict this body as vulnerable and in need of protection, by using drugs, pregnant women are perceived as consciously abandoning that sort of protection and putting their bodies and fetuses in jeopardy. The pregnant drug user is the embodiment of risk. A pregnant drug user is viewed as doubly disgusting – she is pregnant and she consumes drugs. In this context, whether sick or healthy; drug using or non-drug using; 'good' or 'bad'; male, female, transgendered or intersexed; Black, brown, White or coloured; etc. bodies scrutinized by the scopic drive are inevitable merely experimental objects. Here, there is an assumed transparency of bodies. For pregnant drug users,

this assumed transparency means that 'seeing' into her womb or visualizing her embodiment reveals not only fetal but also social damage.

Side by side the scopic drive generated by science and medicine is a powerful desire to classify all forms of deviance, situate them in biology and guard them in wider cultural and social spaces. Urla and Terry (1995: 1) contend that since the 19th century, the somatic territorializing of deviance has been part and parcel of a larger effort to organize social relations according to categories denoting health versus pathology, normality versus abnormality and national security versus social danger. Moreover, deviance, translated into the early 21st century, has become 'embodied' – a matter of somatic essence facilitated by moral discourses surrounding addiction and other bodily anomalies (Urla and Terry 1995: 2). Urla and Terry argue that as a result of these complex cultural embodied processes, bodies have become marked and social relations organized in terms of deviant and conforming bodies. Crucially, pressing social issues and cultural concerns are being displaced onto the body.

However, before cultural conceptions of normal or abnormal, conformity or non-conformity and health or pathology can be made, there needs to exist a collection of bodies upon which these categories can be inscribed. In particular, the unique process of inscribing bodies as 'healthy' or 'diseased', 'good' or 'bad', 'ordered' or 'disordered' and 'lovely' or 'monstrous', etc. is performed by authoritative discourses and scientific practices, targeting bodies. A whole series of discourses and practices shape the drug using body as somatically different from the non-drug using body. When a fetus is added to this equation, the moral character of the pregnant female body is put into question. She is viewed not only as behaviourally aberrant but also as social disruptive by the very fact that she uses drugs while pregnant. As we have seen, she embodies disgust both by being pregnant and consuming illegal drugs. More importantly, the cultural fear is that by embodying disgust, she will reproduce something disgusting – a fetus – which will be ghastly, deformed or less than normal.

Mixing Drugs with the Regulatory Regime of Reproduction

All bodies must confront the bodily task of reproduction upon which society sets certain cultural requirements. In this context, Turner (1996: 109) contends that for every society there is strict disciplinary regime and bodily order which means that society is compelled to reproduce its members. The discipline of Western, urbanized civilization with its neo-liberal ideology is one requiring that most, if not all citizens reproduce. In terms of procreation and replicating bodies, medical and other experts' disembodied visions of these bodies have had a major impact on contemporary notions of reproduction. Consistently, the future embodied products of these procreative gendered bodies have taken priority over the process of reproduction (Newman 1996).

While drug use in pregnancy holds the interest of clinicians and public health officials alike (Markovic et al. 2000), this type of drug use tends to produce a punishment response (Young 1999) as well as scapegoating policies which are not conducive to the well-being of the pregnant user (Paone and Alpern 1998). In this area, moral panics are often generated relating to society's perceptions regarding the race, class (Duster 1970: 20–21) and gender of those who are using drugs. It is a shame that empathy is lacking in these cultural responses, as previous research (Fiorentine, Nakashima and Anglin 1999) suggests that women drug users, particularly those in treatment, respond favourably to an empathic environment.

In order to best contextualize the notion of embodiment and to understand the conditions and experiences of embodiment *vis a vis* living, reproducing, female drug using bodies, we need to be cognizant of whole series of complex cultural practices and moral discourses which target these pregnant bodies. If we return to the ideas of Braidotti (1994: 80), we see that within a logocentric economy and phallocentric discursive order, there is a traditional association of women with monstrosity. In this context, Braidotti uses the image of a pregnant body to provide clarity. For example, a woman's body can change shape in pregnancy and childbearing. The pregnant body defies the notion of fixed bodily form – visible, recognizable, clear and distinct shapes as that which marks the contours of the body (Braidotti 1994: 80). What's more, the pregnant body is 'morphologically dubious'; the fact that this female body can change shape so drastically is 'troublesome' within the context of the logocentric economy within which to see (as we have seen earlier) is the primary act of knowledge (Braidotti 1994: 80).

