What is Health?

Health is something of an enigma. Like the proverbial elephant, it is difficult to define but easy to spot when we see it. ‘You look well’ stands as a common greeting to a friend or a relative who appears relaxed, happy and buoyant – ‘feeling good’. Any reflection on the term, however, immediately reveals its complexity. The idea of health is capable of wide and narrow application, and can be negatively as well as positively defined. We can be in good health and poor health. Moreover, health is not just a feature of our daily life, it also appears frequently on the political landscape. Health scares such as BSE/CJD, SARS and even the prospect of bio-terrorism have all exercised politicians and their medical advisers in recent times, and have all provided a steady stream of media stories. Health risks seem to proliferate, even if, for most of us most of the time, these are less than urgent concerns.

In all such instances, and in our more mundane experience, health is also related to other complex ideas such as illness and disease. This constellation of terms: health, disease and illness, and the experiences and forms of knowledge to which they relate, are the subjects of this opening chapter. In order to structure the discussion, the chapter is organized round four themes:

- The medical model of health and illness
- Lay concepts of health
- Health as attribute and health as relation
- Health and illness – physical and mental
These themes comprise substantive topics in their own right, but the discussion of them will also act as a lead into the subsequent chapters of the book. Many of the wider dimensions of health and illness – including their cultural and political features – will figure throughout the book. Examples of the most recent controversies in health are dealt with particularly in the latter stages. In this opening chapter, however, we need to begin with the basics and establish a conceptual map of the field.

The Medical Model of Health and Illness

On the surface it may seem somewhat perverse to begin a book on the sociology of health and illness by considering the medical model. However, given the importance, not to say dominance of medical science and medical practice in modern times, understanding the medical approach to health is a necessary starting point. Much of what contemporary populations think about health and illness, and much of the focus of research – including sociological research – is strongly influenced by the prevailing medical model. In public debate, the medical approach remains central. It is therefore with this topic that we begin.

It is often said that the medical model of health is a negative one: that is, that health is essentially the absence of disease. Despite bold attempts by bodies such as the World Health Organisation (WHO) to argue for a definition of health as ‘a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity’ (<www.who.int/about/overview/en>), most medically related thought remains concerned with disease and illness. This is hardly surprising, given the fact that people turn to medicine in times of trouble, not when they are feeling well. It has also been found that promotion of positive health, whether by doctors or ‘health promoters’, competes with other valued goals, for individuals and for societies as a whole. Matters become even more complicated when it is realized that the presence of ‘disease or infirmity’ does not, in any event, mean that people always regard themselves as unhealthy – as we shall see below. The phrase ‘complete well-being’ remains as elusive as it is positive, and health, illness and medicine are related in complex ways. The medical model of health, though often charged with ‘reductionism’, at least has the attraction of cutting through some of these knots.

As historians such as the late Roy Porter (2002a) have pointed out, the medical model, as we now know it, took on its main characteristics in the eighteenth and nineteenth centuries. Prior to this date most medicine in Western countries was committed to observation and the exhaustive classification of symptoms. Although this attachment to observation
entailed a rejection of existing authorities (represented especially in Galen’s writings) and was linked to a reformist view of science and society, developments were not straightforward. For many physicians in the seventeenth and eighteenth centuries, emerging views concerning the nature of disease were anathema. Physiology in France and chemistry in Germany were bringing the laboratory sciences to bear on human health and disease, and many thought this undermined the doctor’s traditional role at the patient’s bedside. However, during the nineteenth century, the development of bacteriology and pathological anatomy marked a major change in both thought and practice.

Instead of the seemingly endless classification of symptoms, the idea of ‘specific aetiology’ took hold, tracing the pathways of disease from underlying causes to pathology in human tissue or organ, and then to the manifestation of symptoms. Thus, specific causes were linked to specific diseases in particular organs, and the task of the physician was to trace the presenting symptoms back to their underlying origins. This model of disease flourished in the late nineteenth and early twentieth centuries, and was particularly associated with the discovery of the mechanisms that lay behind the infections – the so-called germ theory of disease. Although not all physicians, even then, as Porter (2002a) makes clear, accepted the idea of disease specificity, preferring to see sickness occurring when ‘normal functions went awry’ (p. 78), the pathologically based and causally specific medical model became increasingly dominant.

In order to illustrate what is meant here, let us take an example: the case of tuberculosis, an infectious disease responsible for a quarter of all deaths in the second half of the nineteenth century and the most important threat to health at that time (Webster 1994). In the medical model of disease, tuberculosis is defined as a disease of bodily organs (usually the lungs, but sometimes other sites such as the spine) following exposure to the tubercle bacillus. This exposure leads to pathological changes in the body’s systems, and can be observed at x-ray as damage to the surface of the lungs, in the case of respiratory tuberculosis. The bacillus can be identified through culturing blood or sputum. The development of the illness involves symptoms such as coughing, haemoptysis (coughing up blood), weight loss and fever. In this model the underlying cause of the illness is the bacillus, and its elimination from the body (through anti-tubercular drugs) is aimed to restore the body to health. In 1944, streptomycin was found to be active against the tubercle bacillus.

