RJS

The Rutgers Journal of Sociology
Mind, Body and Society
Volume I, 2011

Rutgers, The State University of New Jersey, New Brunswick

About RJS

The Rutgers Journal of Sociology: Emerging Areas in Sociological Inquiry provides a forum for graduate students and junior faculty to present well-researched and theoretically compelling review articles on an annual topic in sociology. Each volume features comprehensive commentary on emerging areas of sociological interest. These are critical evaluations of current research synthesized into cohesive articles about the state of the art in the discipline. Works that highlight the cutting edge of the field, either in terms of theoretical, methodological, or topical areas, are privileged.

Guidelines for Submissions:

We accept original reviews of relevant research. Reviews must not be under review or elsewhere published at the time of submission and should be no more than 10,000 words, including references, notes, tables, figures, acknowledgements and all cover pages. The first page should contain a title, author's affiliation, a running head and approximate word count. The second page should contain the title, an abstract of no more than 250 words and should not contain the names of the authors. Papers should be double-spaced, using Times New Roman font size 12, with 1.25" margins on all sides. For full guidelines, please see http://sociology.rutgers.edu/RJS.html.

Submissions
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EDITORS' INTRODUCTION

KATHRYN BURROWS DENA T. SMITH

We are delighted to introduce the first edition of *The Rutgers Journal of Sociology: Emerging Areas in Sociological Inquiry*. The mission of *RJS* is to provide a space for review articles on new areas in the discipline, something scholars in their formative years are likely to produce. *RJS* provides a forum for highlighting these creative, insightful, cutting-edge papers. The journal is organized around annual themes so that each edition can serve as a resource for scholars beginning work in a given topic area. This year, we are thrilled to present a collection of articles on issues surrounding Mind, Body and Society, an area with deep roots in classical sociology, which has recently re-emerged.

Our discipline has a rich tradition of connecting body and mind experiences to social structural conditions. Until the late 1800s (and again today), the mind and the body were generally considered individual, even biological, phenomena. In founding the field, Durkheim[1] showed that even suicide, seemingly the most personal of experiences, is a social phenomenon and therefore can be studied from a collective point of view. Likewise, Marx[2] described the emotional and physical experience of alienation and exploitation stemming from the system of capitalism. Weber[3], too, described bureaucracy as an institutional system that destroys creativity and alienates workers, making them feel like nothing more than cogs in a machine; under bu-

reaucratic conditions, he argued, mind and body become robotic and mechanistic.

In much the same way as the founding sociologists, Mills[4] reminds us of the intimate connection between personal experience and historical moments. For example, in the realm of mental health, one might conceptualize depression as a personal trouble stemming from unique, stressful events or disordered brain chemistry and manifesting in experiences such as sadness, sleeplessness, or fatigue. But one can also see the root of such a condition in poverty, discrimination, age, gender, and other cultural and social structural factors, which are equally, if not more, powerful explanatory factors[5]. Further, theorists such as Giddens[6] point to the lack of ontological security in modern society, which can lead to experiences that the medical profession might call depression and anxiety. Without sociological understanding, medical concepts of suffering are incapable of truly capturing the nature of suffering or of uncovering effective ways to eliminate the root causes of such pain.

The medical field has, in the last several decades, become the legitimate lens through which to view the mind (conceptualized as brain) and the body (conceptualized in a Cartesian manner as something separate from the mind). For this reason, we feel that this first edition of *RJS* serves as a valuable reminder to sociologists that the interdependent relationship between the mind, the body, and society is ours to explore; this kind of work follows a thread that emerged in classical theory and continues into contemporary research.

In reviewing the many excellent submissions for this year's edition, we were thrilled to see such innovative work in the area of mind, body, and society. We are proud to present six articles, the first two of which describe social structural influences on the mind and the body. The first paper, *Towards a Pro-Social Conception of Contemporary Tattooing: The Psychological Benefits of Body Modification,* by David Paul Strohecker, tackles the mental health literature on tattooing and considers the positive social and psychological benefits tattooing affords the individual. Our second paper, *The Role of Physicians in Regulating Access to Reproduction in the United States*, by Alicia VandeVusse, argues that

American doctors have contributed to a racialized, heteronormative vision of appropriate childbearing, and have restricted access to reproductive options in order to promote a certain family ideal.

The last four papers in the journal investigate the extent to which gender is a primary organizing force in understanding the body. *Not Just Gender: Expanding the Boundaries of Self-Salience Theory,* by Philip A. Gibson, discusses the possible implications of expanding Rutgers Professor Sarah Rosenfield's concept of "self-salience" to account for the complex relationships between mental health, race, class, gender, and self-concept. The fourth paper is Katherine Martinez's *Gendered Consumptions: Cannibalism as a Form of Patriarchal Control*. Martinez explains that cannibalism is a pathological expression of a patriarchal structure that allows men to consume, both metaphorically and literally, female and feminized bodies.

Our fifth paper, *Weight Self-Concept: Formation, Stability, and Consequences*, by Elizabeth Aura McClintock, describes how weight self-concept resembles other dimensions of the self-concept and self-esteem in terms of its coalescence in adolescence and resistance to change after that time. The final paper, *Lesbian, Gay, Bisexual, Transgender, and Queer Adolescent Dating Violence: A Review and Discussion of Research and Theory,* by Leandra M. Smollin, focuses on the intersection of race, class, gender, and sexual identity in experiences of violence and abuse in lesbian, gay, bisexual, transgender, and queer adolescent relationships Smollin shows how important and understudied these dynamics are for this population. Taken together, these six papers provide broad and fascinating insights into the work taking place at graduate programs throughout the country. Before presenting these fine papers, we are happy to offer a brief introduction to the study of mind, body and society, written by Rutgers faculty Joanna Kempner and Kristen W. Springer, who graciously agreed to explain why the topic is so important as an emerging area in sociological inquiry. We close the issue with profiles of four Rutgers graduate students who are currently doing research on topics related to the intersection of mind, body and society.

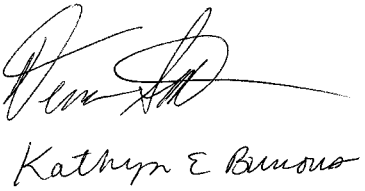
Finally, we would like to thank everyone who worked so hard to make *RJS* possible. It takes an enormous collective effort to get a journal off the ground. First and foremost, we are grateful to Jorie Hofstra, our amazing Managing Editor, and her diligent assistant, Lauren Murphy. We feel lucky to have had them managing the daily life of the journal. We are likewise indebted to Angel Butts, who designed our review process. We are thankful to have a fantastic editorial and faculty advisory board, as well as dozens of reviewers at Rutgers and beyond. To our six authors, whose papers are provocative and fascinating, we are honored to have your work in our first edition. We are thankful for our wonderful Graduate Director and Faculty Advisor, Ann Mische, whose advice and dedication to getting *RJS* off the ground have been a support we could not have managed without. We would also like to thank Allan Horwitz, Dean of Social Sciences, for his advisory and financial support. We could not have foreseen the innumerable tasks associated with starting this publication, so to Karen Cerulo, our department chair, who offered us her expertise, we are greatly appreciative. Karen also graciously allowed us to host our launch party in conjunction with a mini-conference on intersectional research here at Rutgers, thus providing a lively forum in which to celebrate this first edition. We would also like to thank Maria Malyk, Monique Porow, Alicia Raia, Sarah Al-Kabour and Kirsten Song for working so hard to make the launch party a great success.

We would like to thank the Graduate Student Association for providing most of our funding, the Graduate Union of Sociology Students (specifically Étienne Meunier) for mediating between the Graduate Student Association and the journal staff, Elizabeth Minott for her legal advice, Harvey Waterman for his continued support of the sociology program, and Jon Hansen of University Publishing, who assisted in our learning the ropes of printing a journal. Thanks are due to Chris Jackson, who provided the initial ideas for cover design, as well as to Neha Gondal who provided web support. Last but not least, great thanks go to Deborah Carr and Phaedra Daipha, our graduate advisors, for their advice and support in helping us get the initial approval to start this project, as well as over the course of the last eight months as we worked

to produce the final product. The continued success of the journal would not be possible without this amalgam of talented and supportive individuals.

We hope you enjoy this first edition of *RJS*, which we present with great enthusiasm, and we hope you will continue to follow *RJS* over what we are certain will be a long and successful tenure.

Sincere regards,



Dena T. Smith
Kathryn Burrows

NOTES

1. Durkheim, Emile. 1951. *Suicide*. New York: The Free Press.

2. Marx, Karl and Friedrich Engels. 1998 [1845]. *The German Ideology*. New York: Prometheus Books.

3. Weber, Max. 1978. *Economy and Society*. University of California Press: Berkeley.

4. Mills, C. Wright. 1959. *The Sociological Imagination*. Oxford: Oxford University Press.

5. See, for instance: Horwitz, Allan. 2002. *Creating Mental Illness*. Chicago: The University of Chicago Press.

Blazer, Dan. 2005. *The Age of Melancholy: "Major Depression" and its Social Origin*. New York: Routledge.

6. Giddens, Anthony. 1991. *Modernity and Self-Identity: Self and Society in the Late Modern Age*. Stanford: Stanford University Press.

THE SOCIOLOGICAL PROMISE OF BRIDGING MIND, BODY AND SOCIETY

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This inaugural issue of *The Rutgers Journal of Sociology*, focusing on the theme of Mind, Body, and Society, is a welcome addition to a critical, emerging area of sociological inquiry and demonstrates the importance of an *intersectional* approach to the study of mind, body, and the social environment. Engaging in a sociology of mind and body demands attention to the complexity of social life that is experienced through and shaped by social structures, physical embodiment, and emotional/cognitive processes; can draw from and use the entire range of sociological tools, including experimental designs, quantitative analyses, ethnography, qualitative interviews, and historical research; and encompasses a wide range of sub-areas in sociology, including cultural sociology, cognitive sociology, sociology of gender and sexuality, and medical sociology.

Engaging in the sociology of mind, body, and society enables sociologists to rethink perennial questions in our field. Take agency as only one example. Scholars who seriously grapple with the questions raised by cognitive studies, neuroscience, and embodiment would not mistake agency as the sole province of the mind. Instead, the sociology of mind, body, and society refocuses attention on the tangibility and embodiment of agency, as well as on the socially prescribed facilitators of, and constraints on, agency. For example, being agentic can be directly read onto the body through ornamentation (e.g., tattoos, piercing), or indirectly through physical and mental health statuses associated with power and autonomy (which positively

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affects health) or the stress and strain of responsibility (which negatively affects health).

Furthermore, agency—and the embodiment of agency—is shaped by social structures and social norms. This is true in our everyday lives. For example, mundane negotiations with our partners over physical tasks (e.g., cooking dinner, childcare, sex) are inevitably structured by the stresses incurred from economic instability, wage inequity, and gender norms. But bodies can become intensely powerful agentic spaces for challenging power structures as well. One need not look any further than recent events across the Middle East to see how agency (of those in official power and those with the power of the populace) is directly affected by the local, regional, and international milieu. A Tunisian man's self-immolation, in which he dramatically presented his will in bodily form, inspired a revolution in his country and imitative protests across the region. Egyptian protestors, emboldened by the success of the Tunisian revolution, made their will known by putting their bodies in harm's way and camping out in Tahrir Square. The agency of the protestors embedded in these contexts was experienced by mind and body—through depression, joy, triumph, pain, dismemberment, and death. In short, focusing on the intersectionality of mind, body, and society offers the possibility of a more holistic, sociologically informed analysis of agency.

Sociological approaches to the mind, body, and society can take a number of forms and approaches. We now discuss our own research to illustrate some of the ongoing work being produced by serious attention to this area.

Mind, Body, and Society: Migraine (Kempner)

In describing my work, I draw on my research on migraine to discuss the ways in which new neurobiological research has altered the cultural meanings of diseases that exist at the intersection of mind, body and society. The mind is increasingly understood and treated as an emergent feature of the brain, a development that promises to legitimate conditions that were previously understood to be mental in origin. Migraine confounds the Cartesian separation of mind and body, bringing into question what constitutes "real" versus "unreal" and threatening the

legitimacy of both the disorder and the moral and psychological integrity of the people who have it. Until recently, migraine was understood to be a psychosomatic condition, affecting neurotic men and women who worried needlessly about their privileged lives. I ask whether a new neurobiological paradigm for migraine has enabled medicine to produce a causal model for migraine that places less blame on the individual's moral character. The short answer is no. While new migraine medicine attributes the condition to a dysfunction of the brain rather than to a disordered psyche, the new "migraine brain" maintains all the same gendered and classed character flaws as the migraine personality that it replaces. Like the old model, the migraine brain is hypersensitive, demanding, and high-maintenance. The only difference is that these character flaws have been reduced from the level of the psyche to the level of the neuron.

People often hope that new neurobiological models for mental illness will help legitimate and destigmatize these conditions, in part by alleviating sufferers' sense of personal responsibility, which was endemic in psychosomatic models of disease. But this research suggests that this might not be the case. Neurobiological models risk reinventing and rearticulating the same cultural stereotypes and hierarchies that they purport to replace.

Mind, Body, and Society: Masculinity and Health (Springer)

In this description of my work, I draw from my research on masculinity ideals and health outcomes to highlight the new and exciting possibilities of incorporating direct biological measurement into sociological inquiry into mind, body, and society. My research on the intersection of mind, body, and society focuses on understanding the real, physical, health effects of the psychological internalization of gendered ideals. Specifically, I use quantitative analyses of existing datasets to explore how socially prescribed hegemonic masculinity ideals influence the health of aging men. The results indicate that the disjuncture of the male breadwinning social ideal and the lived reality of wives' higher earnings lead to poorer health for men—especially among upper-class men who have the strongest expectation of male breadwinning. Further, older men who strongly believe in socially defined

hegemonic masculinity ideals are significantly less likely to get recommended preventive health care compared to men without these strong masculinity beliefs.

The findings from this masculinity research suggest a mechanism whereby men embody the psychological/cognitive distress associated with failing to meet socially defined and expected ideals. However, this research provides only *suggestive* evidence of the pathway connecting mind, body, and society. Fortunately, recent low-cost and minimally invasive biological collection techniques provide unprecedented opportunities for directly measuring the embodiment of psychological distress and social structures, and point to one of the new and burgeoning areas of mind, body, and society. For example, physiological stress hormones such as cortisol are sensitive to acute stressors, and prior research has also demonstrated that chronic exposure to cortisol activation is harmful for health. Future research on masculinity could measure a man's cortisol response to the cognitive disconnect of having strong masculinity ideals but receiving experimentally manipulated reports of low scores on masculinity assessments. These types of experimental designs can help trace the actual mechanisms tying together the mind, body, and society.

In closing, we are delighted to briefly introduce this inaugural issue of *RJS.* The Mind, Body, and Society theme is a critical and emerging area in sociological inquiry, and the refreshing diversity of review articles in *RJS* is an exciting next step in advancing this important area of research.

Rutgers Journal of Sociology
Volume 1, 2011

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TOWARDS A PRO-SOCIAL CONCEPTION OF CONTEMPORARY TATTOOING: THE PSYCHOLOGICAL BENEFITS OF BODY MODIFICATION

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The existing social science literature on tattooing follows roughly two divergent paths. The first interpretation comes from the mental health community and paints tattooing as an outward manifestation or a predictor of future deviance. The second comes largely from anthropology and sociology and characterizes tattooing more positively as a new form of making meaning and identity formation. I show how the former interpretation is losing validity and how the latter provides a more conducive frame within which to interpret this increasingly popular social phenomenon. I then incorporate concepts from social psychology to show how tattooing may now serve as a pro-social activity rather than an anti-social action expressing social disaffection. These concepts include coping, mastery, self-efficacy, and narrative as part of the construction of the self. Finally, I question whether contemporary body modification practices are simply a form of privilege for Westerners, who have adopted these practices from non-Western others. I conclude with some suggestions for future research.

Introduction

Tattooing has become increasingly popular over the past several decades. What was once considered a deviant form of self-expression has now become a popular form of displaying one's individuality in our consumption-driven society (Atkinson 2002a; Irwin 2000; Kang and Jones 2007; Polhemus 2004; Rubin 1988; Sanders 2008; Turner 2000). Although the medical and mental health literatures bemoan the dangers of tattooing as a predictor of deviance and a source of negative sociality

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(Armstrong et al. 2002; Armstrong and McConnell 1994; Armstrong and Pace-Murphy 1997; Carroll et al. 2002; Koch 2005; Pitts 1999), recent research in the fields of sociology, anthropology, and cultural studies reveals the multiple reasons individuals become tattooed in the contemporary United States (Atkinson 2002a; DeMello 2000; Pitts 2003; Rubin 1988; Sweetman 1999; Vail 1999). Analysis of these works shows that many individuals become tattooed to face social-psychological challenges and to exert control over themselves and their lives through the modification of the body. Specifically, the study of contemporary body projects like tattooing illuminates social-psychological concepts regarding the self, including: coping, mastery, self-efficacy, and the construction of the self through life narratives.