On a similar ontological level, Longhurst (2001: 81) contends that pregnant embodiment disrupts dualistic thinking given that expectant women go through a bodily process that transgresses the boundaries between inside and outside, self and other, one and two, mother and fetus, subject and object. Furthermore, when occupying public space, pregnant bodies are to be dreaded not trusted, given that they threaten to break their boundaries, to spill or to leak (Longhurst 2001: 82). When drugs are placed within this cultural mix, pregnant drug users not only upset dualistic thinking but also represent leaky bodies who endow dangerous substances with mystical properties (Sedgwick 1993: 132). Taking these magical or mind-altering supplements (i.e. drugs) is seen to operate corrosively on the self and thus, imply a lack of moral fiber. The pregnant drug using body is not only the abject or monstrous body who threatens to leak but also the 'bad' body whose leakiness contaminates the rational, public world of the logocentric economy. This body infects or contaminates the intimate, private spaces related to inside and outside, self and other and mother and fetus.

If we look at the social and cultural processes, marking the boundaries between 'good' and 'bad' bodies, we see some of the cultural components of the scientific, legal and medical orthodoxies which shape these reproductive female bodies as abnormal bodies. Within the regulatory regime of reproduction, we need to envisage the reproductive body and more specifically, the drug using, reproductive body as the end-product of a whole system of cultural relations. Drug use in

pregnancy is heavily stigmatized and can be legally punishable (Goldstein et al. 2000: 356). Indeed, coercive and punitive sanctions can be imposed on pregnant or post pregnant female bodies. These measures may include: incarceration to prevent damage or further damage to a fetus or invoking criminal sanctions such as being charged with reckless homicide; criminal mistreatment of a child; reckless endangerment, child abuse and child neglect (DeVille and Kopeland 1998: 239–40). While pointing out that many women will be punished for behaviour that results in no harm to the newborn, these authors (DeVille and Kopeland 1998: 251) rightly ask, 'In what other context does society punish individuals criminally with potential imprisonment merely for creating a risk of harm?' Furthermore, to get pregnant women into treatment other criminal and civil approaches may involve treatment in lieu of prosecution, involuntary civil commitment, removing child custody and denial of public benefits (Nishimoto and Roberts 2001: 162).

These types of harsh disciplinary practices are not just about the surveillance of pregnant bodies within the institution of reproduction. They are also about the cultural imperative impelling women to perform 'correctly' or 'normatively' their pregnant bodies in the regulatory regime of reproduction. We know that one basic requirement of this regime is that reproducers, especially female ones should be free from any and all substances viewed as harmful, addictive or mind altering. This requirement is linked to the cultural expectation which is part of a more general, fairly recent trend towards increasingly severe 'rules of pregnancy' (Oaks 2001: 19). These new 'rules of pregnancy' are derived from the medical professions' changing knowledge on fetal health and furthermore, results in a visible biomedical policing of pregnant women's lifestyles (Paone and Alperen 1998).

While Oaks (2001) looks specifically at pregnancy through the lens of women smokers, we are able to recognize similar 'rules of pregnancy' or stringent disciplinary practices operating for women drug users. For example, Oaks (2001: 19) contends that the discovery over the years that women's reproductive biology (Read bodies) fails to protect the fetus has strengthened the idea that women's behaviour while pregnant must be regulated and supervized by health professionals as well as by each pregnant women herself. But, of course, the 'pregnant addict' is viewed as incapable of regulating her own health and behaviour. For her, 'rules of pregnancy' usually mean the experience of stigma and discrimination in relation to not only her drug use but also her race, gender, and socioeconomic status (Abercrombie and Booth 1997). In this context, all pregnant bodies are directed by physicians and scientific experts to play out their reproductive roles in biomedically approved ways, as these bodies are pushed into the service of 'doing pregnancy' the correct way. The fact that a pregnant woman is a subject situated within a labouring body with her own point of view (Sbisa 1996) tends to be minimized by clinicians within the institution of reproduction. Any woman's choice to take drugs is seen not only to pollute her reproducing body but also to be regarded by others as unnatural, deviant, selfish or evil (Lewis 2002: 40).

Bordo (1993a: 93) contends that in contemporary society women's reproductive rights are being fought over as well as their status as subjects within cultural arrangements which, for better or worse, the safeguarding of the 'real' subject, the foetus, is central. In an attempt to understand why the cultural idiom of reproduction has such credible social power, we are able to see important, sometimes not so visible, social processes and disciplinary practices being played out. This is especially true when we attempt to envisage this cultural idiom through the lens of drug use. In this context, Murphy and Rosenbaum (1999: 1) note that when people believe the hand that rocks the cradle would rather be taking drugs, various constituencies unite in moral outrage and condemnation – for women, drug use is viewed as the antithesis of responsible behaviour and good health during pregnancy.