The main point of this model of disease is that it attempts to uncover underlying pathological processes and their particular effects. The problem with earlier, symptom-oriented approaches to health was that no such sequences of events could be established, and treatment could
only be symptomatic. In the case of tuberculosis, the symptoms described above are also found in other diseases, and this problem of linking symptoms to specific underlying mechanisms frustrated medical development. Fever, for example, is common to many infectious disorders. Once the specific aetiology approach was accepted, such symptomatic approaches were relegated to the margins of medicine. Although observation and the treatment of symptoms were established practices in early modern medicine, and have remained important to physicians ever since, it was often difficult to distinguish such approaches from a wide variety of unorthodox practices. Today, these are often referred to as forms of ‘complementary medicine’ – herbalism and homeopathy, for example – that treat symptoms ‘holistically’ – but do not rest on the idea of underlying, specific pathological disease mechanisms.

The medical historian Christopher Lawrence has argued that by 1920 in Britain, and in other developed countries such as the USA, the medical model, as outlined briefly above, had come to dominate medical thought and practice and, increasingly, society’s attitude to health as a whole (Lawrence 1995). The medical model was essentially individualistic in orientation and, unlike earlier approaches, paid less attention to the patient’s social situation or the wider environment. This narrowing of focus (towards the internal workings of the body, and then to cellular and sub-cellular levels), led to many gains in understanding and treatment, especially after 1941, when penicillin was introduced, and the era of antibiotics began. But it was also accompanied by the development of what Lawrence calls a ‘bounded’ medical profession, that could pronounce widely on health matters and could act with increasing power and autonomy. Doctors now claimed exclusive jurisdiction over health and illness, with the warrant of the medical model of disease as their support.

This situation meant that modern citizens were increasingly encouraged to see their health as an individual matter, and their health problems as in need of the attention of a doctor. It is this which Foucault (1973) saw as constituting the ‘medical gaze’ which focused on the individual and on processes going on inside the body – its ‘volumes and spaces’. Wider influences on health, such as circumstances at work or in the domestic sphere, were of less interest to the modern doctor. This ‘gaze’ (extended in due course to health-related behaviours) underpinned the development of the modern ‘doctor–patient’ relationship, in which all authority over health matters was seen to reside in the doctors’ expertise and skill, especially as shown in diagnosis. This meant that the patient’s view of illness and alternative approaches to health were excluded from serious consideration. Indeed, the patient’s view was seen as contaminating the diagnostic process, and it was better if the patient
occupied only a passive role. It is for this reason that the ‘medical model’ of disease has been regarded critically in many sociological accounts. The power of the medical model and the power of the medical profession have been seen to serve the interests of ‘medical dominance’ rather than patients’ needs (Freidson 1970/1988, 2001) and to direct attention away from the wider determinants of health.

However, before we proceed, two caveats need to be entered. Whilst medicine in the last 20 years has continued to focus on processes in the individual body, such as the chemistry of the brain or the role of genes in relation to specific diseases, the current context is clearly different from that which existed at the beginning of the twentieth century. Today, in countries such as the UK and the USA, infectious diseases are of far less importance as threats to human health. Though HIV/AIDS has become one of the most serious infectious diseases in history, its major impact is being felt in developing countries, especially in sub-Saharan Africa, and those of the former Soviet Union. In the West, notwithstanding the importance of infections when they do occur, the major health problems today are the so-called degenerative diseases associated with later life – conditions such as heart disease and cancer, and disabling illnesses such as arthritis and stroke. This has been referred to as the ‘health transition’ (Gray 2001: 127).

The medical model, today, therefore, is as likely to emphasize the complex or unknown aetiology of a disease as it is to discover its specific ‘cause’. Many diseases can properly be recognized only by referring to a set of criteria (often arrived at by international groups of doctors) rather than identifying one underlying factor; diagnosis is often probabilistic rather than definitive. Treatment, in turn, may often be ‘palliative’, that is, trying to reduce the impact of symptoms, or contain the disease, rather than hoping to cure it completely. In addition, many doctors today work within multidisciplinary teams, rather than as isolated practitioners. They recognize (as the more thoughtful doctor has always done) the wider influences on health and the impact of disease on patients’ lives. Indeed, the rhetoric currently surrounding ‘patient partnership’ and ‘shared decision making’, to be found in many developed health care systems, need not be treated entirely cynically. Many health care professionals are attempting to reshape health care to meet the new needs and demands of their patients. These changes need to be borne in mind as we look at the issues of medical power and the continuing influence of medical science later in this book.

Second, the individualistic approach to disease is not the only approach to health to be found in a more broadly defined medical model, though it may be the dominant one. Most developed societies have also had a long tradition of public health, focusing not on the individual but
on the health of populations. Here, the diagnosis and treatment of individuals is less important than measures of health for whole groups and societies, however much these rely on medical scientific explanations of disease and illness. The most important of such measures are rates of mortality, morbidity and disability, data on which are collected and studied by the scientific arm of public health, epidemiology. Their regularity among and between groups of people is the focus of enquiry. As one leading UK epidemiologist has put it, epidemiology may be contrasted with the clinical observation of patients or the controlled experiment in the laboratory as the study of the health and disease of populations and groups in relation to their environment and ways of living... and is being applied to a variety of health services as well as health. (Morris 1975: 3)

Public health research, especially during the period dominated by the infections, was preoccupied with mortality data, especially the how, when and why of early death. For example, one of the most important measures of population health is the infant mortality rate (IMR), which calculates the number of deaths in the first year of life per thousand live births. Today the IMR for the UK is 5.5 and for the USA, is 6.8. However, the IMR for India is 63, and for Mali in West Africa, 121. Such statistics have been, and still are, an indication of the different life circumstances and health of the populations in these countries, in that high infant deaths are associated with poor maternal health and poor social circumstances. However, in Western countries, mortality statistics have become less sensitive indicators of population health as social conditions have improved (for mothers and other groups) and as the rates at all ages have continued to fall. None the less, as we shall see in chapter 2, much epidemiological research, and medical sociology work related to it, still rely on mortality data.