More importantly, contemporary tattoo practices address the fluidity and malleability of the middle-class body, and reveal the changing nature of middle-class tastes with regard to "body work" (Atkinson 2002a; Shilling 1993). But these trends also raise questions about the efficaciousness of contemporary tattoo practices. Most specifically, what are the implications of semi-affluent white Westerners' adoption of the body marking practices of non-Western others?

Existing Literature on Tattooing: From Anti-Sociality to Self-Adornment

Mental Health Research: Tattoos and Deviance

One vein of research on tattooing has been undertaken by the mental health community in the form of survey data (Armstrong 1994; Armstrong et al. 2000; Armstrong et al. 2002; Armstrong and McConnell 1994; Armstrong and Pace-Murphy 1997; Carroll et al. 2002; Carroll and Anderson 2002; Koch 2005). This research concludes, generally, that tattoos and other forms of body modification serve as predictors of future deviance—a highly deprecatory view of tattooing. For mental health experts, who share the assumption that voluntary inscription of the body is an indicator of social maladjustment or self-hatred, tattoos serve as outward reflections of inner pathology.

Exemplifying this viewpoint, Stirn and Hinz (2008) have argued that there is a connection between tattoos, body piercings,

and self-injury. Their survey data was collected from 432 individuals with body modifications, who were asked questions about personal histories and views of self. The researchers sought to draw a parallel between childhood experiences, self-cutting, and current body modification practices. In short, they conclude that body modification arises out of a history of abuse and hatred for the body.

The problem with this work (and many more like it) is that it relies too heavily on survey data for its conclusions. This precludes capturing the more nuanced reasons that individuals get tattooed as well as the more diverse personalities that undergo the process. For example, survey data comes almost exclusively from college students located on the premises of university research facilities. This creates striking generational differences between one's sample and the population to which one generalizes. For this reason, one needs to supplement survey data with in-depth narratives of people who are tattooed. The tattoo community is not entirely college-aged, but much more diverse than Stirn and Hinz's data would suggest (see Atkinson 2002a, 2002b, 2004; DeMello 2000; Pitts 2003; Sanders 2008; Vail 1999).

Furthermore, what Stirn and Hinz, along with their colleagues, fail to consider is that notions of the body as static may no longer be suitable for our late-capitalist, consumption-driven society, a society predicated on the manipulation and self-fashioning of the body. As Pitts (2003:17) has argued, the body is often now treated as a "limitless frontier of exploration and invention" rather than the fixed, ontological whole that it once was. And similarly, consumer culture has shifted from disguising the body behind restrictive clothing to emphasizing the body's visible contours (Featherstone 2000; Polthemus 2004). The body has become a site of consumption and explicit self-construction (Polhemus 2004), and this new conception of the body provides a new terrain upon which identity is constructed.

To capture the nuances of this changing bodily aesthetic, we must locate our research on the ground, in the trenches of self-formation and consumer capitalism, where tattooing has made large strides in being incorporated into middle-class consumption habits. For this task we must look at the work of DeMello (2000),

Pitts (2003), Atkinson (2002a, 2004), Sanders (2008), and Vail (1999), who each offer an intimate look at the tattoo community from a vantage point of ethnographic experience.

Ethnographic Accounts: Social Science on the Ground

A second vein of interest in the practice of tattooing has developed in the fields of anthropology, sociology, and cultural studies. Specifically, these works pursue analyses of tattooing from a strictly qualitative, mostly ethnographic bent. Such work provides a much more nuanced look at the practice of contemporary tattooing than do mental health surveys. These works contain rich narrative data and capture the diversity of the body modification community more generally. Most importantly, these works capture the changing nature of the tattoo in recent decades, as it has become a site fit for middle-class consumption (Atkinson 2002).

For instance, DeMello (2000) shows how the "Tattoo Renaissance" of the 1970s (Rubin 1988) changed the face of the tattoo community in America. DeMello shows how middle-class hippies, punks and neo-tribalists appropriated tattooing—formerly a practice reserved for working-class white males—and turned it into a lucrative art form (2000). Whereas the original clientele were bikers, servicemen, carnival workers, and other working-class men, the new tattoo culture is more varied and diverse. The enthusiasts come from a variety of backgrounds and now order large, ornate, custom pieces specifically designed for themselves rather than choosing from the simple, standardized flash drawings on the walls of tattoo shops (Atkinson 2002a, 2004; DeMello 2000; Sanders 1988; Sanders 2008; Vail 1999).

There emerged a new emphasis on the artistic merit of the tattoo artists as well, as more middle-class students with art degrees began buying tattoo machines and opening up shops in well-travelled urban locales. This method of self-teaching strictly contradicted the traditional method of apprenticeship, mentoring, and experience (Atkinson 2002a; DeMello 2000; Sanders 2008). And with the increasing visibility of tattooing among celebrities (e.g., Joan Baez, Janis Joplin, Peter Fonda, Flip Wilson, and Cher), more middle-class youth began to get tattooed as a

means of accentuating their socio-political beliefs, lifestyles, and desires to be unique or different (DeMello 2000).

But such changes were not without conflict. DeMello keenly points out the class conflicts that have emerged within the tattoo community as more and more middle-class artists and clients have appropriated the art form from working-class subcultures. She draws on "highbrow" (middle-class art magazines) and "lowbrow" (biker magazines) texts to compare the discursive strategies employed by each group in the conflict over the definition of the art form. She shows how writers of each group seek to control the art form and claim authenticity for themselves. Finally, she shows how the newer, middle-class clients and artists seek to distance themselves from the traditional, working-class connotations of their art form by imbuing each of their tattoos with deep emotional meaning as well as emphasizing the rational, methodical, and well-thought decisions behind each of their tattoos (2000). This acts as a discursive strategy to counter the still-prevalent stereotypes of tattooing as impulsive, tasteless, or indicative of social deviance.

In a similar vein, Sanders' ethnographic account of the modern-day tattoo shop reveals how the social response to tattooing has been affected by its redefinition as "art" in recent decades (2008). Following Becker's model (1982), he shows how this formerly subcultural practice has been appropriated, rearticulated, and commodified as a legitimate art form by middle-class artists and consumers. This is due to many factors, including: the greater *originality* of the custom pieces provided to middle-class clients, the increased *technical skill* required to produce intricate designs, the expanded *aesthetic* purposes of tattoos for individuals, the increased *professionalization* of the field through legitimating organizations like the National Tattoo Association and sanitation laws for tattoo shops, and the *collectibility* of contemporary tattoo art from a plethora of styles and artistic traditions (Sanders 2008).

Drawing from the methodology of his mentor, Sanders, Vail continues in the tradition of ethnographic research by chronicling the views of "heavily-modified" tattoo collectors. These individuals can be distinguished from the more casual consumers of tattoos by their commitment to the art form and lifestyle, their ra-

tional approach to the acquisition of tattoos, and their planning for an entire "body suit" (1999). For these men and women, the tattooed body has become their "master status" (James 1968; Stryker and Burke 2000), and they invest considerable time and money in their tattoo collections.

Atkinson's extensive research on tattooing in Canada has done much to accelerate the study of body modification in the West (2002a, 2002b, 2004). His work (2002a), traces the development of tattooing in the West from a figurational standpoint (Elias 1978). Atkinson sees the development of tattooing in terms of social networks/webs, which he calls "figurations;" different individuals are located in various permutations of social figurations. Based on their differential placement in various figurations, individuals (and collectivities) are exposed to different habituses and forms of corporeal display (Bourdieu 1984). Individuals and collectivities thereby adopt particular forms of self-presentation as a means of articulating their identities, their socio-political views, and their placement in the social order (Atkinson 2002a).

At the crux of Atkinson's work (2002a) is the notion of the middle-class habitus (Bourdieu 1984), or the changing tastes of the middle class and their relationships to their bodies. In this regard, Atkinson shows how contemporary body politics have redefined the tattoo as a legitimate form of self-exploration, identity construction, and "body work" for middle-class consumers (Atkinson 2002a, 2004). He also connects this changing bodily aesthetic to the identity politics of the 1970s, the era of the Tattoo Renaissance, when more middle- and upper-class celebrities and rock icons became visibly tattooed. He states:

> In line with the sentiments of self-exploration, physical experimentation, and mind expansion ingrained in this era (1970s), dabbling in and with the socially avant-garde—including tattooing practices—became chic for the middle and upper classes. As countercultural icons, popular rock musicians, and cultural heroes were seen with tattoos, the young middle class started to frequent local tattoo parlors. (2002a:44)

Atkinson also traces the psychogenesis of the individual tattoo enthusiast (2002a). He shows how individuals come to acquire tattoos and how they later manage the self-identity vis-à-vis their body markings. Drawing on the existing literature and his own interview data, he delineates several motivations for the tattooed individual, including the desires to: become part of a "we" group (DeMello 2000; Elias 1978; Sanders 2008), enact ritual transformation of the self (DeMello 2000; Pitts 2003; Rubin 1988; Vale and Juno 1989), pursue self-actualization (Atkinson 2002a, 2004; Pitts 2003; Sanders 2008), and exert cultural commentary on the larger social order (Atkinson 2002a; Featherstone 2000; Hewitt 1997; Sweetman 1999; Turner 2000).

Finally, Pitts' work dissects body modification from the vantage point of post-structuralist theory. She "reject[s] the notion that there is an 'essential,' proper, ideal body." Instead, she argues that "the body, along with social laws, nature, and the self, is seen as always open to history and culture, and always negotiable and changing. Instead of one truth of the body or of ontology there are competing truths that are productions of time, place, space, geography, and culture" (Pitts 2003:28).

But rather than moral relativism, Pitts advocates a body politics informed by history and critical of power. As such, she sees the rise of tattooing and body modification amongst white Westerners as "identity tourism," where Cyberpunks, neo-tribalists, Goths, and others appropriate the cultural practices and corporeal rituals of non-Western Others (Pitts 2003). Although these individuals may be well intentioned in their desire to frame "traitorous identities" in solidarity with non-Western cultures, they nonetheless reify the very modern-primitive divide they seek to displace (Pitts 2003; Rosenblatt 1997; Turner 2000). Rather than an act of subversion, the tattooed body (and other modifications such as stretched lobes, scarifications, or brandings) represents the privilege of Westerners to name and claim the cultural Other as their own.

The ethnographic work on tattooing reviewed here captures contemporary tattoo practices more fully than does the survey research of the mental health community. Rather than looking at trends en masse, these on-the-ground accounts allow for the

emergence of inductive theories about social-psychological motivations that are not wedded to *a priori* interpretations of the tattoo. The interview data provided by Atkinson (2002a, 2002b, 2004), DeMello (2000), Sanders (2008), Vail (1999), Irwin (2003), and Pitts (2003) collectively provide a more robust understanding of the changing meaning of the tattoo for middle-class consumers.

But this literature does not adequately incorporate social-psychological concepts of the self into our understanding of contemporary tattoo practices. Though these researchers do not address the topic directly in their accounts, the interview data they provide does yield a corpus of first-hand understandings of the tattoo. From these accounts, we can infer how contemporary tattoo practices can contribute to coping, mastery, self-efficacy, and the construction of the self through life narratives. By incorporating these social-psychological concepts, we can see how the meaning of the tattoo has changed for many contemporary tattoo enthusiasts. No longer is it simply a form of social outrage as proposed by much of the mental health literature.

Psychological Benefits of Contemporary Tattooing: Coping, Mastery, Self-Efficacy, and the Construction of Self

Although popular knowledge might indicate that people get tattooed to express their disaffection with society, this is clearly an overly-simplistic portrayal of tattooed individuals. According to the social science literature, the reasons individuals tattoo their bodies include: displaying one's individuality in our postmodern, consumer society (Atkinson 2002a, 2002b, 2004; Irwin 2000; Kang and Jones 2007; Rubin 1988; Sanders 2008; Turner 2000); searching for a connection to lost spiritual forces such as nature, God, or the Goddess (DeMello 2000; Pitts 2003; Rush 2005); expressing one's affiliation with a social group, subculture, or community (Caplan 2000; DeMello 2000; Pitts 2003; Rush 2005); marking important life events or displaying love for significant others (Atkinson 2002a; DeMello 2000; Oksanen and Turtiainen 2005; Sanders 2008; Sweetman 1999); resisting social norms surrounding gender and sexuality (Braunberger 2000; DeMello 2000; Mifflin 1997; Pitts 2003; Sullivan 2002); and to a lesser extent, expressing one's disaffection with mainstream

cultural standards (Atkinson 2002a; Copes and Fortsyth 1993; Featherstone 2000; Govenar 1988; Hebdige 1988; Rubin 1988; Vale and Juno 1989).

Thus it is important that we move away from mass survey data that labels tattooing as an indicator of deviance. While there remains a minority of people who tattoo their bodies in order to foster "conspicuous outrage" (Sanders 2008), many contemporary tattoo enthusiasts use their corporeal modifications for positive, uplifting, and generally pro-social purposes. This is a result of the changing nature of tattoo clientele since the tattoo renaissance of the 1970s (Atkinson 2002a; DeMello 2000). In short, tattooing has in many ways moved from the carnival and alleyway to the shopping malls of America and it now serves as a form of expressing individuality in our late-capitalist, consumption economy (Atkinson 2002a; Kosut 2000; Polhemus 2004).

As individuals react to stressors with varying degrees of distress, they rely on their individual resources to cope with, mitigate, and alleviate the level of distress they subsequently suffer (Pearlin 1989). Conceptualizing tattooing (and body modification in general) as a coping resource, as a means of establishing mastery over the self, as an attempt at self-efficaciousness, and/or as an attempt to construct the self through a life narrative, helps elucidate the social-psychological benefits of modifying the body through tattoos. It also helps to explain some of the emerging reasons that individuals become tattooed, to mark their bodies in remembrance of important life events.

Tattooing as a Coping Resource

Consider the following hypothetical example: suppose an individual is having trouble grieving over the death of a loved one. The symbolic gesture of getting a tattoo memorializing their loved one may help them progress through the grieving process. The physical pain involved, the penetration of the skin with needles, and the subsequent bleeding, as well as the healing process that follows, may serve as a powerful ritual for the grieving individual. Overall, it appears to help the individual cope with their loss (Atkinson 2002a, 2004; Sanders 2008). Also, the memento that they take with them serves as an indelible, physical connection to the deceased.

In a similar vein, Atkinson argues that tattooing allows individuals to express emotions that would normally be displaced, subverted, and pushed away from public view (2002a; 2004). In this way, individuals can confront their fears, their worries, their hopes, and their dreams. The result is that they can avoid the potentially negative psychological costs of keeping the emotions evoked by these sorts of stressors inside them. By confronting especially negative emotions, tattooing can act as a cathartic valve that prevents more self-destructive or harmful behaviors (Atkinson 2002a, 2004). Of the 92 clients and artists Atkinson interviewed, 34% stated that their tattoos kept them from lashing out at others, engaging in physically destructive behaviors, or further repressing these emotions (and increasing the strain felt) (Atkinson 2004:129).

Pitts (2003) has also argued that tattooing serves as a means of stress management for the disenfranchised, the marginalized, and the subordinated. Her interviews with members of the LGBT community, working class tattoo enthusiasts, female tattoo collectors, and "modern primitives" reveal that each of these groups uses tattooing as a means of coping with stress. Whether it's a desire for self-affirmation, the need to overcome personal tragedy, battling with poverty, or finding voice in a hostile society, these individuals all find solace in the act of tattooing their bodies.

For instance, many of Pitts' and Atkinson's interviewees were women who had been sexually abused at one point in their lives. The tattooing ritual helped them to overcome these traumatic experiences and locate their bodies once again, as shown in this narrative:

> I can't believe I'm sitting here talking to you [about being raped]. I was out of my body for almost two years … I felt numb. I tried not to think about my body because I felt dirty, ashamed, and I wanted to crawl out of myself … I thought a tattoo might help me re-claim my body, bring it back to my control, you know … I cried the whole time I was being tattooed, all the fear, and hate, and sorrow came to the surface, and every time the needles struck me I relived the pain of the rape. I don't think any

> amount of talk, with whoever, could have forced me to get back in touch with my body like that … I consider that day my second birthday, the day I really started to move on with my life. (Atkinson 2002a:196)

Although tattooing may be conceptualized as a coping resource in the stress process (Pearlin, 1989), thereby decreasing the distress suffered by the individual, it is not without costs. Though tattooing has been documented as providing a variety of benefits for the wearers in terms of moderating stress (such as allowing them to express themselves, to overcome crises, to come out of the closet, to form a community, or to self-actualize) (Atkinson 2002a; Braunberger 2000; DeMello 2000; Mifflin 1997; Pitts 2003; Vale and Juno 1989), the deviant status of the body markings may create additional stress for the individual.