Pregnancy, Drugs and the Disordered Body

At its core, the regulatory regime of reproduction privileges an individualistic, mechanistic view of the pregnant female body with the result that the full importance of the cultural and biological processes of reproduction is lost for many of these women. Of course, this view, modelled on the workings of an inorganic object is not new in medicine, science and culture. Within this sort of paradigm, the body is ministered to as a machine and it is the doctor, the mechanic, who repairs it (Martin 1992). It is interesting to note that conceptions formulated within 'the body as machine' perspective facilitate the maintenance of gender prejudices rather than gender impartiality (Mahowald 1994). Indeed, the science of biomedicine is embedded in gendered social practices and like all gendered social practices (Lorber 1997: 3), these are able to transform bodies.

While drug use may alter the bodies of those who use drugs (see de Belleroche 2002), pregnant drug users are affected in particular by scientific research on reproduction and childbirth in which gendered practices and norms are embedded. Scientific research helps to establish, manage and perpetuate the 'rules of pregnancy' which affect all pregnant women, drug using or not. Bertin (1995: 384) contends that certain tendencies are entrenched in this type of scientific research and these include an overstatement of women's biological and behavioural responsibility for the well-being of the next generation; an underestimation of the importance of paternal biological and behavioural factors for the well-being of the next generation and the use of scientific maxims to reinforce social behavioural norms, particularly the definition of appropriate behaviour.

Pregnant drug users feel the brunt of these tendencies and usually experience an acute sense of how 'bad' they 'do pregnancy'. While women drug users are generally pathologized (Haller, Miles and Dawson 2002, Jainchill, Hawke and Yagelka 2000) and viewed as scientifically disordered, pregnant drug users tend to become the objects of disgust in contemporary culture. Disgust is seen to take over these material sites (e.g. pregnant drug using bodies) as 'objects'. Disgust is

a type of all-encompassing affective, embodiment. Disgust is the very designation of badness that society assumes is inherent in these bodies (Ahmed 2004: 84).

Here, scientific research and social disgust fuel the cultural and at times, self-imposition of badness, shame or guilt (Murphy and Rosenbaum 1999: 69) for these drug using women. Furthermore, if and when these women give birth and their drug use is extended to motherhood, some researchers believe that their irresponsible, embodied choices reflect 'the chaotic values of the mother's behaviour regarding the needs of the child' (Stocco, Calafat and Mendes 2000: 15). In the end, a pregnant drug user is viewed as being in a no win situation bodily, emotionally, relationally and culturally.

Linking the pregnant drug using body to the discourse of scientific research, I want to look briefly at Bordo's (1993a) critique of biomedicine in an attempt to further elucidate disordered embodiment. Bordo (1993a: 67) contends that the body of the subject in the medical model is the passive tablet on which 'disorder' is inscribed and deciphering that inscription is the working domain of the medical expert who alone can unlock the secrets of this disordered body. These notions suggest that the injunction on activity and focus on disorder may have special effects on pregnant women who experience all sorts of gendering practices when masculinist science re-conceptualizes reproduction as a technological rather than natural process.

Within the regulatory regime of reproduction, governed by these scientists and biomedical experts, pregnant women are encouraged to treat their bodies as passive instruments of new emergent technologies (Bordo 1993a: 86). For pregnant drug users, it would be disastrous if they treated their bodies as 'passive instruments'. As pregnant users, they need, in order to survive and 'do a successful pregnancy', a type of active embodiment which may involve choosing strategies for reducing drug related harm such as switching to 'safer' drugs; counteracting drug use by taking vitamins and other remedies; altering their drug using lifestyles by forcing oneself to sleep or moving from drug using neighbourhoods and in some instances, seeking prenatal care (Rosenbaum and Irwin 2000).

Regardless of these survival strategies for pregnant drug users, recent developments in biomedicine shape new values for the standards of reproduction – values to which all pregnant women even pregnant drug users are told they must conform. In this context, for the feminist theorist, the disordered body, like all gendered bodies, is engaged in a process of making meaning, of 'labour on the body' (Bordo 1993a: 67). Here, the notion of reproduction as a valuable, material site of embodied experience for all women emerges. Nonetheless, we must work hard and labour so that feminine ontology of the female body is privileged, especially when we are looking at a specific form of reproductive embodiment that presents opportunities for resistance, for making meanings that oppose or evade the dominant ideology (Bordo 1993b: 193).