In recent years, though, public health and medical sociology have been concerned to develop more sensitive measures of health, still broadly within what one might call a ‘socio-medical’ model of health, but dealing with morbidity and disability (Bury 1997: 116). In such an approach, morbidity refers to measures of illness, and disability to measures of activity restriction and functional limitation, together with measures of quality of life. The important point to grasp at this stage is that the medical model contains a number of different strands of thought about human health, and different approaches to its study. This holds true, also, for the medical profession, which includes physicians, surgeons and general practitioners, together with public health doctors and epidemiologists. Whilst most medical practice has been individualistic in orientation, some forms of medicine (especially that focusing on human
populations) have adopted a larger vision, and this often overlaps with sociological concerns. Medicine, like health, covers a wide range of phenomena and human activity, and this needs to be remembered when general statements about the ‘medical model’ or ‘the medical profession’ are made.

Lay Concepts of Health

If the above account of the growing dominance of the medical model is reasonably accurate, it might be expected that lay concepts of health in modern societies would be strongly influenced by it in modern times. Explanations for events such as illness are rarely couched, for example, in religious terms, at least not by the majority of lay people in countries such as the UK and the USA, though such ideas may be prevalent in particular communities. Medical information is disseminated and available in numerous ways today, especially through television, the Internet and other media. If the development of an individualistic medical model has shaped lay understanding and experience of health, then modern cultures have been equally conducive to its widespread acceptance. It would be surprising, under these circumstances, to find an entirely separate system of ‘folk beliefs’ about illness, shaped by a non-medical culture.

At the same time, enough has already been said to indicate that health, illness and medicine refer to a wide range of events and experiences, and ideas about these are bound to contain tensions and contradictions, as well as ambivalence about the role of medical treatments in dealing with them (Williams and Calnan 1996: 17). Sociological research on lay concepts of health has provided important insights into the complexity and sophistication of views about such matters. Whilst this work has shown the widespread absorption of medical messages about health, it has also shown how this is translated and reconciled with other areas of life, and assessed against alternative sources of information. Modern ideas about health and illness can also draw on earlier notions, such as the need for ‘balance’ in sustaining well-being.

In the first place it needs to be recognized that health may be an overriding concern to health care professionals and researchers, including medical sociologists, but not for lay people in everyday life. Health, for many, and for most of the time, is part of the ‘natural attitude’ to life, in which taken-for-granted meanings are an essential background and are unconsidered for much of the time. In his study of risk behaviour and HIV, Bloor (1995: 26), for example, drawing on the writings of Alfred Schutz, distinguished between ‘the world of routine activities’ and ‘a world of considered alternatives and calculative action’ in interpreting how health risks were perceived by his respondents. Bloor’s study
reinforces the view that daily life presupposes health, unless it is threatened by events or information that draw the layperson into considering alternatives. Health risks vie with the routine nature of daily life, with its own pressures and pleasures, constraints and potentialities. As we shall see below, only a minority of people are forced, or choose, to abandon an assumption of health as a given. Those concerned with health promotion (as opposed to the treatment of illness) who wish to encourage lay people to become more health-conscious have to face this issue in doing so. Health is not necessarily a pressing and overriding value, consciously considered on a daily basis. Information on health risks is actively interpreted within specific social contexts (Alaszweski and Horlick-Jones 2003).

In addition to this, lay thinking about the causes or origins of good and ill health has been found to be characterized by complex considerations. Even if health is often taken for granted, and only missed when it is felt to be compromised, this does not mean that lay people lack clear ideas about the relationship between health and illness. In one of the earliest and most influential studies of lay concepts of health, Herzlich (1973) showed how, among a sample of 80 middle-class French respondents (mostly from Paris) health was linked to the connections between individuals and ‘the way of life’. Health beliefs, or the ‘representations of health’ as Herzlich called them, located the source of illness in the character of urban living, with its tendency to create stress, fatigue and nervous tension. This, it was felt, could ‘facilitate’ or ‘release’ forces that could aid the development of illness. But such forces could also ‘generate’ illness – that is, be more pathological in their own right – and not just exacerbate existing problems, for example, by making an infection worse.

Positive health, on the other hand, was seen to be inherent in the individual. The balance or ‘equilibrium’ between the healthy individual and illness could be upset by a number of features of the environment. Cancer was linked to allergies, and to the nervous strain of city life and the polluted atmosphere found there. Mental illness was linked to the ‘restlessness’ of modern living, and heart disease to the ‘many worries which make people live in a certain state of anxiety’ (Herzlich 1973: 22). Whilst the respondents in this study recognized that individual attributes might contribute to poor health, these attributes were never seen as both necessary and sufficient. The individual’s ‘nature’, heredity, temperament or predisposition might make the individual vulnerable, but the ‘way of life’ remained crucial to the development of poor health.