For instance, one tattooed woman recalls the great lengths to which she goes to hide her tattoos from her mother:

> My mom still doesn't know I have a tattoo … and I have four! She believes that tattoos are scummy, and warned me if I ever got one that she would wring my neck. I've always been perfect in her eyes, and I've really done whatever she wanted me to do no matter what … but I'm terrified about how she would feel if she knew I have tattoos. I have to show her someday, or she might find out by accident, but I'll wait until she's in an old-age home and she can't climb out of her bed to kill me. (Atkinson 2002a:214)

Due to the longstanding association with deviance, tattooed individuals may cut themselves off from significant sources of social support. For instance, the more visibly tattooed may become stigmatized in public settings, their occupational opportunities may be limited (Atkinson 2002a; Sanders 2008; Vail 1999), their potential pool of friends or romantic partners shrinks (DeMello 2000; Pitts 2003), and their relationships to existing family and friends may be strained or severed completely (Atkinson 2002a; DeMello 2000). Obviously, the benefits of tattooing are dependent on the individual as well as the social context in which he/

she is located. What provides advantages in coping resources for some may also provide additional stressors for others. One thing is certain: many contemporary enthusiasts approach the tattoo with strikingly different social-psychological motivations than simply a desire to create social outrage. Many enthusiasts are now approaching the tattoo as a form of coping with stress and managing the changing landscape of contemporary identity work.

Tattooing as Mastery over the Self

Many social-psychologists have shown the importance of mastery, or perceived self-control (Avison and Cariney 2003; Cohen and Wills 1985; Pearlin 1989; Rodin and Langer 1980) for the development of the self-concept. Mastery, according to Avison and Cariney, is the ability to control one's emotions or temperament in the face of environmental forces. Most significantly, they argue that mastery plays a large part in the stress-process model (Pearlin 1989), whereby environmental factors that cause distress are buffered by one's level of mastery, or the ability to control one's emotional temperament in the face of stress (Avison and Cariney 2003).

One can argue that tattooing is a form of self-control and mastery, in large part based on the narratives provided by tattoo enthusiasts who undergo the process for coping with stress or tragedy (DeMello 2000; Sanders 2008; Vail 1999), for reclaiming their bodies after abuse or sexual trauma (Atkinson 2002a; DeMello 2000; Pitts 2003), and for coping with the changes of the larger social order in late-capitalism (Featherstone 2000; Rosenblatt 1997; Sweetman 1999).

In fact, Atkinson has shown that many middle-class Canadian tattoo enthusiasts undergo tattooing as a marginally-acceptable form of coping with anti-social emotions. His interviews with over 90 tattoo clients and artists reveals that many young men and women engage in this body marking as a cathartic means of expressing their troubles, hardships, and anger/resentment. Their narratives reveal how tattooing serves a form of "tolerable deviance" that allows them to control their emotions. This is a form of mastery. Rather than taking drugs, being violent towards others, or engaging in other forms of deviant behavior, tattoo

enthusiasts channel their emotions into body markings, thereby regaining a sense of mastery (Atkinson 2002a, 2004).

Pitts has also shown the importance of tattooing for women who were victims of sexual assault or domestic violence. For the women she interviewed, tattooing provided a means of re-establishing control of their own bodies, something they had not been able to do as a result of the abuse. For other women, getting tattoos and piercings are a means of re-establishing control over parts of their bodies that they had lost (Pitts 2003).

Women also got tattooed as a means of establishing agency over their bodies in a culture that continually objectifies them (Atkinson 2002a; Braunberger 2000; DeMello 2000; Mifflin 1997; Pitts 2003). For instance, one of Pitts' interviewees provided the following rationale:

> So, the dragon was my way of claiming my body, claiming my breasts. Because I grew up having very large breasts and having men ogle me. Being 14 or 15 years old, to be walking down the street and have guys drive by and yell, 'hey baby.' It made it really difficult for me to feel comfortable in my body. So having the dragon put on my breast was a way of saying, 'this is mine.' It was an evolution of that whole process of keeping myself safe and keeping myself whole. (Pitts 2003:59)

Both tattooing and piercing, for many women, are a means of successfully coping with trauma and reaffirming their human value and self-worth (Braunberger 2000; DeMello 2000; Mifflin 1997). These findings mirror those of other scholars whose interviewees remarked on how their body markings helped them regain a sense of self after a period of crisis or loss (Atkinson 2002a, 2004; DeMello 2000; Featherstone 2000; Rosenblatt 1997; Rubin 1988; Sanders 2008; Vail 1999).

Tattooing as an Efficacious Act

Tattooing can be seen as another means of establishing control when no other recourse is available, as the body is one of the last resources available to those who feel powerless to change the world around them (Rosenblatt 1997; Scott 1990). By publicly

stating one's views, by altering one's shape or appearance, or by visibly stating one's adherence to alternative cultural standards, individuals who get tattooed feel they have more control over their lives and their destinies (Pitts 2003; Rosenblatt 1997; Sanders 2008). According to Atkinson (2002a:42), this is a result of the tattoo coming to serve as a popular billboard for "doing identity politics." With the rising popularity of tattooing among middle-class consumers since the 1970s, it has become more acceptable and normal to use one's body as a statement about one's socio-political views.

For example, Pitts has shown how many individuals in the LGBT community use body modifications like tattooing, piercing, and branding as a means of asserting their independence in a world that marginalizes them. Shawn and Matthew, a gay couple in New England, each respectively describe their body modifications, which include tattoos, stretched earlobes, and self-brandings:

> And that's one thing I love about [body modification]. It's in your face. I will be different. This is my body. I will have it my way. (Pitts 2003:105)
>
> Whenever I see these [body markings] it's a reminder of my decision to take control of that and say fuck this to the normal conventions of society. That whatever's in my future, these are coming with me. (Pitts 2003:105)

Similarly, Irwin (2003) has studied the importance of tattooing for "elite" tattoo artists and collectors. For these extremely devoted tattoo collectors who travel the world getting the most expensive and well-crafted body suits, their tattoos serve as a means of reaching celebrity status on the fringes of society. Irwin locates these individuals in a place of contradiction, as they are simultaneously praised and scorned for their full-body suits and other modifications. She argues that these individuals are able to craft deviant identities that are both positive and negative, that is, they are celebrated by many for their extreme pursuit of individuality and artistic creativity as well as shamed because of their unconventional and bold corporeal displays. Thus, for some, tattooing is a means of crafting a deviant identity that is both praised and scorned by mainstream society. They approach tat-

tooing as a means of creating a social space of reverence and fear around them.

As Irwin's work indicates, it is important to note the limits of one's agency in this regard. By altering one's appearance or enacting resistance through bodily display, an individual does not actually change the material conditions of his/her life (Atkinson 2004). Likewise, one cannot control how their symbolic representations are interpreted by others (Pitts 2003; 2000). Many tattooed individuals find themselves mistaken for gang members, Satanists, or anarchists; discriminated against in restaurants; followed while shopping; and stopped by police and authorities (Irwin 2003; Larratt 2009). This is the inherent danger of tattooing. One places oneself in alignment with the Other, and is thereby suspect in many public settings. The tattooed body becomes a body of surveillance due to its longstanding associations with deviant subcultures.

Tattoo Narratives and the Construction of the Self

Some scholars have argued that tattooing serves to help frame individual life narratives (Kosut 2000; Oksanen and Turtiainen 2005). Research has shown the importance of tattooing for constructing the life narratives of prison inmates (Belsky 1981), but these trends also emerge in the general tattooed public. For instance, Oksanen and Turtiainen (2005) have studied the narratives in tattoo magazines and found that all the individuals framed their life histories by their tattoos and their tattoos by their life histories. In this sense, the tattoos serve as "guideposts" in their life narratives (Sweetman 1999). Each tattoo reflects a particular experience or life event, as each tattoo connects to a highly personal memory, somewhat like a photo album. In this way, tattoos serve as sources of stability in an everchanging world (Gergen 2000; Gubrium and Holstein 2004; Sweetman 1999). This accounts for why so many tattooed individuals do not regret their tattoos, even after several years and changes to their self-concept and station in life (Armstrong 1994; Atkinson 2004; Sanders 2008).

Sweetman's work with "hardcore" body modifiers lends credence to this claim. His interviews suggest that tattoos may act

as a "permanent diary" that "no one can take off you" (1999:69). Sweetman argues that although many "lightly" tattooed individuals see their adornments as mere fashion accessories, those who are more committed to the body project see their tattoos as more of a personal journey marking specific periods of their lives. According to him, this is but one means of coping with the challenges of late-capitalist society. Tattoos help to root the self in a period of uncertainty and contradiction. They are something that is permanent and will not change (Featherstone 2000; Sweetman 1999; Turner 2000). As one tattoo enthusiast stated:

> By marking myself I thought I could … keep … what I felt when I was 18, 19, for the rest of my life, 'cause I'd always remember the time … Just looking at them reminds me of that time, and hopefully it will stop me from forgetting who I am, when life starts to get, you know, kick the door in a bit more. The older you get, mortgage, kids, whatever. (Sweetman 1999:69)

Similar themes emerged in work done by Oksanen and Turtiainen. One of their respondents captures the stabilizing permanence of tattoos quiet poignantly:

> Some time ago, it came to me that what I enjoy the most about tattoos is the permanence of them. I've lost both parents, people who were close to me, and I realized that things that I hold important in life are sometimes fleeting, but my tattoos are permanent … It's something that can't be taken away. (2005:124)

In this sense, contemporary tattooing plays into overarching trends of self-fashioning, self-actualization, and body work. If a conceptualization of tattooing is to be productive, it must consider tattooing as a "body project" that an individual might engage in (Pitts 2003; Shilling 1993). By inscribing images into the skin, individuals can create unique pieces of art that reflect their personal values, ideals, or experiences. Rather than lamenting this change as an indicator of deviance, social scholars have placed tattooing within the larger body of socio-historical trends of corporeal modification and as simply another means by which

individuals create selves in contemporary society. Indeed, the tattooed body can be a site of narrative identity construction.

Conclusion

Body Projects as Privilege?

Work on tattooing (and body modification in general) would benefit from incorporating social-psychological theories on coping, mastery, self-efficacy, and the construction of the self through life narratives. Through concepts like coping, mastery, and self-efficacy, we can see how individuals use tattooing as a means of establishing control over their lives. Also, by incorporating the concept of the life narrative, we can see how tattoos serve to situate the self across the life course.

It is important to locate tattooing within wider trends of corporeal modification in late-capitalist society (Atkinson 2004; Featherstone 2000; Klesse 2000; Pitts 2003; Rush 2005; Sullivan 2002; Sweetman 1999; Turner 2000). "Body projects" (Shilling 1993) like dieting and exercise are considered pro-social behaviors that signify one's commitment to the modern social order and middle-class practices of self-cultivation (Sweetman 1999). Just as practices like breast augmentation and liposuction have also become acceptable means of adapting the body to social norms of beauty (Featherstone 2000), tattoos reflect the overwhelming trends of contemporary, industrialized society and its predilection towards bodily control. In fact, such body projects have become a necessary and almost expected ritual for displaying one's mastery over the self. They are more than just corporeal manipulations, they are an indelible trait of the late-capitalist consumer. As Vail articulates in his work with tattoo collectors:

> To the collector, tattoos are not something one owns. Rather, they are a part of him or her, no less important than the color of his or her hair or skin and no more easily removed from his or her identity than his or her deepest beliefs, most profound concerns, or idiosyncratic sense of humor. (1999:270)

However, we cannot neglect the privileged place that individuals must be in for these body projects to be effective (Klesse

2000; Pitts 2003). Being able to manipulate the body in Western society almost always requires time, resources, and freedoms that certain social groups do not have. So the tattooed body, as a fluid and malleable object, is really a body of privilege (Pitts 2003). As DeMello states of contemporary tattoo enthusiasts:

> Tattooing has become for many a vision quest; an identity quest; an initiation ritual; a self-naming ritual; an act of magic; a spiritual healing; a connection to the God or Goddess, the Great Mother, or the Wild Man. For members of the tattoo community who see their tattoos as connecting them to ancient or primitive cultures, the reality of those cultures is not important. Rather it is an idealized version of primitive cultures—considered closer to nature, in harmony with the spiritual realm, egalitarian, nonrepressive—that provides the appropriate image. (DeMello 2000:176)

It would seem that Westerners who utilize the body markings of indigenous cultures are merely continuing a long history of cultural appropriation and colonialism. By removing traditional body modification practices like tattooing from their non-Western origins and imbuing them with exoticism and spirituality, Western modifiers use them in ways that serve their own particular interests rather than respecting the cultures from which these practices originated. This position, taken by many post-structuralists (Featherstone 2000; Pitts 2003; Sweetman 1999), is important to keep in mind when studying the emancipatory functions of tattooing in contemporary society. Though they may provide the illusion of freedom for the individual, tattoos play into the long-standing historical trend of Western expropriation of indigenous rituals. They may provide a feeling of mysticism or closeness to the primitive body, but they likewise play into historical tropes of the non-Western Other as closer to nature.

In this regard, Rosenblatt's analysis of the "modern primitives" movement reveals many of the contradictions in contemporary body modification practices (1997). He shows that many practitioners presume that "primitive" peoples were somehow more liberated than we are nowadays. Whether it means sexu-

ally, morally, aesthetically, or spiritually, this assumption is an outgrowth of the colonial stereotypes of the Other as more instinctual, emotional, animalistic, and somehow closer to nature (Atkinson 2004; Featherstone 2000 Pitts 2003; Rosenblatt 1997). Rosenblatt's criticism is based on the interviews contained within Vale and Juno's (1989) work with the Modern Primitives Movement as well as those found within Mains' (1984) work within the leathersexuality subculture. He states that the Modern Primitives Movement is laden with the very same biases and tensions that it seeks to rebel against (Rosenblatt 1997; Turner 2000). Indeed, even the very term "modern primitives" makes two implicit claims: First, it presumes that what Westerners do with their bodies today is somehow like what occurs in the indigenous cultures where these practices were "always done." Second, it conveys a sense that these practitioners are somehow on the cutting edge of cultural history (Rosenblatt 1997). It thereby reinforces the modernist notion of progress as well as the modern-primitive dichotomy that has long been used to rationalize colonialist expropriation (Atkinson 2004; Pitts 2003; Rosenblatt 1997; Sweetman 1999; Turner 2000).

Likewise, post-structuralists are also keen to note the limits of agency, for altering the body, as noted above, does little to change the actual conditions of one's life or the structural conditions of consumption (Atkinson 2004; Pitts 2003; Sweetman 1999). Although they can visibly change their appearance, gender-bend, attack mainstream standards of beauty, or fashion new forms of humanity, all body modifiers are subject to the scrutinizing gaze of the "generalized other" (Larratt 2009; Mead 1934).

Body modifications, like tattooing, are inherently symbols. They can serve to display one's social position in society or commitment to the tribe (Govenar 1988; Rubin 1988; Rush 2005; Turner 2000), or they can serve to express one's disaffection with mainstream society (Atkinson 2002a; Rosenblatt 1997). Although corporeal modifications that remain hidden may have powerful meanings for the bearers who interpret these symbols themselves through self-reflection (Mead 1934), one cannot control how the public audience interprets them if they become visible. Simmel would argue that all symbols require *both* a speaker and

an audience (1972). All symbols, including body markings like tattoos, mean nothing in isolation from the larger social context. One must weigh the costs and benefits of altering the bodies on "public skin" (Atkinson 2002a, 2004; Sanders 2008; Vail 1999), for the costs of stigmatization are dire in many social circles, as argued above.

Towards a Pro-Social Conception of Tattooing

A potentially strong case for a pro-social conceptualization of tattoos comes from recent research by Wade and Sharp (2010). Their interest in the "self-fulfilling prophecy" led them to interview a man named Zombie, who has his entire body tattooed to look like a rotting corpse, including his face, hands and neck. Testing the theory that people's reactions to our appearance determine how we see ourselves, or Cooley's classic theory of the looking-glass self (1968), they found that despite his grotesque appearance, people were drawn to Zombie and judged him favorably. Instead of pushing people away with his appearance, he drew them in. And as a result, he became the sociable, friendly person that strangers thought him to be. As Wade and Sharp state, "Zombie tattoos were a way for him to tell off the world, but the world didn't get the message" (2010:81).