From this feminist standpoint, drug use during pregnancy is under no circumstances purely selfish, self-indulgent, irresponsible or bad, under no circumstances purely a fall from grace or embodiment of evil. Nor is being

pregnant while using drugs facilitated by cultural images of 'crack whores' or 'pregnant addicts'. Drug use during pregnancy is not 'behaviour derived from immorality rather than from illness' (Paone and Alperen 1998: 101) nor a licence for doctors to treat pregnant users harshly (Boyd 1999: 66). Rather drug use during pregnancy may be an attempt to embody particular cultural values and norms and to construct a gendered, expectant body that will speak for itself in a consequential and powerful way. For example, these pregnant drug users may use drugs to cope with the strains of family life (Raine 2001) or to increase their sense of authority or control over their difficult situations (Taylor 1993). For pregnant women, drugs can be used as a resource or a survival strategy to help them endure the problems they face as women drug users and victims of abuse (Sales and Murphy 2000: 709) or to make their lives more manageable and inclusive of a little, if not some leisure.

Sales and Murphy's (2000) research revealed that drugs were used by pregnant women to relieve pain, to create a sense of control or to prevent partner violence and abuse. Other research demonstrated that worries or fears about the welfare of others were important for these women, especially their concerns for the welfare of their children (Copeland 1998: 333, Baker and Carson 1999). Obviously, the cultural belief that presumes these pregnant women are uncaring and totally irresponsible is erroneous. Women drug users are not merely 'victims' of their circumstances but by using drugs may be attempting to cope with a range of issues in their lives in which drug use forms part of a coping strategy (Malloch 2004: 388). Nevertheless, in order to manage their status as pregnant drug users, women need to navigate a safe passage through a series of perceived risks such as losing custody of their children, causing fetal damage or being severely stigmatized in public settings (Irwin 1995: 635). Here, pregnant drug using bodies are capable of being employed as a conduit for the expression of a variety of at times conflicting concerns, desires and predicaments, existing in society. Within this type of viewpoint, illuminating drug use in pregnancy does not necessitate expert knowledge. Rather, what is needed is attentiveness to the myriad strata of cultural representations that are embedded in this type of gendered, 'disordered body' or 'deviant body'.

For example, ideas surrounding pregnancy in contemporary society are spurred on by the surveillance practices of biomedical experts and materialize as resistance to autonomous motherhood (De Gama 1993). Furthermore, beneath the compelling cultural apprehension of drug addicted babies and the development of public health programmes designed for the special needs of certain populations especially minority women who are or would like to be pregnant (Balsamo 1999: 241) lies a basic animosity and resistance to women's self governance (Campbell 1999: 917).

This cultural animosity reveals the problematic and politicized nature of human reproduction and the fact that whether pregnant drug users bring their babies to term or have an abortion, they are unable to experience any form of normality in and through the biomedical discourse. Inevitably, female drug users will bear the three stigmata of being immoral, sexually indiscrete and inadequate caregivers –

stigmata which become even more punitive when women are seen to abuse drugs during pregnancy and perpetuated by unprofessional behaviour and pejorative attitudes of health care providers (Carter 2002: 302). It is important to note here that negative social responses to pregnant drug users such as stigmatization and imputing legal liability may impact disproportionately on racialized women and women of low economic status (Goldstein et al. 2000: 364–5). Here, there is a sense of urgency for treaters to be aware of the emotional, psychological, economic and social impacts of these issues and to try to actively engage *all women drug users* in caring environments (Curet and Hsi 2002). The above type of negative expert response exists side by side controlled scientific reproduction (Spallone and Steinberg 1987: 15) which not only fragments the meaning of motherhood (Hill Collins 1999: 279) but also brings both the physician and the pregnant woman into a system of normative surveillance which for pregnant drug users means that the dominant narrative is one of maternal excess and fetal victimization (Balsamo 1999: 243).

In conclusion, this chapter has demonstrated that the cultural workings of reproduction, drugs and the gendered body expose the long-standing feminist unease that the medicalization of reproduction, pregnancy and childbirth has more often than not been against the interests of pregnant women, making them objects of medical care rather than subjects with agency and rational decision making powers. Compound this situation with using drugs and we can rightly say that, ‘All hell breaks loose’. In the above discussions, I have outlined how cultural representations of pregnant drug users in the somatic society and within the regulatory regime of reproduction become ‘eye food’ for biomedical experts in their visualization of these disembodied/deviant female subjects. I have attempted to weave together the notions pregnant drug use, somatic society, drug use, scopic drive, disgust and disordered bodies in order to demonstrate their symbolic relationship in popular culture.

As a feminist theorist, I have wanted to make meaning and labour on the drug using reproducing body in order to further demonstrate how an embodiment approach is able to illuminate some of the complexities of pregnant drug users’ intractable, social situation. The very act of using drugs during pregnancy is confounding the dominant discourse on drugs and reproduction. For pregnant users, there may be power and pleasure (see Ettorre 2007a, 2007b) in this type of embodied cultural work. Resisting normalization may produce some benefits. At the very least, their disordered bodies are resisting the grip of the regulatory regime of reproduction on their ‘deviant’ bodies and attempting to give those experts employing the all pervasive scopic drive a proper black eye.

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