If Herzlich’s work set out to provide a framework for understanding the links between way of life and the individual in lay concepts of health, subsequent work has explored their variation across different age and
social groups. In a study which builds conceptually on Herzlich, but
draws on a large national study of health and lifestyles in the UK, Blaxter
(1990) has provided a detailed picture of some of these variations. This
study also shows that health is not a single or unitary concept, but one
that has a number of dimensions as applied to different areas of life and
lifestyles (see also Blaxter 2003, 2004).

Blaxter’s (1990) discussion of lay beliefs is drawn from responses to
open-ended questions about health put to 9,000 respondents in England,
Wales and Scotland. Overall, these responses show that for lay people
‘health can be defined negatively, as the absence of illness, functionally
as the ability to cope with everyday activities, or positively as fitness and
well-being’ (p. 14). However, there are two important additions to this
general picture. The first is that health has a moral dimension, reflecting
not only the adoption or maintenance of a healthy lifestyle, but also how
people respond to illness and deal with its aftermath. Illness runs the risk
of devaluing a person’s identity, either because of its causation (e.g.
smoking, sexual contact, failure to ‘keep well’) or because of inappro-
priate behaviour in the face of symptoms. Moral dimensions of health
have been found in a number of other studies, such as Conrad’s (1994)
study of students in the USA and G. Williams’s (1984) study of middle-
aged and older people with arthritis in England. From this viewpoint
illness is not simply a deviation from biological norms, as in the medical
model, but a significant departure from social norms.

Second, Blaxter shows that health, illness and disease are not always
mutually exclusive in lay thought. Respondents in her study often
reported that they saw themselves as healthy despite having serious con-
ditions such as diabetes. There is clearly a strong motivation towards
feeling and being seen to be healthy, if at all possible. This issue becomes
particularly salient when the question of disability is considered, given
the complex relationship between health and a range of different dis-
abling conditions. For individuals with stable disabilities, or conditions
that are not accompanied by generalized illness or ‘malaise’, being
healthy may be redefined to incorporate how the person feels now, not
in relation to a general norm. Adaptation to illness or disability alters
the baseline from which the individual judges the nature of health and
its implications. As we shall see below, however, and in more detail in
chapter 4, the relationship between disability and health has become
highly controversial.

One of the main strengths of Blaxter’s study is that it shows the impor-
tance of gender and age to such definitions of health. Blaxter argues that
health in much lay thinking can be seen to constitute a form of ‘reserve
stock’, to be invested in by adopting healthy behaviours, or diminished
by self-neglect or unhealthy behaviours (Blaxter 1990: 16). The ‘health
capital’ we are born with can be seen as a function of heredity and as being shaped by development in the early years of life. But people in later life may feel that their ‘stock’ is diminishing or running down. Problems with mobility, eyesight and hearing are obvious examples. In Blaxter’s study older people did, indeed, report more negative views of their health, with men under the age of 40 more likely to emphasize a positive notion of ‘fitness’. Health as functioning – being able to carry out self-care and other routine tasks – is likely to increase in importance with age, and likewise is largely taken for granted among the young. For young women, however, Blaxter’s study underlined the importance of social relationships, as well as being patient with children and ‘coping with the family’ (Blaxter 1990: 27).

In Blaxter’s study, then, the nuanced and multidimensional character of lay health beliefs is underlined. This is of particular note, especially in a period when health risks appear to be multiplying. For example, fears have been expressed that the ‘new genetics’ will overwhelm modern populations with burdensome information about potential health risks and the need to make choices about an ever wider range of medical and health-promoting interventions (including screening programmes). The incorporation of an increasing number of human and social problems into the medical and genetic orbit has led sociologists to analyse the various forces, concerns and dilemmas involved (Conrad 2000). Even, here, though, empirical research has found that lay people are able to absorb or deal with even the most technical and complex information in creative and practical ways. A brief example to conclude this section of the chapter can serve to illustrate the point.

As part of an ongoing programme of research at Cardiff University, Parsons and Atkinson (1992) reported on the knowledge and beliefs of 22 mothers and 32 daughters who had a known risk of carrying the gene responsible for Duchenne muscular dystrophy, a disease that leads, slowly, to a progressive degeneration of muscular tissue. It is inherited through a recessive, sex-linked gene, so that only boys are affected, and only women can pass it on. There is no effective treatment for the disease, and the outlook for many affected individuals, in the medium term, is poor. It might be expected that under these circumstances reproductive decisions on the part of the women in the study would be likely to be highly problematic. Each woman in the study had gone through several assessments and tests, resulting, finally, in two sets of risk figures, one for her carrier status and one for her risk of passing on the gene to any offspring. In fact, Parsons and Atkinson found considerable confusion on the part of some women as to the nature of the statistics they had been given. However, the point of the study was not to demonstrate the
women’s ability to account for their carrier status, or otherwise, but to explore how the knowledge they did have was incorporated into daily life. Parsons and Atkinson found that the women had invariably translated statistical risk into ‘descriptive categories that had become routine recipes for their reproductive behaviour’, so that specific figures could be seen, for example, as putting them at high or low risk of transmission (Parsons and Atkinson 1992: 441). Far from being disempowered by expert knowledge, the women were able to use these descriptive statements to inform action, in ways that the medical information could not. Probabilistic knowledge derived from genetics was turned into more certain guidelines that could deal with both decision making and social relationships. For much of the time the women were able to relegate their carrier status to a ‘low zone of relevance’. In this study health beliefs were shown not only as sophisticated but also as practical, being fashioned and refashioned as contexts and experiences changed. As we saw earlier, health beliefs are integrated, where possible, into the routine actions that constitute everyday life.