Similarly to Irwin's work with elite tattoo collectors as "positive deviants" (2003), I propose that the case of Zombie is indicative of the changing social acceptability of tattooing. What would normally liken one to a carnival performer now draws praise and esteem from strangers. And as we move past the longstanding associations tattoos hold with deviance and we begin to see them as mundane, normal, and a generally self-expressive activity for middle-class consumers and patrons, tattoos may no longer serve to distance individuals from the larger social world. Perhaps tattoos have now become the pro-social activity that social scientists of the ethnographic bent have long been arguing. Perhaps instead of an indicator of anti-sociality, they are becoming a means of indelibly connecting individuals to the people and places that mean the most to them.

According to Kosut, this is where we are headed. She observes that America has become a tattooed nation, where you

can purchase tattooed Barbie dolls and other children's toys, where somewhere around twenty percent of the adult population is tattooed (2006), and where tattooing was proclaimed one of the top high-growth industries of the mid-90s (Vail 1999). Kosut focuses on tattoos in popular culture, by examining media, film, and television to explain why tattoos have such mass appeal in American society. For instance, the film *XXX* centers on the dangerous exploits of a heavily-tattooed man played by Vin Diesel, playing into the traditional association of tattoos as deviance but also serving to personify the practice for youth. "The message for eighteen- to thirty-year-old movie consumers was clear—*XXX*'s hero is no Roger Moore, he is composedly cool and fierce. He gets the girl, saves the world, and does it with subcultural style" (Kosut 2006:1037).

However, Kosut also questions how much longer the tattoo will be seen as deviant, as more and more clean-cut celebrities proudly display their own ink. She recalls an exchange between Diane Sawyer and Carrie Fischer on ABC's *Good Morning America.* The interviewer, Sawyer, commented on Fischer's new anklet tattoo. Fischer, in a dramatic instance of role reversal, proclaimed that her daughter did not approve of her new tattoo. As Kosut quips, "How much longer can tattoos keep their lingering status as emblems of rebellion if obviously uncool, middle-aged women chattily discuss them on a major network morning show owned by Disney?" (2006:1038). This sums up the popularization of tattooing quite nicely; perhaps it is time we begin to see the tattoo as a pro-social, almost mundane consumer behavior.

As argued above, existing research outlines some psychological benefits related to tattooing that can be articulated within the frames of coping, mastery, self-efficacy, and self-construction. But these insights must also be complemented by more sociological work focusing on the changing nature of the tattoo in the American marketplace. Social science must locate tattooing within the middle-class aesthetic towards "body work" and self-presentation. Atkinson's work does much to elucidate this trend. According to his work (2002a), the tattoo has been successfully incorporated into middle-class taste, or habitus, to use Bourdieu's terminology (1984). The tattoo is no longer reserved for

the working class, but has become a highly specialized, customized, and lucrative form of self presentation. With the changing nature of the tattoo industry since the Tattoo Renaissance of the 1970s (DeMello 2000; Rubin 1988; Sanders 2008), we now have an industry that caters largely to middle- and upper-class clientele. As Atkinson states, "In a culture that privileges individual choices and the right to assume control over one's body, tattoo styles are now much more heterogeneous and personalized than ever before" (Atkinson 2002a:48). We must see the tattoo not as something distinctly deviant, but as something that plays into middle-class notions of bodily control and self-personalization. In this sense, middle-class consumers are as much playing into traditional semiotic values of the tattoo as deviant as they are creating new meanings for the tattoo as something normal (Atkinson 2002a; Hebdige 1988; Rosenblatt 1997).

A truly cogent analysis of tattooing in the 21st century will have to address the collective movements towards body modification and self-construction through body modification (Atkinson 2002a). In this regard, social-psychological theories will need to incorporate the larger social body as part of the group process. The works of Atkinson (2002a, 2002b, 2004) and DeMello (2000) provide good starting points for this task. Atkinson's figurational approach to the development of the tattoo culture (2002a) and DeMello's historical analysis of the class antagonisms inherent within the contemporary tattoo community (2000) provide a foundation from which we can build. Rather than simply isolated individuals engaging in body modification, contemporary tattooing is a subculture of consumption (Schouten and McAlexander 1995), where individuals from a variety of backgrounds engage in processes of self-construction which change the nature of the art form and push the boundaries of how identity is constructed in the 21st century.

Scholars can then use more specialized studies of particular social groups to complement the study of the wider social processes that undergird American tattoo culture. For instance, Vail's work on heavy body-modifiers (1999), Irwin's work with elite tattoo collectors (2003), and Pitts' work with the LGBT community (2002) yield a more nuanced look at the body-modification prac-

tices of diverse subcultures within the broader tattoo community. Tattooing is not a homogenous practice, and these micro-level analyses provide an important look into distinct subgroups within the larger practice.

Finally, theorists must endeavor to integrate the works of diverse fields, such as anthropology, sociology, cultural studies, art, and history, while acknowledging the privileged place that tattooing now finds itself in. Not only is it unwise to see the tattooed body as something new and different, it is also poor science to see Western trends towards corporeal modification as something distinct from the larger history of nonwhite body modifications. As Pitts (2002) and Rosenblatt (1997) argue, the tattooing practices of affluent white Westerners play into colonial traditions of exoticizing the Other. Theorists must acknowledge the diverse traditions of non-Western peoples when analyzing the contemporary tattoo, while integrating the works of diverse fields. Only then can we achieve a level of understanding that transcends specialized distinctions of our fields and truly represents the changing nature of the tattooed body.

Author Biography

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Rutgers Journal of Sociology
Volume 1, 2011

http://sociology.rutgers.edu/RJS.html

THE ROLE OF PHYSICIANS IN REGULATING ACCESS TO REPRODUCTION IN THE UNITED STATES

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In this review, I examine how American doctors have used reproduction to further their cultural authority and maintain their professional autonomy, with the consequence that white, middle-class, heterosexual women's reproduction is facilitated and that of non-white, poor, and queer women is hindered. By exploring the intertwined histories of birthing, abortion, contraception, eugenics, sterilization, and reproductive technologies, I argue that American doctors have contributed to a racialized, heteronormative vision of appropriate childbearing by using their personal interactions with patients and their cultural authority as a profession to restrict access to reproductive options and to promote a certain family ideal.

Introduction

This article examines the literature on physicians' roles in regulating access to various arenas of reproductive choice in the United States. I focus in particular on how the actions doctors[1] have undertaken in their pursuit of professional status have often had the effect of encouraging the reproduction of certain groups, specifically middle-class heterosexual whites, while discouraging childbearing in other groups, including people of color, people with fewer resources, and gays and lesbians. In short, I argue that American doctors have contributed to a racialized, heteronormative[2] vision of appropriate childbearing by using their personal interactions with patients and their cultural authority as a profession to restrict access to reproductive options and to promote a certain family ideal.

Thus, the realm of reproduction provides a lens through which to view the efforts of physicians as both *professionals* com-

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mitted to preserving their own cultural authority and *individuals* who utilize schemas[3] of appropriate reproduction, thereby giving different meanings to the reproduction of women with different social statuses. Even as technological change has altered the bodily experience of conception, contraception, and birth, social characteristics such as race and sexual orientation have continued to have real effects on the reproductive care offered to and received by women.

This paper examines how doctors have exerted their influence in several areas crucial to reproduction, including birth, abortion, contraception, sterilization, and the eugenics movement. In addition, I examine the emerging research on physicians' gatekeeping status with regard to assisted reproductive technologies. I address these particular domains because each of them relates directly to the social process of reproduction. Moreover, historical and contemporary controversies regarding each of these topics reflect the intimate way in which individual decisions regarding childbearing are bound up with broad visions of society's future. In each of these domains, questions of what constitutes appropriate childbearing are at the forefront. Thus, this review includes literature on physicians' roles in the debates and decisions regarding reproduction in all of its various forms.

Before delving into specifics, I must note that physicians are by no means solely responsible for creating or enforcing disparities in healthcare. Significant disparities result from the current system of health insurance in the United States, whereby millions are under- or uninsured (Institute of Medicine 2009). In addition, payment structures set up by insurance companies and hospitals play a large role in incentivizing certain forms of treatment and discouraging others (McConnell 2009). There are, in short, many actors who influence healthcare delivery in the United States, and all of these actors co-construct the problem of healthcare inequality. This paper focuses only on physicians in order to highlight their unique role in enacting inequality in the care of reproduction, because doctors influence both the individual level of care provided to patients as well as the societal debates regarding the role of medicine in reproductive care.

Childbirth

Pregnancy and childbirth occupy unique positions in the catalog of medically treatable conditions. Only female-bodied people can physiologically experience these particular events, and most pregnancies and births occur without the need for acute medical intervention (Block 2007). Yet over the past two centuries, American society's orientation toward childbirth and pregnancy shifted dramatically, due in part to a campaign undertaken by certain healthcare providers (Zola 1972). Whereas at one time these experiences were viewed as normal and the care of childbearing women was the province of other women, childbirth and pregnancy have been transformed into pathological states requiring dramatic interventions in order to protect both mother and child (Conrad and Schneider 1980). Understanding how this occurred requires consideration of an intricately linked set of factors.

First, I examine the intertwined histories of the rise of obstetrician-gynecologists and the decline of midwives. Then, I describe how medical developments led to increasing demand for these services, which allowed doctors to tighten their monopoly over treatment for reproductive conditions. Thus, I trace the history of how factors combined over time to create the current situation of highly medicalized birth, that is, in the hospital, at the hands of an obstetrician, with the use of numerous medical interventions. In these histories, I demonstrate how the professionalization of physicians and the medicalization of birth excluded certain groups from attending women during childbirth, while exacerbating the inequality in the care of laboring and birthing women.

Obstetrical Men vs. Midwives

Scholars have documented how physicians worked to eliminate female competition for status as healers. Up until the mid-eighteenth century, women not only "dominated midwifery [but] in many families they provided the only available medical care" (Walsh 1977:2). As doctors made medical advances that aided in treating difficult cases and the American Medical Association lobbied for licensure regulation of the profession, physicians succeeded in raising the status of obstetrical specialists at

the expense of midwives (Bak 2005:19). To further weaken their competition, doctors frequently labeled their competitors incompetent and exploited the idea that women were destined for the domestic sphere (Borst 1995; Rooks 1997).

However, the early struggles of medicine to become a recognized profession did not immediately lead to the expulsion of women from medical practice. As licensing gained traction, a number of women succeeded in joining the profession (Walsh 1977). This was a time when the medical profession was still working to define itself, and the barriers to entry it initially erected actually aided women by providing those competent enough to pass them with the credentials to prove themselves (Walsh 1977). The social sex roles of the time held that women were inherently adept at nurturing, which meant that physicians in the nineteenth century also had to work to convince the public that medicine was indeed a profession suited to masculine aptitudes (Smith-Rosenberg 1985). By advocating the popular idea that women's nurturing nature was uniquely suited to the home sphere, doctors were able to prohibit women from joining the ranks of medical doctors for years to come. Moreover, aspiring women physicians had little recourse when informal quota systems were established by medical schools seeking to maintain society's sex roles and preserve places for male applicants (Walsh 1977:242-245).

During the 1800s, most women spent the bulk of their adult lives giving birth and raising children (Wells 1985). Thus, childbirth was one of the surest sources of income for medical professionals. Yet, there was significant debate regarding the decency of male doctors treating female patients (e.g., Parsons 1951:458). Obstetricians, more than doctors in other specialties, had to convince women to choose them over their female midwife competitors. As certain interventions were developed—forceps in the late eighteenth century and forms of anesthesia in the late nineteenth century—doctors convinced more upper-class women to use their services (Bak 2005). By enticing women with the allure of a painless birth in the hospital, doctors were able to gradually convince the upper-class clientele they catered to that their services were superior to those of midwives (Wertz and Wertz 1989:30).

Physicians succeeded in siphoning clientele from midwives despite evidence of midwives' superior outcomes. In 1914, for example, a report given to the New York Committee for the Prevention of Blindness concluded: "however bad the midwife is, we are sorry to have to admit that on the whole a patient is often better off in her hands than in the care of many of the physicians who compete with her" (quoted in Rooks 1997:27). Thus, even when midwives' outcomes were empirically superior to physicians', their effectiveness was deemphasized. The depth at which distrust of midwifery had been ingrained already is highly evident in the wording of this telling excerpt. The report specifically notes the authors' regret at having to assert midwives' better outcomes, revealing that physicians had all but succeeded in discrediting their competitors, despite physicians' own questionable outcomes.

Yet midwives were largely unable to mount a convincing response to the denigration propagated by physicians. As the nurse-midwife and epidemiologist Judith Rooks notes, "midwives were poorly situated to counter the [physician] campaign against them," as they were female, illiterate, black, immigrant, and/or poor (1997:24; see also Luker 1984; Rothman 1982). In addition, midwives were not coalescing as a profession. As doctors gained upper-class clientele, midwives became increasingly associated with (and dedicated to) their service to poor women and women of color, which further contributed to their loss of status (Rooks 1997). More recently, professionalized midwives have managed to associate themselves with the fervor for "natural" approaches to health and personal care, now serving 10% of the birthing clientele (Martin et al. 2009:16), yet they still struggle for recognition as skilled professionals and face physician opposition to their professionalization and increase in stature (Bak 2005). During the nineteenth and early twentieth centuries, however, midwives and other women interested in medical careers were not successful at overcoming the powerful separate-spheres ideology that relegated them to the domestic sphere, nor were they able to mount a significant counter to the concerted efforts of the newly professionalized physicians eager for clients (Walsh 1977).[4]

Standardization and Hospitalization of Birth

Although midwives have managed to regain a portion of the clientele of pregnant and birthing women in recent decades, they have done so largely by embracing the medical model of birth, in particular by not actively countering the physicians' claim that birth in the hospital is safer than home birth. Thus, 99% of births in the United States take place in hospitals (Block 2007), in which doctors have significantly more power and authority to guide practice than do midwives. Obstetrical training has long embraced the "pregnancy-as-disease" model (Ratcliff 2002:210), with Dr. DeLee, head of obstetrics at Northwestern University in the early 1900s, even speculating that, "…nature may have intended women, like salmon, to be 'used up in the process of reproduction'" (quoted in Rooks 1997:25). Indeed, pregnancy and childbirth are prime examples of medicalization, a "process whereby more and more of everyday life has come under medical dominion, influence and supervision" (Zola 1983:295). By defining birth as a medical procedure that requires medical care, physicians succeeded in medicalizing childbirth. Conrad cites childbirth as "perhaps the classic example" of physicians using medical surveillance as a form of social control, wherein "certain conditions or behaviors become perceived through a 'medical gaze' and physicians may legitimately lay claim to all activities concerning the condition" (1992:216). As a consequence of their conceptualization of childbirth as pathological, obstetricians have attempted to standardize childbirth, by delimiting which events can be considered safe and normal and which cannot (Bak 2005). For example, doctors have developed a standardized timetable for birth progression, known as Friedman's curve, using the average length of time for each stage of labor as a yardstick for the adequate succession of birth, with longer-than-average being defined as abnormal. This, in turn, encouraged doctors to use further interventions to speed up labor when it did not fit the predetermined timetable, regardless of whether the birthing women was in distress (Block 2007).

Additionally, various painkillers have fallen in and out of fashion at different times in the history of childbirth, beginning with "twilight sleep"—a method that involved injecting the birthing

woman with morphine, to eliminate pain, and scopolamine, to erase memory—and presently with epidurals, a technique refined during the twentieth century to cause the loss of feeling in the lower half of the body (Ratcliff 2002:212). Many pregnancy and childbirth interventions that have been widely adopted are taken up with little or no scientific testing to determine effectiveness or safety, and often these same interventions are subsequently curtailed due to findings of their detriment to birthing women or developing fetuses. Episiotomy,[5] for instance, was widely used in the 1970s and 1980s both to decrease the duration of labor and to avoid extensive vaginal tearing, but the practice has been found to actually increase the severity of tears when used routinely (Bak 2005; Block 2007). As another example, thalidomide was widely prescribed in the late 1950s as a counter to morning sickness during pregnancy. The drug was subsequently found to cause severe birth defects, and its use during pregnancy was curtailed (Brynner and Stephens 2001). Even today, routine interventions cannot be assumed to be necessarily beneficial. There are some who claim that the contemporary practice of routinely monitoring fetal heartbeat during birth results in scores of unnecessary cesarean sections (Block 2007).