This is not to say that all lay health beliefs are true or unproblematic. While medical sociology has made an important contribution to understanding the rationality, relevance and socially contextualized nature of lay health beliefs, it is important not to overstate the argument. Whilst individuals have unique insights into their own situations, these cannot be substituted for expert knowledge in all and every circumstance (Prior 2003). The economist Amartya Sen (2002) has shown, for example, that when a comparative perspective of lay views is adopted, anomalies quickly appear. Quoting data from India and the USA, he shows that the higher the level of education in a population, the higher the level of reported illness. This stands in contrast to more ‘objective’ measures, such as mortality rates and life expectancy, which, as indicated earlier in this chapter, are much more favourable in the USA than in a country such as India. We should not conclude from their stated beliefs or behaviours that people in the USA are less healthy than people in India. Rather, we should see lay beliefs and behaviour, as well as the medical model, as components of a dialectic, interacting in complex ways, and mediated by different cultural settings.

Health as Attribute and Health as Relation

The previous two sections have explored, in outline, the medical model and lay beliefs about health. One of the ways we can think sociologically about the tension between the two is to consider health in terms of
attribute and relation. The relationship between these two approaches also provides us with a framework with which to approach some of the most puzzling features of contemporary health phenomena.

If we take the idea of attribute first, much medical knowledge, and considerable areas of lay belief influenced by it, make the assumption that disease or illness is a property or attribute of the individual. Disease from this viewpoint is an ‘it’ which the person has or harbours. In early modern medicine it was often felt that scientific investigation ran the risk of ‘reifying’ disease – that is, of creating a ‘thing’ separate from the individual patient, where only observed symptoms could properly be identified. Humoral medicine treated disease and its symptomatology as one and the same. With the ascendancy of the ‘pathological anatomy’ perspective, ‘reified’ disease became increasingly dominant. In this new view, disease was seen as a separate entity, both from the attempts to conceptualize it or deal with it, and from the symptoms that might or might not be related to it. Diseases such as tuberculosis, and bodily organs such as lungs, exist, in this realist view, whether we name them or not, or whether we live in a culture or a period of history which has a different understanding. Moreover, many diseases exist without symptoms, especially in their early stages – in some forms of heart disease and cancer, for example. And the plethora of observable symptoms often do not map on to disease in a one-to-one manner. The existence of cultures (or histories) that do not conceptualize disease as an independent property of the body does not mean that people do not have diseases or organs such as lungs, hearts or livers (Craib 1995). Though diseases may be caused by outside agents (bacteria, viruses), their essential character reside in the human body, as an attribute of its physical make-up.

A relational view of health, by contrast, does not focus on the biological determinants at work in the individual’s body. Rather, it points to the social or psycho-social forces that influence the pattern and expression of illness. This can be conceptualized in two ways: either in terms of the ‘social creation’ of illness patterns through inequalities or environmental factors, or in terms of the ‘social production’ of illness in individuals through the contingencies and negotiations that surround its identification, naming and treatment. This latter approach is especially relevant to forms of chronic illness (Gerhardt 1989). Here, the process of recognizing or naming a disease, by medical staff or lay people, involves a range of factors, including the severity of symptoms, the age and tolerance level of the sufferer, the social circumstances of the individual (work or family difficulties, for example), and the interactions between the person and the health care system. Many chronic conditions are difficult to separate from the normal, again, especially in their early stages, and there may not be a key hallmark, comparable with a bac-
terium or virus, that can act as a definitive marker for the disease. In this sense the disease or illness may be ‘negotiated’ before a definite name or plan of action is agreed upon.

At this point, it may be thought that an attributional view of health is largely the province of medicine and the medical model of health, and a relational view that of lay people or, indeed, of the sociologist. In many situations this may well be the case, but again the idea of dialectic is important. Take the case of a disease such as osteoarthritis, a common disorder of later life, involving progressive deterioration in the joints of the body, especially the hips. As the disease is associated with age, many people tend to discount the aches and pains which accompany it as features of growing older, and treat them as more or less normal. Or, at least, it has been found that people attempt to do so (Sanders et al. 2002). Thus, reporting of such symptoms to the doctor is likely to be highly variable. At the same time, the fit between symptoms and degree of disease progression is often difficult for doctors to judge. Patients with low levels of pain may have badly affected joints, and those in considerable pain may not show signs of major physical changes (for example, at x-ray). How the severity of the disease is judged, and whether or when to intervene (for example, by surgical replacement of a hip), is, in part at least, a matter for negotiation. It may be contingent on a host of factors, not least the presence of a waiting list for surgery.

In this respect the medical view of disease cannot easily operate within an entirely attributional perspective. Returning to our earlier point, and as Healy (1999: 12) has pointed out, the ‘specific disease model’ of the late nineteenth century overcame earlier confusions created by a form of medicine which relied on a combination of theory and observation. Healy cites the case of diphtheria in this period, which was often confused with other throat problems, and only resolved when a specific diphtheria organism was isolated. To repeat, the new medical model emphasized that specific causes gave rise to specific diseases. Whilst this may still hold true for some diseases today, the rise in importance of degenerative conditions requires that medical knowledge and medical practice often adopt a ‘multi-factorial’ model of illness, wherein physical, psychological and social processes are recognized as playing an important part. Even where genetic knowledge is giving renewed impetus to the specific cause approach, it is recognized that genes may express themselves in different ways in different individuals and within different environments.

By the same token, a relational view of health is not always characteristic of lay views. An attributional view of disease has, in recent years, become highly attractive among some lay people, especially in connection with problematic and contentious disorders. The ‘way of life’ may
not always be the main emphasis in lay thinking about disease causation. Conditions such as Attention Deficit Hyperactivity Disorder (ADHD), Myalgic Encephalomyelitis (ME) or Chronic Fatigue Syndrome (CFS), and Gulf War Syndrome are among the best publicized in this regard. ME/CFS is held by many sufferers to be the result of a viral illness, and not, as many doctors think, the outcome of psychological problems including depression. The paradox lies in the fact that it is patients, and not doctors, who are claiming that the illness results from an underlying biological attribute, and it is doctors who are warning against the ‘medicalization’ of ‘non-diseases’, fuelled by genetics on the one hand and an expansionist pharmaceutical industry on the other (Moynihan and Smith 2002). Claims made about the ‘objective’ or ‘real’ nature or causes of a disorder do not themselves, of course, mean that they are true.

Nevertheless, the attraction for many lay people of regarding a condition such as ME/CFS as a biological attribute seems unstoppable. The UK organization Action for ME states, for example, that the disorder is a ‘potentially chronic and disabling neurological disorder, which causes profound exhaustion, muscle pain and cognitive problems such as memory loss and concentration . . . it is estimated that around two thirds of all cases are preceded by a viral infection of some kind’ (Action for ME, <www.afme.org.uk>). Activists in areas such as this can become hostile to arguments, especially from medical sources that fail to share such an approach. To repeat, ME/CFS is only one among a number of health problems which express a complex relationship between attributional and relational issues, that do not necessarily follow the disease = medical, illness = lay distinction.

If we bring disability into the picture again, these problems are thrown into sharp relief. As G. Williams (2000) has noted, for most doctors and lay people the idea of disability has been as a ‘property’ of the individual. Impairments resulting from disease or trauma, that alter the structure or functioning of the body, become disabling. By this is meant that the affected individual has difficulty or is unable to perform the usual tasks that a non-impaired person would be able to carry out, such as self-care or mobility. The causal chain of disease/trauma → impairment → disability reproduces the essential characteristics of the medical model described earlier. This attributional view of disability has dominated not only medical thought, but also lay understanding. Indeed, without it, it would be difficult to make any assessment of the degree of disability or to allocate resources (for example, designated parking places or disability allowances) with any degree of fairness. If it is not possible to distinguish between the able-bodied and the disabled in attributional terms, then such issues become almost impossible to resolve.
In recent years, however, radical voices in the disability movement have sought to separate disease, impairment and the body, on the one hand, from disability, on the other. In this view disability is wholly relational, in that it is seen to be a product of social oppression and discrimination (Oliver 1996: 35). The idea of disability being a property or attribute of the individual has become anathema to some, and its essentially relational character a test of radical disability credentials. Considerable argument has ensued about the nature of disability between these two poles, both within the disability movement and between disability activists and medical sociologists (Bury 1996; Shakespeare 1999). G. Williams notes that sociologists such as Irving Zola (who was himself disabled) have argued that moving too far in either the relational or the attributional direction oversimplifies the complex problems involved. Instead, Zola favoured a formulation widely used in the USA: namely, that of referring to ‘people with disabilities’ (G. Williams 2000: 139; Zola 1993), recognizing both the bodily and the social dimensions at work.

These issues will be returned to in greater detail in chapter 4 of this book. The main point to note here is that in the field of health and illness, and in areas such as psychosomatic disorders or disability, a tension between attributional and relational aspects is inevitably present. A critical sociological view of health has at its centre the dialectic of physical and social dimensions. This is not the same, however, as arguing that health and illness are merely ‘social constructs’, in the sense that they depend only on shifting social contexts and different interests at work. The difficulties with a sociological view that gives no place to the biological and ‘embodied’ character of health is that it leaves the body and its make-up (especially in the current period, its genetic make-up) to medical scrutiny alone. To argue that health has a social dimension is not to say that it has no independent or physical basis; nor is it to argue that medical knowledge is little more than the exercise of unwarranted power over the layperson. Some disorders are controversial and difficult to define, others are not. In some circumstances physical symptoms inexorably overwhelm the individual’s body, in others they are recognized only through a more negotiated process. Indeed, these different aspects of experience will often unfold in varying ways in the course of a particular illness. How perceptions, experience and action work their way through in specific disorders is a matter for empirical analysis. This book will suggest that a dynamic view of health is needed, one in which changes over time (across the individual lifecourse, and in different societies at different historical periods) become the focus of analysis. In such a view, attribute and relation are necessary concepts for a full understanding of health.
Health and Illness – Physical and Mental

Up to this point the discussion has been largely concerned with physical health and physical illness or disability. Indeed, much of this short book will necessarily be confined to physical health and illness. None the less, this introductory discussion cannot properly conclude without considering, if only briefly, the difficult issues presented by mental health.