While medical intervention in birth continues to escalate, outcomes are not improving at a corresponding rate. For instance, the infant mortality rate has increased in recent years (Block 2007:xv). Additionally, maternal mortality also recently increased, with one in 4,800 women dying from pregnancy complications, which places the United States forty-first in worldwide rankings of maternal mortality, tied with Belarus and just above Serbia and Montenegro (Block 2007). The disparities in outcomes between different racial groups are particularly striking. Infant mortality rates for African American infants are double those of white infants (Goldberg, Hayes, and Huntley 2004:5), and the maternal mortality rate of non-Hispanic black women is almost four times the rate of non-Hispanic white women (Hoyert 2007:15). In addition, there are vast disparities in *how* birth experiences are medicalized for different racial groups. Notably, black women giving birth for the first time have a shockingly high rate of Cesarean section: 49%, compared to 33% of white women and 27% of Hispanics (Declerq 2006:68).

The high rate of Cesarean section for black women is an illuminating instance of how complicated and interrelated factors can result in overuse of medical intervention. The variables explaining this disparity are complex, but one can reasonably posit that it is in part related to black women's lower use of midwives, their higher use of Medicaid as a source of payment for medical services, and their lower social support in the hospital room, all of which is documented by Declerq et al. (2006). I would argue that this is likely accentuated by the stereotyping that takes place among providers, as doctors may still support outmoded racial schemas that posit that black women have an easier time birthing and may harbor negative stereotypes about black women, particularly single black women, as deserving less support for their "bad choices."[7] Black women are more likely to have an obstetrician as their primary care provider than a family doctor or midwife, and Declerq et al. find that only 37% of women who had an obstetrician "felt that they had received supportive care in labor from a physician," compared to 66% who used a midwife.

Lack of social and emotional support "may be a major contributor to women's desire for, and acceptance of, medical pain relief during childbirth" (Fox and Worts 1999:338), which may in part explain higher Cesarean rates among black women who experience less medical (and often less social) support during labor. In addition, black women receive on average less prenatal care than white women, in part because they are more likely to be uninsured (AHRQ News and Notes 2007); insufficient prenatal care could leave a woman feeling unprepared for birth. Lack of insurance may also encourage doctors to over-perform Cesarean sections for financial reasons, as Medicaid reimburses $5000 more for a Cesarean section than for a vaginal birth, with an even higher reimbursement paid by most private insurance plans, despite the shorter amount of time the physician has to be available (McConnell 2009).

While the causes for the high rate of Cesarean section among black women have not yet been empirically untangled, additional evidence of doctors' negative use of racial schemas is found in their treatment of drug-addicted, pregnant black women. Doctors have been said to express "deep contempt" for these women

as they give birth (Roberts 1997:174). Patients in this situation have reported experiencing abuse and degradation from their doctors while in labor (Roberts 1997). Furthermore, studies have shown that doctors are ten times likelier to report black women to the authorities for drug use than they are white women (Roberts 1997:175). Black women are also more likely to have doctors override their wishes during the birth, for instance by requiring a Cesarean section despite a birthing woman's protests, as Roberts notes: "Just as doctors more readily breach the confidentiality of pregnant Black patients by reporting their test results, they more readily violate the autonomy of pregnant Black patients by forcing them to undergo unwanted medical procedures" (1997:176). Thus, even as obstetricians have worked to standardize birth to meet their own ends, they continue to use their own racial schemas about patients to guide their treatment of individual patients.

Thus, over time, doctors in the United States usurped pregnancy and birth from the purview of midwives, firmly establishing obstetrics and gynecology as medical specialties and, further, ensuring that births take place almost without exception in the hospital. Doctors effectively excised the social support women once had during birth, and replaced it with medical interventions ("obstetrical rituals") (Davis-Floyd 1992:63-65) that increased their relative power over their patients. The standardization of birth has not prevented providers' racial schemas from continuing to influence care of women during birth, as the differing rates of medical interventions demonstrate. Doctors, then, have managed to use reproduction to both professionalize and to further their cultural authority, while employing schemas of appropriate reproduction to guide their treatment of patients. In the next section, I detail how doctors used (and to some extent incited) political debates over abortion to further solidify their societal power during the mid-nineteenth century, much as they undertook the campaign against midwives to eliminate their female competitors.

Abortion

Between 1800 and 1973, abortion law underwent several significant legal shifts. The first of these shifts—during which abortion went from being an unregulated technique largely ignored

by the general public to an outlawed procedure allowed only with the approval of medical doctors—resulted from the concerted lobbying efforts of the newly founded American Medical Association (Wolinsky and Brune 1995). The early 1800s were a time when abortion was "essentially legal" due to lack of regulation (Flavin 2009:12). Many homeopathic and self-applied remedies for unwanted pregnancy were in circulation (including exercise, herbs, and vaginal insertions), and abortion was often treated as "obstructed menses," as there were no reliable methods to distinguish between amenorrhea and early pregnancy (Mohr 1978:15).

As abortion became more widely used in the mid-nineteenth century, particularly by "married, middle-class or upper-middle-class, native-born Protestant women to control the spacing and number of their children," regulation became a pressing public issue (Flavin 2009:12). The American Medical Association, formed in 1848, lobbied extensively against abortion soon after its inception (Smith-Rosenberg 1985). The association's efforts were motivated by two major concerns: first, to cement the professional status of physicians and eliminate their competitors, and second, to support the belief that women's duty was essentially to reproduce and care for children, which made abortion evidence of individuals' moral failing and a threat to the reproduction of society (Mohr 1978).

In the late nineteenth century, doctors were keen to secure upper-class clientele, which drove physicians to publicize their views on abortion by catering to upper-class Victorian values. In the years before the American Medical Association's major campaign against abortion, obstetricians had a particularly hard time gaining legitimacy, as Victorian mores led to heated debates over the decency of a male physician conducting any kind of vaginal exam (Smith-Rosenberg 1985:231). At the time, "irregular" physicians and "abortionists" were common, and sale of abortifacients was common (Mohr 1978:59). By lobbying the state to sanction the practice of abortion, physicians were able to undermine the practicing abortionists and move medical care toward monopolization.[8]

Physicians' efforts against abortion were not motivated solely by the desire to promote the status of doctors. Many physicians

were in fact morally opposed to abortion because they did not support the popular view of fetal life as beginning at quickening but rather grappled with the difficulty of determining when life begins (Mohr 1978). However, many anti-abortion physician activists also supported a broad worldview professing women's place in the home and as mothers, the same argument they used to exclude women from the medical profession and to delegitimize female midwives, as Mohr notes: "To many doctors the chief purpose of women was to produce children; anything that interfered with that purpose…threatened marriage, the family, and the future of society itself" (1978:169). The concern of these doctors was heightened because of the eugenic fears circulating at the time. Abortion in the mid- to late nineteenth century was most common among white, native-born, Protestant women, which fueled the concern of many physicians of the time about immigrant populations, people of color, Catholics, and the poor reproducing more quickly than middle-class, native-born, Protestant whites (Petchesky 1990). Hence, the physician campaign against abortion was "aimed…at the redomestication of married WASP [white Anglo-Saxon Protestant] women" (Petchesky 1990:78-79).

The actively organized anti-abortion physicians of this era promoted powerful images circulating at that time to gain support for their campaign against the procedure. First, doctors latched on to the "image of the willfully aborting bourgeois woman" to bolster their arguments against abortion (Smith-Rosenberg 1985:238). In other words, they played on upper-class male fears of female empowerment and the threats to the social order that such power represented in order to gain support for their campaign against abortion. These physicians positioned abortion as "part of a concerted atheistic attack upon the sanctity of the home, of Christian morality, and of the traditional role of woman as nurturing and subservient" (Smith-Rosenberg 1985:238). Secondly, toward the end of the nineteenth century, doctors succeeded in combining the vision of the upper-class woman—too self-indulgent to reproduce—with growing nationalist and xenophobic fears of immigrants. These doctors promulgated the idea of "race suicide" overtaking the powerful white bourgeois class that dominated

the United States at the time, leading to the inevitable downfall of the bourgeois order unless counteracted by the medical profession's and the state's intervention into women's bodies (Flavin 2009; Mohr 1978; Smith-Rosenberg 1985).

Despite the fact that the organized physicians argued for legal sanctions against abortion, the ultimate goal of most doctors was not to completely outlaw the treatment of unwanted pregnancy (Luker 1984; Mohr 1978). Most physicians recognized that they had plenty of patients requesting abortions, and they did not want to drive those patients into the arms of their competitors (i.e., irregulars, abortionists, and midwives). Thus, physicians developed the compromise that would become the "medical model" of abortion, in which doctors were uniquely qualified to determine when abortion is "medically" necessary (Luker 1984:31-33). On the one hand, they argued that abortion was morally wrong, as it took the life of the fetus, something that they were uniquely equipped to determine because of their scientific training. On the other hand, these doctors averred that their technical training combined with their exceptional moral stature made them the best and in fact the only actors able to discern when an abortion was warranted. Through their campaign, physicians succeeded in bringing abortion under the purview of the law, with only physician-performed abortions being recognized as legal (Luker 1984).

By shrouding the issue of abortion in the cloak of medical control, physicians' mobilization effectively kept discussion of abortion out of the public sphere for several decades (Burns 2005). Significant numbers of abortions occurred in the first half of the twentieth century at the discretion of physicians. Medical advances made abortion less frequently necessary in order to preserve the physical life of the mother, yet there was no corresponding decline in the abortion rate (Luker 1984). Widespread poverty during the Great Depression contributed to physicians' increasing willingness to take into account social conditions when deciding whether to perform therapeutic abortions (Flavin 2009:14). Thus, the medical community gradually became aware that the standards among practitioners regarding when to perform an abortion varied widely. By the mid-twentieth century, physicians'

status was firmly established, and doctors were intent to maintain their "right to make sensitive and tolerant decisions without the state looking over their shoulders" (Mohr 1978:75-76). Doctors throughout the early part of the century adopted a "medical, humanitarian frame, which…depended upon a discussion limited to legislative and professional elites" (Burns 2005:205). So long as abortion was kept out of the public eye, the consensus that allowed doctors to treat patients according to each doctor's own private judgment went unchallenged.

Physicians' professional discretion over abortion decisions meant that individual physicians' schemas related to race and class differences were particularly important in determining who received abortions and who did not. Black women had limited access to abortions. As Roberts notes, "Of all therapeutic abortions performed in New York City [in the 1960s]…over 90 percent were performed on white women" (1997:101). Black women also suffered many maternity-related deaths due to botched illegal abortions in the early twentieth century—twice as many as white women (Solinger 2005:193). Although little is known about specific interactions between doctors and their patients, one can reasonably assume that doctors were enforcing their own valuations of chastity as crucial to white women's status and irrelevant to black women's.[9] In addition, although through no fault of individual abortion providers, many women face a financial burden in paying for abortions. This is especially difficult for women with fewer financial resources. Even today, most states refuse to fund most abortions except in cases of rape, incest, or the endangerment of the life of the mother (Flavin 2009:61). Thus, even at reduced-cost clinics, poor women must pay around $400 to finance an abortion (Flavin 2009).

In 1962, the private control exercised by physicians over abortion access abruptly faced challenges, when a very public debate erupted around the case of Sherri Finkbine. Finkbine was a middle-class white woman who suspected her pregnancy had been severely impaired by prescription medication containing thalidomide (given to her during a trip to Europe). She thus attempted to obtain an abortion. Because the case involved abortion not to preserve the life of the mother, and because the situa-

tion was widely publicized, she was unable to find a doctor willing to perform an abortion in the United States (although ultimately she traveled to Europe, where she had an abortion, during which it was confirmed that the fetus was severely deformed).

As a result of Sherri Finkbine's widely publicized situation, physicians had to account publicly for the fact that there were doctors who strictly reserved the use of abortion for rare cases where the mother's physical life was endangered by her pregnancy, while others broadly interpreted the directive to apply in cases where the woman's mental health was at stake or where the fetus was likely "damaged" in some way (Luker 1984). Over time, doctors had developed a more elaborated understanding of the "disastrous consequences of abortion laws", which gradually led most physicians to favor widespread abortion legalization (Flavin 2009:15). When the issue of the fetus' "personhood" became publicly debated, many physicians actively pressed for reform of abortion laws, mainly to gain consensus and protection for themselves and their varied practices (Luker 1984:77), a desire that was largely satisfied with the Supreme Court decision legalizing abortion in 1973.

The public use of the medical framing of abortion has diminished considerably in the years since abortion was legalized (Burns 2005), and often-incompatible moral claims have since usurped the discussion. Doctors have faced increasing threats to their moral authority due to their circumscribed support of abortion, and their power has even been forcibly curtailed due to moral arguments of anti-abortionists at times, such as from 1988 to 1993 (Roberts 1997:233). During this period, doctors were subject to the "Gag Rule", which forbade clinics receiving federal funds from informing women about abortions or referring women to abortion clinics (Roberts 1997). Nonetheless, the history of physician involvement in abortion demonstrates how doctors have successfully utilized this arena of reproduction to establish their professional status and to promote their cultural and moral authority. In the next section, these themes are reflected once again, as I examine doctors' forays into debates over the legalization of birth control, the politicization of reproduction during the eugenics movement, and the use of sterilization to enforce doc-

tors' visions of appropriate reproduction. These visions connect the reproduction of society to that of individuals, intimately tying each woman's childbearing to the perceived characteristics that her potential child will bring to bear on the nation. Thus, women with "desirable" characteristics in both body and mind are perceived as reproducing to the benefit of society… and "undesirables," to its detriment.

Contraception, Sterilization, and Eugenics

This section examines the topics of contraception, sterilization, and eugenics together, not to equate these phenomena but to recognize their interrelations. I outline these overlapping histories in order to gain purchase on ways in which doctors advocated the reproduction of certain women while discouraging or obstructing that of others.[10] These domains may seem incongruent, given the different public discourses that surround them, with eugenics widely reviled and contraception frequently heralded as increasing reproductive choice. However, the historical period when eugenics was most popular in the United States overlaps substantially with the era in which activists pressed for the legalization of contraception, and these movements shared some supporters. At times, eugenic arguments were made in favor of contraception's legalization. In addition, sterilization was used involuntarily against many women as a result of eugenic arguments, although sterilization is also a form of contraception that may be freely chosen. Thus, these three reproductive domains are covered simultaneously in order to draw out the similar ways in which physicians regulated reproductive access with respect to contraception, sterilization, and eugenics.

The pseudo-science of eugenics was developed by scholars who theorized that many traits were heritable (May 1995). Therefore, if persons of "good stock" were to marry and procreate, they would produce superior children, and, likewise, if the "feeble-minded," criminals, or the insane reproduced, they would have children also bearing these "undesirable" traits (Flavin 2009:31-33). During the early 1900s, several factors combined to create a large-scale eugenics movement, among them rising concerns about immigration, a growing belief in the neces-

sity of controlling population, and the advancements of science and technology (Connelly 2008). The eugenics movement thrived on the idea that the procreation of certain people (read: white, middle-class, married, and Protestant) elevated the nation, while other groups (immigrants, lower-classes, people of color, those who were unmarried, and/or those who were less-educated) reproduced to the detriment of the society in which they lived, and many health professionals shared these views (Schoen 2005:23).

Doctors were by no means universal advocates of eugenics in the early years of the twentieth century, but eugenics was promoted as a science, and its physician supporters did much to give it the veneer of objectivity and validity (Kluchin 2009). The American Medical Association did not take an official stance on eugenics, but several of its presidents were "affiliated with the eugenics movement" in the early twentieth century (O'Reilly 2007), and many doctors received training in "racist science and medicine" during this period (Connelly 2008:271). Much as individual doctors had viewed their role in abortion as necessary to keep women in their place, they saw themselves as defending "the WASP establishment against rising immigration and proletarianization" (Petchesky 1990:79). In addition, some doctors participated in the eugenics boards that were convened during this period. These boards were "medical panels established to grant or deny doctors the right to sterilize anyone with a real or imagined physical or developmental disability" (Ordover 2003:79). Thus, many doctors were active participants in eugenicist efforts.