In recent years, as Busfield (2000) has pointed out in a useful review, developments in genetics, neuroscience and pharmacology have tended to reinforce a perspective of mental health as being determined by bodily processes – what here has been called an attributional view. The idea that mental health is a product of the individual’s biological make-up has proved attractive to lay people as well to those in medicine in many different periods of history. A materialist – not to say mechanical – view of the body, and especially the brain with its structures, linkages and chemistry, has dominated medical and psychiatric thought since early modern times, following the rejection of ‘demonic’ and religious-based explanations of mental disturbance. Developments in psychology, and the influence of thinking such as Freud’s on the role of early development and fantasy in human affairs, have not displaced the desire among most psychiatrists to remain in the medical mainstream. Not surprisingly, therefore, a medical model of mental health has continued to be influential in lay cultures. The apparent neutrality of the medical model also has its attractions. As with other forms of illness, to be told that a mental disorder is the result of an organic disturbance provides a way of resisting claims that it may result from a failure of character or from a weak will.

Indeed, one of the main difficulties with mental illness is that it often involves changes in behaviour which attract moral opprobrium. Strange, difficult or threatening behaviour, as Fabrega and Manning (1973) and Goffman (1971) argued over 30 years ago, reflect on the selfhood of the putative patient and create interactional difficulties. In physical ill health it is often possible to distance oneself from the disorder in question by appealing to independent influences such as germs or viruses, or to other non-motivational factors. As was shown above, however, concepts of health and illness often carry moral connotations; even a simple infection such as influenza may be thought to be the result of self-neglect, and more serious illnesses are often linked to poor lifestyle choices such as smoking or over-indulgence in food or alcohol. Nevertheless, mental health is particularly prone to negative judgements, because the very definition of the problem is linked to the person’s self or behaviour. For an individual to say that they cannot work because of an infection or other
more serious physical illness is, even today, quite different from disclosing the presence, for example, of depression or psychosis. The latter illnesses almost always raise questions about the individual and their personality (including the risk of dangerous or disturbing behaviour), and this contrasts strongly with disclosures of physical illness. It is no wonder, then, that an ‘attributational’ view, which locates mental illness in the person’s biological make-up, has proved attractive to professional and lay audiences alike, even though this may only reduce rather than eliminate negative reactions.

By the same token, approaching mental health in relational terms – in terms of interpersonal and social processes – does not always find favour in professional or lay circles. Studies of the family dynamics of mental illness in the 1960s appeared only to end up ‘blaming the victim’ – in this case the families caring for seriously mentally ill individuals. Yet, psycho-social theories and the social circumstances of many of those suffering from mental health problems provide a continuing basis for sociological research and policy. As Busfield (2000) makes clear, sociology has had, and continues to have, much to contribute to the understanding of mental health by examining its social dimensions. Following the discussion in the last section, it is possible to distinguish the role of the social in the ‘creation’ or causation of mental illness, from its ‘social production’ – that is, the expression and definition of the illness and the way it unfolds in social interaction.

As Busfield states, there is a long history of social and epidemiological research on the creation or occurrence of mental illness. Whilst this has sometimes been criticized by sociologists for taking the medical definition of illness (or ‘mental disease’) as given, much of the work has challenged the individualistic orientation of psychiatric thought. In early pioneering studies in the USA, Faris and Dunham (1965 [1939]) and Hollingshead and Redlich (1958) attempted to show that mental disorder was not a random event, dependent solely on the individual’s biological characteristics, but was patterned by social circumstances (including poverty) and social class. In this way, mental health has been located as an aspect of health inequalities (Rogers and Pilgrim 2003), showing that its occurrence is significantly determined by social factors. However, debates concerning the role of factors such as ethnicity and racism in serious mental illnesses such as schizophrenia (Littlewood and Lipsedge 1997; Kelleher and Hillier 1996) vie with evidence indicating their universality across social groups. This indicates that social influences on their causation are open to doubt (Hafner and an der Heiden 1997) and require careful assessment.

One of the difficulties in explaining mental disorder is that much of it is hidden. At any one time the number of people being treated is only
a fraction of those living with undiagnosed illness in the community. If the study of mental illness concentrates on those already in contact with the services, little can be said about its origins, unless a clear account can be given of the selection process that has led some to receive treatment and some not. Moreover, social conditions may change between the onset of a disorder and making contact with services, acting as a further confounding factor. Although the US studies, mentioned above, tried to estimate this effect, large-scale epidemiological studies in the community are difficult and expensive to mount (and run the risk of creating large estimates of illness which fuel the ‘medicalization’ of whole communities, and provide new markets for the pharmaceutical companies). In Britain, one of the best-known studies of mental disorder in the community (in this case, depression) attempted to control for the possible confounding factors involved by making rigorous assessments of the circumstances surrounding the onset of illness among community-based samples (Brown and Harris 1978). This study challenged prevailing definitions of depression by showing that severe life events involving loss and threat had a major impact on the onset and development of depression, in the presence of vulnerability factors such as early loss of a mother, low socio-economic status and the lack of a confiding relationship. Subsequent work in this tradition has shown that neglect and abuse in childhood also have a significant influence on the occurrence of adult depression, indicating that genetic influences are unlikely to be a major determining factor in this disorder (Bifulco and Moran 1998).

As far as the ‘social production’ or shaping of mental health is concerned, a number of important studies, especially in the USA during the 1960s and 1970s, employed a deviancy perspective to try to explain the medicalization of disturbing and distressing behaviours in terms of illness. Perhaps the best-known study of this period is Scheff’s *Being Mentally Ill* (1999 [1967]). Scheff’s argument, essentially, revolved round two key concepts. The first of these is ‘residual deviance’, which, he argued, helps explain the wide variety of disorders and conditions which are held to make up mental illness. ‘Residual deviance’ is essentially behaviour which is found to be unacceptable, but which is not categorized in other ways, such as being regarded as criminal. This approach to mental illness draws heavily on labelling theory, in that the behaviour designated as mental illness is that which attracts the label. Behaviour so labelled in one time or place might not be so labelled in another time or place. Goffman (1963a) famously pointed to the example of praying. Being on one’s knees in a praying posture is acceptable in a designated religious building, but not on the street outside. The contexts and contingencies surrounding particular problems help explain their labelling, or otherwise. Homosexuality, once regarded as a mental disorder by psy-
Psychiatry, is not regarded as such now, having been voted out of psychiatric classifications by American and British psychiatrists in the 1970s. In such ways mental illness can be produced, or not, depending on social contingencies.

Second, Scheff argued that ‘societal reaction’ to residual deviance helps explain the career of mental health patients. Once labelled, the individual is likely to take on the characteristics of the label, thus confirming the original social response. Like Goffman (1963b), Scheff saw that identity could be powerfully influenced, and indeed spoiled, by one characteristic of the individual being generalized to their whole self. The stigma of mental illness, as a diagnosis, could have real effects, independently of any underlying disorder. Institutional ‘warehousing’ of psychiatric patients in large mental hospitals, which had come to dominate the pattern of care during the twentieth century, seems to have served only to reinforce this process. Though critics such as Gove (1974) argued that negative societal reaction was the last, rather than the first, resort of families and communities to disturbing behaviour, Scheff’s work, along with other ‘anti-psychiatry’ arguments at the time, provided a powerful challenge to social and professional attitudes towards mental illness.

In recent years, the writings of Foucault (1967, 1973) have been used to supplement and reinforce a critical view of psychiatry, medicine and social control, in ‘producing’ mental illness. For Foucault, the control of mental illness was expressed by the ‘great confinement’ in eighteenth- and nineteenth-century France, leading to the repression of ‘unreason’ and the policing of troublesome and threatening behaviour. Here the state and the medical profession were seen as treating mentally ill people as excluded from the world of reason, and consigning large numbers of them to the degrading conditions of mental hospitals. However, as Porter (2002b) has argued, such a picture is simplistic and over-generalized, especially when applied to other countries such as the USA and UK, where hospitalization of the mentally ill was on a relatively small scale until the end of the nineteenth century. Porter also shows that a number of vested interests (and safeguards) were at work in shaping responses to mental illness, though he also sees that by the Second World War many large hospitals had ‘degenerated into sites dominated by formal drills, financial stringency, and drug routines’ (p. 120), with some 150,000 inmates being in such institutions in Britain in 1950. Their numbers had dropped to some 30,000 by the 1980s (p. 211).

It is somewhat paradoxical, perhaps, that attempts to ‘de-institutionalize’ the mentally ill in the last 20 years have gone hand in hand with a renewed emphasis on the biology and genetics of mental health, as much as on its ‘relational’ character. One way in which this paradox is
explicable is, of course, to be found in the widespread use of anti-psy-
chotic, anti-depressive and anxiolytic drugs. Though based on chemical
and neurological theories of mental illness, they have effectively ‘damp-
ened down’ symptoms and made patients relatively more manageable in
the community. The pharmacological revolution in psychiatry has been
married with policies to develop widespread forms of ‘community care’.
Whether this counts as a more effective way of treating the mentally ill
and helps to reduce its ‘production’ or has led to a more tolerant view
of mental health problems is a matter of judgement rather than hard evi-
dence. The ability of people in different social contexts to tolerate and
respond positively to a range of illness states is clearly contingent on
many factors, including the degree of disruption of social interaction they
involve and the level of tolerance of families, workmates and wider com-
munities. Nevertheless, mental health continues to present particular dif-
ficulties, especially when people ‘translate disgust into the disgusting and
fears into the fearful’ (Porter 2002b: 62). The distinctions between social
responses to mental illness and physical illness raised here remain pow-
erful ones and need to be borne in mind in discussions about health.

Concluding Remark

Health can be seen as a multifaceted dimension of human life, and as a
‘reserve stock’ (Blaxter 2003, 2004) of vitality, fitness and strength
(whether psychological or physical or both) which individuals can draw
upon to pursue their goals and actions. From a sociological viewpoint
health can be seen as both ‘attribute’ and ‘relation’, simultaneously
involving biological and social factors. This suggests a *dynamic* view of
health and illness, changing across biographical and historical time. The
experience of health, both good and poor, is likely to be influenced by
the circumstances into which people are born and the contexts and
actions which prevail at different stages of life. Health and illness thus
take us to a crucial intersection of biography and history. The social pat-
terning of health which results from this intersection is the focus of the
next chapter.