Scholars have debated the extent to which the birth control cause of this same period overlapped with the eugenics movement, and there is ample evidence that the fiercest advocate of birth control, Margaret Sanger, was content to use eugenicist arguments to advance her cause at certain times (e.g., Connelly 2008:63; Roberts 1997:73-76). Furthermore, birth control advocates learned early on that the support of physicians was crucial to their fight for legalization (Burns 2005). Physicians, on the whole, were in favor of contraception (and sterilization) in cases of diagnosable diseases, yet physicians as a group were slow to embrace birth control as a family planning technique, as many feared that "contraceptives, 'indiscriminately employed,' would

undermine personal morality and national strength" (Kennedy 1970:174). Yet doctors at the beginning of the twentieth century were "appalled by white middle-class women attempting to enhance their status in the domains of marriage and motherhood," viewing their attempts to control fertility as "unattractive and dangerous egotism," "self-indulgent," and "rebellious" (Solinger 2005:73). Thus, most doctors were against the legalization of contraception on the grounds that it would endanger the nation if only the "wrong" kind of people reproduced.

As eugenic arguments began to fall out of favor in the 1940s, particularly after the Nazi horrors of the Second World War, medicalization was taken up as another strategically viable frame for supporting contraception (Burns 2005:78). Margaret Sanger campaigned for years to involve physicians in the cause of birth control legalization. Finally, in 1937, doctors rallied behind the cause, in part to limit the influence of "radicals" such as Sanger (Burns 2005). In doing so, they firmly ensconced themselves as the appropriate arbiters of birth control, as they promoted themselves as "ideologically neutral" and "separate from larger moral agendas" such as those championed by feminists, socialists, and Catholics, three of the groups most involved in the birth control debate (Burns 2005:80).

When U.S. federal courts removed contraceptive information from the classification of "obscene" materials, the courts handed "power to determine what constituted legitimate use" to medical doctors (Connelly 2008:108), in part with the hope of maintaining sexual morality and middle-class social norms by keeping control of contraceptives out of the hands of women directly. Yet physicians were aware of growing demand from their patients for birth control services, and the American Medical Association provided doctors with an official seal of approval for prescribing birth control methods in doctor-approved cases in 1937 (Connelly 2008).

In addition, physicians throughout the early part of the twentieth century utilized involuntary sterilization as a method to prevent the reproduction of women they saw as "unfit," whether because of criminal activity, allegedly low intelligence, or "sexually deviant" behavior (Flavin 2009:31-33). Such practices began in state institutions, such as mental hospitals and prisons, and in

several states, laws were passed that authorized the forced sterilization of certain persons (O'Reilly 2007). However, it was "not the technology of sterilization itself that determined whether women saw the operation as repressive or liberating but the context in which the technology was embedded" (Schoen 2005:79). There were women throughout the twentieth century who attempted to undergo sterilization to prevent further pregnancies. Some of these women had trouble convincing doctors to grant their wishes, especially during the post-World War II, pronatalist period, because they belonged to groups of women whose reproduction was framed as beneficial, even vital to society (Schoen 2005). Thus, "doctors saw themselves as deciding in women's best interests, even when they acted against patients' wishes" (Schoen 2005:118), whether they were refusing to sterilize certain women or sterilizing other women against their will.

During and after World War II, public debates about welfare use among African Americans led to a growing racialization of sterilization campaigns (Roberts 1997). Similarly, physicians often took socioeconomic considerations into their decisions about whether sterilization was warranted. Precisely this set of motivations led many doctors to sterilize unwilling poor women who received welfare benefits, and even into the 1970s, scores of doctors tied medical care for poor black women to their consent to sterilization (Roberts 1997). These doctors often believed that sterilization of the poor would limit "government spending on Medicaid and welfare programs" and thought that they were promoting the financial solvency of the woman's family (Flavin 2009:17). The advent of Norplant in 1990, a contraceptive that had to be implanted and removed by a doctor, once again gave physicians considerable control over patients' reproduction. According to patients, doctors might refuse to remove the devices because they believed that "young unmarried women on Medicaid should not be having children" (Roberts 1997:132). Thus, doctors viewed themselves as uniquely able to judge who should be allowed to reproduce and who should not, just as they argued they were when it came to abortion.

Despite calls to tie receipt of welfare benefits to forced use of contraception or sterilization, the American Medical Association

largely stayed out of the controversy (Flavin 2009).[11] Throughout the history of eugenics, contraception, and sterilization, doctors' professional organizations have largely remained neutral on the major questions of morality, sexuality, and legality, even as individual doctors have acted in biased and sometimes ethically abhorrent manners. I argue that this likely stems in part from the efforts of doctors-as-a-profession to continue to present themselves as ethical actors who make decisions in their patients' best interests, since it is precisely this stance that has long accorded doctors their highly respected position and their influence in promoting their policies.[12] However, this institutionally neutral stance has in no way prevented doctors from enacting their own ideas of parental fitness for patients whose actions or characters they see as immoral, incompetent, or unfit—judgments often closely tied to race and class schemas. In the next section, I examine how doctors are exercising control over the newest forms of reproduction—the procedures, drugs, and treatments that aid fertility and expand reproductive possibilities to previously unknown bounds, collectively known as reproductive technologies.

Reproductive Testing and Technologies

As reproductive technologies have been developed and improved, physicians have successfully maintained that these procedures should be governed solely by the self-monitoring of physicians (Adamson 2005:731). Physician organizations have held that doctors' autonomy is critical to the successful treatment of patients seeking reproductive technologies (Adamson 2005). In short, doctors currently regulate access to these treatments, in a role similar to their former and current roles in regulating abortion, contraception, and sterilization.[13]

Many of the technologies being developed have raised concerns regarding the specter of a science-fiction future in which fetuses are screened for undesirable traits and aborted when they are "unfit"—a futuristic extension of extreme eugenics proposals of the early twentieth century (O'Reilly 2007). Already, new technologies such as amniocentesis[14] allow expectant mothers to have their fetuses tested for genetic irregularities. This newfound ability creates a distinctly modern dilemma:

the decision of whether to carry an "abnormal" fetus to term or to terminate the pregnancy (Rapp 1999). Oftentimes, technologies are developed without any clear sense of their moral implications.

Reproduction was a political, morally fraught issue during eugenic organizing in earlier times, and modern women—particularly white, upper-class, married women—are again facing moral claims about their reproductive decisions. However, the locus of these moral decisions has shifted. Whereas during the late nineteenth and early twentieth century eugenic debates, white upper- and middle-class women faced population-based arguments about the need for them to reproduce the "fitness" of the nation's "stock," today women who undergo amniocentesis are presented with deeply private, personal decisions regarding whether to carry an "abnormal" pregnancy to term (Rapp 1999). Although these decisions are often made in isolation and without reference to the broader population, deciding to abort a child with Down syndrome, for instance, has long-term consequences for our society's definition of normalcy and appropriate reproduction. The technologies now available contribute to the possibility that people will strive to create "designer babies." Interested parties have questioned the extent to which today's physicians are engaging in a modern form of eugenics (Duster 2003; Green 2007).

At the same time that upper-class, primarily white women face new moral dilemmas as the result of certain new fetal tests, pregnant women who use drugs experience routine invasions of their privacy and their doctor-patient confidentiality due to the results of testing undertaken during prenatal care. Despite findings that black and white women use drugs and alcohol at similar rates during pregnancy, doctors are ten times more likely to report substance use by black pregnant women than by whites (Roberts 1997:175). Indeed, in some cases, obstetricians have explicitly violated a patient's confidential disclosure of drug use in order to incriminate a mother in legal trials (Roberts 1997). Providers of reproductive technologies are clearly employing racial schemas when performing a range of prenatal tests, with significant implications for social discourses of parental fitness.

Because doctors performing reproductive procedures are not subject to much regulation surrounding patients' access to services, physicians are able to determine whom to treat:

> … the restrictions placed by physicians on the exercise of artificial insemination are determined by their own personal sense of professional responsibility. Despite the difficulty of assessing the mothering ability of a nulliparous [childless] woman, nearly every comprehensive medical treatise on artificial insemination over the years has cautioned their physician readers to take this responsibility seriously. (Wikler and Wikler 1991:13-14)

Assisted reproductive technologies have encouraged doctors to think of themselves as competent assessors of parenting ability. The determination of who might be a good mother and, by extension, what household constitutes an appropriate family for potential offspring has led physicians to refuse to treat a range of "not good mothers," including "single women, lesbians, welfare recipients, and other women" (Roberts 1997:248).

As in earlier historical periods, race plays a crucial role in how reproductive technologies are used. Providers of assisted reproductive technologies may purposely guide non-white patients away from using reproductive technologies, and they may rely on racial schemas when screening infertility patients differentially based on race (Roberts 1997:255). Thus, the advent of assisted reproductive technologies has allowed doctors once again to employ their own assessments of parental fitness, as well as economic calculations when deciding which patients to treat and how.

For lesbian couples attempting to become pregnant using reproductive technologies, constrained access to these technologies is similarly complicated. For affluent lesbians, the greatest obstacle to treatment is the institutional definition of infertility, adopted in 1993 by the World Health Organization, following a vote of the American Society for Reproductive Medicine (the professional organization for physicians specializing in reproductive medicine) (Mamo 2007:30). The definition adopted requires in-

fertility to be diagnosed only after one year of steady, unprotected, heterosexual intercourse (Mamo 2007). Without engaging in heterosexual intercourse, it seems that lesbians cannot medically qualify as infertile and, therefore, may not receive insurance benefits for treatment. This is particularly problematic for lesbians with fewer financial resources. For lesbians with means, however, reproductive technologies seem to be relatively easy to access (Mamo 2007:137), which implies that the current, consumer-based structure of infertility treatments privileges patients with money above all else (Clarke 2003:170-171). Thus, although doctors may not be able to directly affect health insurance coverage of reproductive technologies or official infertility definitions, they are able to make individual decisions regarding whom to treat. For better or worse, physicians motivated by profit may well accept patients who do not fit the traditional heterosexual family model.

Although health insurance companies play a central role in the modern structure of healthcare, their role in covering assisted reproductive technologies is minimal. This is because many insurance plans have no coverage for reproductive procedures, so an individual's insurance status matters little (Arons 2007). Accordingly, the majority of all patients undergoing fertility treatments pay out of pocket for procedures that cost up to $12,000 per round for in vitro fertilization[15], with multiple rounds of treatment often being necessary and no guarantees of success (Arons 2007). Consequently, new reproductive technologies have raised significant class implications in reproduction, particularly as more women delay childbearing to ages at which the chances of fertility problems are higher (Matthews and Hamilton 2005). In addition, as reproductive technologies fit the biomedicalized model of medicine (Clarke et al. 2003), patients are often viewed as consumers, particularly because fertility clinics often operate as free-standing, for-profit clinics (Spar 2006:49). In short, the class-based dimension of assisted reproductive technologies is particularly stark (see also Conrad and Leiter 2004).

Thus, class and insurance status may be usurping family structure and race as the crucial variables in doctors' decisions to offer or withhold fertility treatments. As demonstrated above,

abortion, sterilization, and contraception were monitored by doctors for years, with little additional regulation, and physicians repeatedly employed their own schemas regarding race and class to assess parental fitness and appropriateness of various treatments. With reproductive technologies, doctors are again able to assess patients based on characteristics they choose. Doctors may now face significant incentives to prioritize economic means over other potential variables such as race and sexual orientation when assessing patients desiring reproductive technologies. While doctors may still utilize stereotypes that position women of color, lesbians, and single women as potentially "bad" mothers, they may well privilege monetary compensation over these other issues, thereby allowing a form of access for certain individuals. As research on these technologies continues, the extent to which doctors treat lesbians—sometimes assumed to comprise an unfit household for children[16]—will provide insight into the weight doctors now give to money when assessing patients and determining treatments.

Conclusion

This article examined the collective and individual means of influence that physicians wield with reference to reproduction. I argue that, due to their broad professional autonomy, doctors are able to employ their own schemas of the deserving patient when providing treatment, which often privileges certain patients over others. By examining reproduction in such detail, I have demonstrated how physicians have regulated the access of various groups to a range of reproductive procedures, employing schemas of race, class, sexual orientation, and appropriate childbearing to determine which patients to serve and how. Doctors have repeatedly utilized tactics of professionalization, advocating for their own competency regarding control of reproduction, with efforts that have resulted in major policy shifts in abortion, contraception, sterilization, and assisted reproduction. Furthermore, doctors have successfully medicalized various procedures, notably birth and abortion, in order to maintain their position as privileged decision-makers in the realm of reproduction. Finally, doctors utilize economic calculations when assessing patients,

and they have strategically advocated for their professional autonomy in all arenas of reproductive regulation. This review of the literature has demonstrated that doctors' efforts reinforce the racialized, heteronormative vision of appropriate reproduction that preferentially supports the upper-class, white, heterosexual, nuclear family and disdains those who reproduce outside of its bounds.

Yet the changing structure of medical care, noted by Starr (1982) and Freidson (1988) and detailed by others more recently (e.g., Casalino 2004; Mechanic 2004), along with shifting discourses regarding parental fitness, may be influencing doctors' assessments in new and unexpected ways. Assisted reproduction has given physicians the ability to regulate previously unimagined instances of lesbian reproduction. As more people wait to have children until later ages, the role of physicians in regulating the provision of reproductive technologies becomes central to a growing number of people. Doctors are once again pivotal actors in a larger political debate over what constitutes a legitimate family and who should be allowed to reproduce. And reproductive technologies provide a stark example of the influence that financial means have on one's access to health care and reproduction in particular.

Going forward, researchers should examine more fully how doctors assess patients who seek reproductive treatments and should further explore how doctors' interactions with patients seeking help for reproductive issues encourage or discourage the creation of certain families—in short, how the characteristics of women's bodies and minds are continuing to influence their treatment in ways that have far-reaching effects for society. Moreover, scholars should investigate how doctors advocate for their exclusive regulation of reproductive technologies, as this provides new information on how professionalization and medicalization are maintained amid changing cultural and technological circumstances.

Acknowledgments

Thank you to Kristen Schilt, Stuart Michaels, and the anonymous reviewers for their insightful comments on earlier versions of this article.

Author Biography

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Notes

1. I use the terms "physicians" and "doctors" interchangeably to refer to medically-trained physicians.

2. Heteronormativity refers to the institutions and practices that legitimize and promote the view that heterosexuality, binary gender roles, and gender itself are "natural" and necessary (see Kitzinger 2005; Schilt and Westbrook 2009). In my paper, heteronormativity refers particularly to the notion that reproduction is natural and acceptable only when it takes place in the context of a married, heterosexual couple.

3. I use schemas to describe doctors' ideas about gender, race, class, sexual orientation, and other differences. As Blair-Loy explains, "schemas are the shared cultural models we employ to make sense of the world," which are "frameworks for viewing, filtering, understanding, and evaluating what we know as reality" (2003:5). While schemas are similar to stereotypes or prejudices, each of these words is misleading because "it implies that something is fundamentally wrong with having such concepts. But hypothesis formation is a natural and essential human activity" (Valian 1999:2). Developing schemas is not wrong, but schemas are easily misapplied and can incorporate errors that have significant effects on the treatment of individuals from a given group.

4. This resulted in much experiential knowledge of women's bodies being ignored or dismissed as irrelevant to the practice of obstetrics for many years. This was remedied to some extent with the substantial women's health movement in the 1970s and the publication of books such as Our Bodies, Ourselves (a series which only recently published a book dedicated to pregnancy and birth) (see Davis 2007 for a review of the series' efforts).

5. An episiotomy is an incision made to enlarge the vagina during childbirth.

7. I am not aware of any studies directly addressing the question of providers' racial schemas about birthing women, but there is an extensive literature exploring the effect of race on physicians' treatment recommendations, spearheaded by Schulman et al.'s study of the differential recommendations made by physicians for patients presenting with chest pain (1999).

8. There were some doctors who did not feel the need to become involved with the affairs of the AMA, nor to follow its directives. The doctors who were involved in the AMA were nevertheless the public face of doctors during this period, and thus the dissenting opinions among unconnected doctors had little impact on the abortion debate of the time.

9. This is similar to the racialized policies surrounding adoption documented by Solinger (1992).

10. Although state policies on abortion are also intimately connected with those on contraception and sterilization (Schoen 2005), I cover that topic in the previous section, as its history is particularly well researched.

11. When legislators attempted to enshrine coercive measures in law, such as financial incentives to encourage low-income women to use Norplant, the AMA held that the health risks associated with Norplant were enough for them to advocate against such a policy (Flavin 2009:135).

12. For instance, in its published history of the organization's first 150 years, the AMA notes: "The reason we are so respected by the public and patients we serve is because our physicians believe that AMA membership is: 1) A pledge that AMA members always put the interests of their patients first. 2) A promise that the AMA Code of Medical Ethics guides the AMA physician. 3) A personal statement that the AMA physician is dedicated to the good health of both patients and the medical profession" (American Medical Association 1997: v).

13. Doctors are able to make individual treatment decisions. However, prior barriers to access are insurance coverage and income.

14. Amniocentesis is a procedure in which a small amount of amniotic fluid (which surrounds the fetus in the amniotic sac) is extracted and tested for chromosomal abnormalities and fetal infections.

15. In vitro fertilization, or IVF, refers to a procedure wherein an embryo is created in a laboratory dish by combining sperm and egg.

16. For example, in 2002, Alabama's Supreme Court "denied custody to a lesbian mother, calling her sexuality 'abhorrent, immoral, detestable, a crime against nature, and a violation of the laws of nature'" (Richman 2009:53).

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Rutgers Journal of Sociology
Volume 1, 2011

http://sociology.rutgers.edu/RJS.html

NOT JUST GENDER: EXPANDING THE BOUNDARIES OF SELF-SALIENCE THEORY

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Self-salience theory has injected an alternative perspective into the discussion about gender differences in rates of internalizing disorders (such as depression and anxiety) and externalizing disorders (such as substance abuse). It has also provided a unique insight into the relationship between society and self-concept that looks beyond the effects of external social factors on the development of mental distress and disorders. In contrast to most research on social determinants of mental health disparities, self-salience theory offers an opportunity to investigate how the integration of social experience *into concepts of self* affects individual mental health outcomes. This article reviews the literature regarding self-salience and discusses its possible implications for understanding how mental health is related not only to gender through the internalization of social experience, but also to race and class. I argue for further research on self-salience theory in the arena of race, gender, and SES, and suggest the future course of such research.

Introduction

One of the most consistent findings in mental health research is that women and men have different experiences of mental illness (Rosenfield 1999; Rosenfield and Smith 2009). Women experience more internalizing disorders such as depression and anxiety, which are characterized by helplessness and blame of the self for one's problems. Men experience more externalizing disorders such as drug abuse and antisocial disorders, which are characterized by acting out in unhealthy ways in response to stress. Although this difference is apparent across the literature on gender and mental health, there is no consensus regarding why this difference exists, and sociologists have not adequately

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addressed the ways in which the internalization of social structures into individual perceptions and roles plays into the development of internalizing and externalizing mental disorders. I review the literature showing that gender differences in mental illness can be explained in large part by differing perceptions of self. I do so within the framework of Rosenfield's (1999) self-salience theory. I then argue for the utility of self-salience theory in explaining interactions between gender, race, and class and their impact on mental health.

Self-salience refers to the way in which individuals conceive of their own and others' importance, with those high in self-salience privileging themselves more, and those low in self-salience privileging others more (Rosenfield, Lennon, and White 2005). The main thrust of self-salience theory is that there are differences between individuals in the extent to which their identity, worth, and well-being is tied to other people. The development of this theory has thus far focused largely on the idea that women are less self-salient than men, meaning that women are more likely to seek self-fulfillment by tending to the needs of others, whereas men are more likely to do so by focusing on their own needs. While self-salience has been researched in terms of its implications for women's and men's experiences of mental health, the concept is fairly new and has not been thoroughly extended to social dimensions beyond gender. I discuss the utility of Rosenfield's unique theoretical contribution for studying race and class differences in mental health and offer a potential model for future research on the impact of gender, race, and class on mental health.

Internalizing and Externalizing Mental Disorders

Self-salience theory was originally developed in order to explain why the likelihood of experiencing an internalizing or externalizing disorder differs between women and men (Rosenfield 1999). Internalizing disorders are those in which an individual attributes problems to him or herself and suffers from unpleasant emotions (Menaghan 2009; Rosenfield 1999). Depression and anxiety are classic examples of internalizing disorders. In both of these disorders, individuals believe they are to blame for their problems and feel helpless to change their circumstances to im-

prove their situation. Externalizing disorders, on the other hand, are expressed in outward behavior such as substance abuse or aggressive behavior towards others (Menaghan 2009; Rosenfield 1999). The primary distinction between these and internalizing disorders is that individuals with externalizing disorders respond to difficult feelings by seeking to alter circumstances outside of themselves. Rather than feel helpless to change their situation, the individual reactively seeks to change their circumstances, albeit in patently destructive ways.

As mentioned earlier, women more frequently experience internalizing disorders, such as mood disorders, while men more frequently experience externalizing disorders, such as substance abuse disorders (Aneshensel 2005; Rosenfield, Vertefuille, and McAlpine 2000). Some researchers have attempted to explain these differences in terms of the acceptability of expressing emotions, as it is traditionally more acceptable for women to do so, but this explanation fails to account for the full spectrum of variation between men and women in mental health, especially considering that a variety of social factors may influence emotional expression (Lively 2008; Ross and Mirowsky 1995). In the case of both men and women, social causes related to an increase in the risk of developing a mental disorder include traumatic life events, stress in relationships, and differing levels of social support (Cockerham 2007).

However, it is insufficient to consider external social stressors alone when considering mental health, because the ways in which individuals respond to similar events are influenced by internalized social beliefs and roles. Payne (2006) points out that women are at greatest risk for episodes of depression during their childrearing years, possibly due to the increased stress involved in the responsibilities of parenthood. This explains why parents would be at greater risk of developing depression, but it does not explain why women are at greater risk than men. Areas of the United States with more gender equality seem to show a smaller disparity between men and women regarding depression, which would suggest that it is not simply the stress of being a mother that increases a woman's chances of becoming depressed, but rather the kind of gender role women are socialized to embody

that increases her risk of depression (Chen et al. 2005). Parenthood therefore provides an example of a seemingly external social cause that actually works interactively with internalized social roles and beliefs to influence mental health.

Outward social behavior is shaped largely by the incorporation of social roles into the individual sense of self. Further, the behaviors available to the individual influence the manifestation of these social roles in healthy or unhealthy ways. Courtenay (2000) suggests that men's and women's health behaviors are determined to a large extent by the social construction of masculinity and femininity. In the case of men, especially younger men, masculinity tends to be oriented towards riskier behavior, which would explain to some extent why men would be more likely than women to develop externalizing disorders such as substance abuse. Courtenay explains that masculinity must be demonstrated in every social situation in which an individual man finds himself, particularly when other men are present. This means that men are likely socialized to engage in risky behaviors. Repeated risk-taking behavior in different settings fulfills the continuous need for men to reinforce their masculinity. Although this research provides a framework for explaining how externalizing behaviors could be a result of expressing masculinity, it does not explain how such behaviors become integrated into an individual male's personality to such a point that a disorder develops, nor does it explain why some men develop full-fledged externalizing disorders while others do not.

In order to better explain differences between men and women in terms of externalizing and internalizing disorders, it is necessary to look at differences in the way the self has been historically constructed for the two genders. A major development in modern history has been the emergence of difference between the private and the public spheres (Rosenfield 1999; Rosenfield and Smith 2009). While the home was once the center of both public and private life, with livelihoods being earned in the family trade, the modern age brought about a separation of economic productivity from the family environment. At the same time, emotions were relegated to the atmosphere of the private life, with reason being the dominant trait upon which success in

the public sphere rested. What resulted was an atmosphere in which reason was considered to be a valued trait for productivity in the public sphere of business, and emotion was something appropriate only for the maintenance of relationships within the private, family dominated sphere.

This split has important implications for gender relations in modern society. Whereas women were once looked at as being simply subordinate to men, the public-private split has meant that the differences between women and men have become more qualitative in nature (Rosenfield 1999; Rosenfield and Smith 2009). Men, associated with the public sphere of business, are expected to be rational beings characterized by assertive and competitive behavior. Women, associated with the private sphere of home, are expected to be more emotional and thus more concerned with the nurturing of the family unit and sensitivity to the needs of others. These differences in personality expectations of men and women form the basis of self-salience theory.

It should be noted that the roles of men and women have become less rigid in recent years, with women's participation in the workplace growing dramatically during the twentieth century and men participating more in domestic work (Padavic and Reskin 2002). The arrangement is still far from equal, however, with women still spending more time, on average, than men do on domestic tasks. Traditional gender roles for work and domestic life continue to influence the development of internalizing and externalizing problems through the generation of gendered selves.

Self-Salience Theory

Rosenfield (1999) posits that the qualitative differences in expectations for men and women generate very different concepts of self. Self-salience theory centers on the basic idea that people compare themselves and their needs to the worth and needs of other people differently, and that these differences tend to align with social categories such as gender (Rosenfield and Smith 2009). For men, their culturally-defined value as reasoning beings who move the public sphere forward generates a self-concept in which they are important to the functioning of the world and are needed by other people more than they need

other people. In contrast, women form self-concepts in which they are dependent on others, not in control of their world, and responsible for serving others.

Self-salience theory builds on this difference to present a model of self-concept that operates on three dimensions (Rosenfield, Lennon, and White 2005). First, self-salience theory proposes that there are differences by gender in how individuals evaluate their self-worth. According to the model, men tend to consider themselves to have high worth on both counts, while women tend to believe they are less valuable. Second, self-salience posits that there are measurable differences between individuals in terms of how they define boundaries between themselves and others. Women are theorized to have less rigid boundaries between themselves and others and to consider the needs of others to be within the bounds of their own needs. Men, on the other hand, have more rigid boundaries between themselves and others, and thus see their own needs as being completely separate from the needs of others. This means that women are more likely to be sensitive to the needs of others and to derive their own value from seeing that those needs are met, while men tend to derive satisfaction from having their own needs met regardless of the needs of others. Third, self-salience posits that there are differences in how individuals rank their needs and wants in relation to others'. Women rank their needs and wants lower than those of others and put their own interests aside for other people, while men rank their own needs as the most important priority, with others' needs being secondary.

Using these three dimensions, it is possible to describe two extremes of self-salience. Individuals with the highest self-salience would be expected to have a high perception of their self-worth, rigid boundaries between themselves and others, and low concern for others' needs. Conversely, those with low self-salience would be expected to have a low perception of their self-worth, porous boundaries between themselves and others, and a high concern for others' needs.

Self-salience theory does *not* suggest that all people fall into one of these two extremes. Rather, healthy functioning should exist in between the extremes of each component. Thus, a men-

tally healthy person would exhibit balance in the way they perceive their own worth in relation to others, the way they maintain boundaries between self and other, and the way they rank their own needs as being equivalent to the needs of others. This theory suggests that differences in self-salience between men and women might explain why there are such pronounced differences in the occurrence of externalizing and internalizing disorders between them, with low-self-salience (feminine) being associated with internalizing disorders and high self-salience (masculine) being associated with externalizing disorders.

The Relationship between Self-Salience and Mental Disorder

To establish the relationship between self-salience and mental disorder, it is necessary to discuss the mechanisms by which self-salience influences mental health. This section thus focuses on the ways in which low self-salience predisposes individuals to experience internalizing disorders, and high self-salience predisposes individuals to experience externalizing disorders.

Rosenfield (1999) suggests that a low evaluation of one's self compared to others allows one to take responsibility for the well being of others, but hinders the individual from taking responsibility for their own well being. In other words, the individual feels as if they can take care of others, but is either unable or unwilling to take care of their own needs. This orientation leads to feeling worthless compared to others as well as feeling responsible for others' problems (Rosenfield, Lennon, and White 2005). Finally, when prioritizing the needs of others above their own needs, the individual may feel guilty about the mere existence of their own needs. This combination of self-worthlessness, internalization of others' problems, and devaluation of one's own needs increases one's risk of poor mental health in the form of depression, which is defined by feelings of worthlessness and helplessness, as well as anxiety, which is characterized by an inability to take action to relieve one's own stress. While low self-salience may thus cause problems for the individual, it can also serve a protective role by preventing acting out against others in destructive ways.

In contrast, high self-salience disposes an individual to blame others for their problems, as others are only a hindrance to the

fulfillment of one's own needs (Rosenfield 1999). Because the needs of others are devalued, others are seen as separate from one's self, and the individual feels they are worth more than others, they feel entitled to violate the rights of those they deem less important (Rosenfield, Lennon, and White 2005). Externalizing problems are the outcome of blaming others for one's own problems; high self-salience also allows the individual to avoid taking responsibility for self-destructive behaviors such as substance abuse. In other words, an individual with high self-salience not only fails to respect the rights of others, but is incapable of identifying the factors in their own behavior that contribute to their problems. While problematic, being highly self-salient can also protect the individual from internalizing disorders by preventing self-blame for social stressors.

Race, Mental Health, and Self-Salience

While self-salience theory originally described only gender differences in how the self-concept is generated, I argue that other social factors exert influence on both self-salience and mental health. Factors such as race play an important role in the development of social identities, and thus may have an impact on self-salience as well. This is evidenced by racial differences in self-salience and mental health, but more research is needed to confirm the existence and nature of these differences (Rosenfield et al. 2006). I argue that such research may provide important insight into the unclear relationship between race and mental health.

White Americans seem to demonstrate the highest general levels of mental disorder. Breslau et al. (2005) tested data from the National Comorbidity Survey (NCS) to investigate differences in lifetime prevalence of mental disorders as well as persistence of disorders across racial categories. They found that African Americans were at a significantly lower risk over the lifespan for both internalizing and externalizing disorders, and that Hispanic Americans had a significantly lower lifetime risk of developing a substance abuse disorder. However, both groups were more likely than white Americans to have a persistent mental disorder: that is, one lasting longer than one year. In a second study,

Breslau et al. (2006) found that the decreased likelihood to develop a mental disorder among African Americans and Hispanic Americans was concentrated at lower education levels. Breslau et al. suggest that something about the socialization experience of minority groups at lower levels of education or SES serves a protective role against social stressors that are normally linked to the development of mental distress and disorder.

Furthermore, African Americans generally have higher self-esteem as well as higher levels of self-worth than whites, and these factors serve a protective role against internalizing disorders such as depression (Hughes and Demo 1989; Twenge and Crocker 2002). This suggests that there is generally higher self-salience among African Americans, and thus, patterns of self-salience observed in studies which account only for gender are not generalizable to other races. Rather, race plays a crucial role in the development of the self-concept, including self-salience.

While some evidence points toward lower rates of mental disorders among African Americans, this finding is far from conclusive, especially when comparing these rates to those of other minority groups. For Hispanic Americans in particular, there is at least some evidence to suggest that their social experience is at least as isolated from the population as the experience of African Americans. Golding, Potts, and Aneshensel (1991) found that while Hispanic Americans did not experience significantly different life events from their white counterparts, they did report significantly greater daily stress. These researchers suggested that the experience of living in a minority culture largely segregated from and ostracized by the majority might account for this disparity. Therefore, while the experience of African Americans and Hispanic Americans may be qualitatively different, the effects of marginalization from mainstream society would yield similar mental health outcomes.

Other research suggests that the experiences of minority groups might lead to the development of self-identities geared toward coping with this stress. A study using data from the National Longitudinal Study of Adolescent Health explored the paradoxical relationship between race and mental health by plotting depression symptoms across adolescence and young adulthood for white, African American, Hispanic American, and Asian Amer-

ican individuals and analyzing them using a structural equation model (Adkins et al. 2009). When controlling for the effects of other social factors, the researchers found that all minorities displayed more depression symptoms earlier in adolescence than their white counterparts, but that these differences decreased with age. The researchers further pointed out that when not controlling for other social factors, the differences were larger between whites and minorities (excluding Asian Americans) across all measured ages. This suggests that much of the difference observed between minorities and whites with regard to internalizing disorders such as depression may be due to stressful social circumstances intrinsic to minority group membership. The decrease in differences that occurs with age suggests that there may be a change in the way members of minority groups respond to social factors in their lives as they age. Self-salience theory can fill in the gaps in the current understanding of mental health disparities by demonstrating how self-concepts develop to protect marginalized individuals from social stressors.

There are thus strong reasons to believe that self-salience plays a key role in the mental health differences observed not only between men and women, but between races as well. The literature on such a relationship is currently thin, but it does suggest that the differences in self-salience between men and women are less clear-cut when considering race. Brown et al. (1999) explain that while white women consistently demonstrate greater occurrences of internalizing disorders and white men demonstrate higher levels of externalizing disorders, African American women demonstrate lower levels of internalizing disorders similar to those of men in general. Men still exhibit greater levels of externalizing disorders across the board, but the greatest gender difference is between white men and white women. Rosenfield, Phillips, and White (2006) found that this pattern could be partially accounted for by self-salience. When controlling for self-salience, the joint effects of race and gender on externalizing and internalizing mental disorders were diminished. The interaction effect of race and gender on internalizing distress in particular became insignificant when accounting for self-salience differences. This suggests a strong case for the inclusion of self-salience

theory in the larger discussion of mental health differences beyond the realm of gender.

Though the literature discussing race and self-salience as connected concepts is limited to one article, its contribution serves as a model for expanding self-salience theory beyond gender. Rosenfield, Phillips, and White (2006) measured not only self-salience differences across racial and gender categories, but also tested self-salience as a factor alongside gender and race to predict mental health outcomes. Their results showed not only that African American men and women had more similar self-salience orientations than white men and women, but also that these similarities were related to smaller differences in rates of internalizing disorders between African American men and women. Future studies involving self-salience theory would do well to expand this methodology across a larger number of demographic categories in order to develop a better picture of the place of self-salience in mental health research.

The relationship between racial marginalization and mental health is far from fully understood, particularly with regard to how this relationship develops and changes throughout the life course (Turner and Avison 2003; Williams, Neighbors, and Jackson 2003). Self-salience theory can contribute here by providing a framework within which we can more fully understand differences between races across the life course. As individuals develop different self-salience orientations, their risks of developing internalizing and externalizing disorders should change. Members of racial minority groups, particularly minority males, develop more self-salient orientations, and they might become less at risk for internalizing disorders and more at risk for externalizing disorders than external social factors alone would be able to explain. Unfortunately, the research on self-salience in relation to race is scarce at the time of this review, and what there is focuses on differences between whites and African Americans rather than within minority groups. Further research utilizing a broader spectrum of racial representation and measures specific to self-salience analysis is needed in order to develop a working understanding of how self-salience contributes to racial disparities in mental health.

Class, Mental Health, and Self-Salience

Social class plays an important role in the likelihood of experiencing mental health disorders. This section demonstrates that both externalizing and internalizing disorders are more common for individuals with lower socio-economic status. I explore the research dealing with the moderating role of gender in the relationship between class and mental illness in order to develop some ideas regarding how self-salience theory can be used to understand the impact of social class on mental health disorders.

Research suggests that lower socioeconomic status (SES) is associated with higher levels of general psychological distress (Mulatu and Schooler 2002). Lower SES is also associated with poor physical health, which also leads to greater levels of psychological distress. These findings suggest that, regardless of the role of self-salience, the diminished resources associated with low SES will be associated with greater likelihood of experiencing mental illness.

Gilman et al. (2002) found that regardless of current SES, coming from a low SES background was associated with higher levels of depression than coming from a high SES background. This suggests that there are factors other than the lack of material resources that contribute to mental disorders in low SES individuals; these factors may include the social roles and identities associated with growing up in a low SES environment. In addition, the difference between men's and women's likelihood of experiencing depression was greater for those who came from a low SES background. This suggests that there may be a gender effect that is greater for low SES women than men. In terms of self-salience theory, this may suggest that low SES is associated with a lower self-salience orientation overall. This effect may be mitigated for men by their socialization to higher self-salience but exacerbated for women by their socialization to lower self-salience. I suggest that future research investigate differences in self-salience between men and women across SES to determine whether or not such an interaction exists.

While there is no current research focusing on class and self-salience, there is evidence that class and gender have a joint relationship with mental disorder. Griffin et al. (2003) found that

control at home and at work was associated with the occurrence of depression. Their findings showed that women who had a low level of control at home and were also in lower grade jobs had the highest levels of anxiety and depression, and that men in middle to high level jobs were at risk for anxiety and depression if they had a low level of control over home activities. The researchers suggested that men were at greater risk of anxiety and depression because their social position was undercut by their level of control over decisions at home, while women who were in lower positions both at home and work felt that they had no control over their lives. This is consistent with the predictions of self-salience theory regarding internalizing disorders, as part of the explanation for women's incidence of internalizing disorders is that they feel powerless to control their lives, which is in line with low self-salience. Likewise, men who perceive themselves as having no authority at home might be expected to show lower degrees of self-salience compared to other men, increasing their risk of an internalizing disorder. Unfortunately, while this study provides a framework for studying the relationship between class and gender regarding mental health, it did not study externalizing disorders. Future research is necessary in this area.

While occupational control and SES background are both good indicators of class, the role of education, particularly with regard to mental health, cannot be ignored. Education is considered to be a key determinant of adult occupational status and income and is therefore a crucial component of SES. Miech and Shanahan's (2000) study of educational attainment, age, and depression used cross-sectional data from participants aged 18 to 90 to determine whether or not educational attainment affected the development of depression throughout the life course. This research found that the number of depressive symptoms was significantly lower for adults with greater levels of education, particularly between those with ten years of education and sixteen years of education. These differences increased with age, suggesting that greater levels of education served to protect individuals from depression *particularly* in older age, a period of life in which depression rates typically increase across all groups. The authors suggest that their results are at least partially explained

by the link between higher education and lower exposure to stress, particularly with regard to physical health.

I propose an alternative explanation grounded in self-salience theory. Rosenfield and Smith (2009) point out that occupational roles offering both autonomy and opportunities to develop relationships with others offer the best chances for good mental health. The occupational opportunities afforded to those with higher levels of education should therefore promote a healthy self-salience orientation: one that allows for balancing one's own needs and worth with others'. While it may seem reasonable that the better mental health associated with higher levels of education is due to lower exposure to stress, self-salience theory gives researchers a tool to explore the reality of this relationship by suggesting that education also gives people the opportunity to develop healthy behaviors and perspectives towards themselves and others.

Other research shows that higher SES mitigates stress, and posits that it is both exposure to stress and the lack of mechanisms to cope with stress that account for class differences in both internalizing and externalizing disorders (Aneshensel 2009; Thoits 2010). The stress of living in impoverished conditions combined with the stress of working in occupations with a low level of control is believed to contribute to higher rates of internalizing disorders such as depression, and Aneshensel (2009) suggests that the mental distress created by these conditions further contributes to stress. Aneshensel proposes that the external social structures in which low SES individuals are situated are mainly to blame for the higher levels of mental distress in the form of both internalizing and externalizing disorders.

The association between external social structures and the higher prevalence of externalizing and internalizing disorders is well supported, but I suggest supplementing this top-down perspective with the perspective proposed by self-salience theory. Factors such as access to social support and personal mastery impact the likelihood of developing mental distress; those who are poor in such resources experience greater mental distress, and greater mental distress exacerbates the effects of stressors (Aneshensel 2009; Thoits 2010). The lack of social support seems

to be a major contributor to distress for low SES individuals, but I suggest further that the experience of ineffective social support could contribute to the development of a highly self-salient social identity. As individuals from low SES backgrounds learn that social support can do little to effectively mediate the stress they experience daily, they likely prioritize their own needs over others', as their experience would show that helping others is rarely reciprocated in a way that meets their own needs.

On the other hand, if individuals experience low personal mastery—a feeling of inability to influence their life chances—then it is reasonable to believe they would develop a diminished sense of their own worth. Research has established the role of personal mastery in the development and proliferation of distress, but it has predominantly been described in terms of social factors external to the individual (Aneshensel 2009). Taking into consideration the self-salience perspective, however, it makes sense that the experience of low personal mastery could become integrated into the individual's ranking of their self-worth as compared to the worth of others.

As discussed earlier, self-salience theory suggests that there are three factors which determine an individual's self-salience; ranking of self-worth against the worth of others, ranking of own needs versus the needs of others, and sense of boundaries between self and other. These three factors are considered to co-vary according to the salience of the self or others for an individual, but in the case of class there is the potential for conflicting orientations regarding the self and others. Previous research has demonstrated the lack of both effective social support and a sense of personal mastery, along with greater prevalence rates of both externalizing and internalizing disorders, among lower SES individuals (Thoits 2010). It is possible that a conflict between the prioritization of one's own needs and perceived inadequacy to meet those needs increases the general stress of low SES individuals as well as the risk of both internalizing and externalizing disorders. Such a predicament might help clarify the heightened prevalence of both types of disorders in the low SES population.

Toward a Model of Self-Salience for Race, Class, and Gender

There is no research that currently evaluates the implications of self-salience theory for mental health considering gender, race, and class simultaneously. Using the established findings on the relationship between self-salience, gender, and race, and incorporating general findings regarding class and its interactions with gender and race, it is possible to propose a model of these interactions for use in future research. Such a model would help develop a more complete self-salience theory that is applicable beyond the borders of gender and will be useful in describing disparities in mental health across a variety of social categories.

Research on the relationship between gender and mental health suggests that self-salience theory may serve as an effective model for describing gender differences in internalizing and externalizing disorders. However, the limited research on race and self-salience suggests that the original model may be limited to white male and female social roles. The finding that African American women had the most balanced self-salience orientations of all groups suggests that race plays a key role in determining self-salience orientation. An updated self-salience model might therefore posit that self-salience orientation is related to culture-contextual gender norms, as more recent self-salience research suggests (Rosenfield, Phillips, and White 2006). Thus, in cultural contexts where women are expected to be more resilient and self-sufficient, it would be expected that self-salience orientations, and thus, occurrences of internalizing disorders, would be more consistent between men and women. Externalizing disorders might still be more common in men, as the literature suggests that even when women are more balanced in their self-salience socialization, men are still oriented toward higher self-salience.

Self-salience theory could also offer a unifying framework to make sense of class-linked patterns of mental disorder. Given the finding that gender differences in depression were exacerbated for individuals from low SES backgrounds, and the tendency toward more depression for all individuals from low SES, it seems reasonable that low SES would be associated with lower over-

all self-salience, and that low SES women would have the lowest overall self-salience as well as the most depression of all groups.

However, the findings also suggest that SES may not have a clear-cut relationship with self-salience. While previous research demonstrates low levels of social support among lower SES individuals, which could lead to higher self-salience, it also suggests lower self-evaluations of mastery and worth. Such findings point towards the possible existence of dualistic self-salience orientations, where individuals simultaneously devalue the needs of others and their own ranking in relation to others. The resulting overall self-salience orientation would appear to be balanced even though the individual factors were oriented to opposite extremes. It may therefore be necessary to consider the possibility that the three factors can develop in opposite directions for individuals from different social backgrounds. Having disparate orientations on the composite factors of self-salience may have important implications for mental health, such as better predicting risks of developing internalizing and externalizing problems simultaneously.

Study of the combined effects of gender, race, and class thus requires a modified use of self-salience theory. Previous research indicates a clear pattern of self-salience disparity between white men and women, but the results when race and SES are considered are not as clear. While African American women were found to have a balanced self-salience orientation, the results for African American men leave much to be explored. I would also suggest that the lack of research on self-salience involving other races besides white Americans and African Americans needs to be addressed in future studies involving self-salience theory. Taking SES into consideration, it seems likely that low SES minority members are at risk to develop a contradictory self-salience orientation in which connectedness to others *and* self-evaluation of worth are both low, making it difficult to predict risks of externalizing and internalizing disorders. One possible outcome of low SES minority membership is that cultural norms pointing toward a highly self-salient masculine social role, combined with a low probability of meeting the expectations of that role, may lead marginalized men to act out more than other men through ex-

ternalizing behaviors such as substance abuse or violence. Such behavior might mask the existence of internalizing disorders such as depression, which would help explain why findings on race and depression are so inconsistent.

A more nuanced model of self-salience theory would therefore be useful for further investigation into the relationships between race, class, gender, and mental health. Hypotheses predicting which factors of self-salience relate most closely to internalizing or externalizing disorders should be developed in order to make better predictions about mental health. An aggressive research agenda focused on exploring self-salience orientations in relation to gender, class, and race is vital in order to develop such a model, and would simultaneously present an opportunity to fill in gaps in the current sociology of mental health literature, particularly the lack of research on how the integration of social experience into individual identities impacts mental health.

Conclusion

In this article, I have argued that self-salience theory has an important place in the study of mental health and illness with regard not only to gender, but also to race and class. Previous research has shown that self-salience correlates to the presence of externalizing and internalizing disorders. Self-salience theory offers a framework within which social scientists can further examine the role of socialized conceptions of self in the emergence of psychological distress and disorder. The gaps in the research on race, class, and mental health in particular demonstrate a clear need for research on how social experiences shape the development of orientations towards the relationship between self and other.

The intersection of gender, race, and class represents a fertile ground for the further development of self-salience as a theoretical framework, but it also presents new challenges to the current theory. Whereas previous research on self-salience has focused on overall self-salience orientations, a research agenda centered on this theory should consider that each of the factors involved in these orientations could develop independently from the others in socially marginalized groups or in the general population.

Research addressing the intersection of class, race, and gender using self-salience theory as a framework is needed not only for the development of this emerging perspective on social experience and the self, but also for the development of a better understanding of the relationship between social experience and mental health.

This article has attempted to provide the beginnings of such a framework and to make some preliminary predictions, which are limited by the lack of research on social class utilizing self-salience. The first step may thus be research on class and mental health using self-salience theory and measures. Following that, research considering race, gender, and class from a self-salience perspective may be possible. Such research would not only grant a richer perspective on the roles of race, gender, and class in mental health, but would also help locate the existence and causes of more complex self-salience orientations. Gender may be associated with differing self-salience orientations, but it is still unclear whether gender is the strongest factor in self-salience. Broader research using an array of social factors can only improve upon self-salience theory and provide a better understanding of how society becomes integrated into the self and influences individual mental health.

Acknowledgements

I would like to thank Belinda Needham and Patricia Drentea, who provided useful insight during the early stages of this work. I am also grateful to the reviewers and editors at *RJS,* who were tremendously helpful and patient throughout the entire process of preparing this article.

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Rutgers Journal of Sociology
Volume 1, 2011

http://sociology.rutgers.edu/RJS.html

GENDERED CONSUMPTIONS: CANNIBALISM AS A FORM OF PATRIARCHAL CONTROL

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This article discusses cannibalism as a gendered phenomenon in which men claim the bodies of women and feminized men for control and consumption. Analysis of the social patterns of tribal societies, Medieval European saints, and modern cannibalistic killers reveals that cannibalism is a pathological expression of a patriarchal structure that allows men to control the bodies of "others" through metaphorical and literal consumption.

Introduction

The image of the cannibal, while not as prominent today as it was in the past, still interests us; we are to some extent still preoccupied with those who consume human flesh for reasons not altogether understood. The most popular associations with cannibalism have been "primitive" tribes and modern cannibalistic killers. For example, Hayes (2003:157) claims that the labeling of certain tribes as cannibals was "used to enforce the 'savagery' of non-Western societies" which, according to Lefebvre (2005:46), "served the interest of colonialism." Lefebvre (2005) claims that this practice is part of a larger frame of consumption, and links cannibalism to capitalism. However, in this article, I argue that this process is more similar to the ways in which the feminine "other" has been produced as an object of knowledge utilized for literal and metaphorical consumption in Western societies. In addition, I describe cannibalism as a violent behavior directly linked to patriarchy and its tenets of sex/gender dimorphism (Calhoun 2003), especially when the consumer seeks to dominate and control the victim(s) as part of the patriarchal active/passive split (Kaufman 1998). Notably, although cannibalism

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is a highly gendered practice, there is no cross-cultural, gendered analysis of cannibalism to date. Additionally, while many gender studies exist on how the objectification and "consumption" of women in media images reinforce gender dimorphisms (e.g., Adams 2004; Bordo 1999), no known studies explore how the literal consumption and control of women through the practice of cannibalism also reinforce and in fact stem from these dimorphisms.

Taking a feminist standpoint, I conduct an analysis of the social patterns of cannibalism, with particular emphasis on how cannibalism acts as an extreme expression of and reaction to the gendered body in a patriarchal structure. I examine how bodies have been dominated via literal consumption. Although it is not certain whether the groups and individuals discussed in this article have consumed bodies *in order to* control—direct, suppress, or change—them, I explain the social conditions in which this gendered consumption results in the domination and control of these bodies. I also note that cannibalism has been a pathological expression of patriarchy, but is not the mark of a specific pathological society. It is not entirely clear whether the "primitive" tribes discussed in this article were patriarchal, but they do express a pattern of gendered consumption similar to the other two groups examined in this study that did live within patriarchal systems: Medieval European saints and modern cannibalistic killers.

I begin this article with a brief historical overview of theoretical perspectives on cannibalism, followed by a discussion of the gendered consumption of animal flesh in relation to human flesh. I provide this comparison in an effort to develop my original argument that as objects of knowledge in patriarchal societies, feminine and *feminized* bodies are literally consumed (like animals) in order to maintain the sex/gender dimorphism in which the consumer seeks to dominate and control the "other". I conclude this article with a discussion of the cultural conditions that allow for gendered consumptions.

A Brief Historical Overview

It is important to note that historically, there have been several different reasons cited for cannibalism including: extreme hunger during famines (natural and man-made) or after accidents

that leave no other choice for survival; for ritual and religious obligations; to achieve sexual gratification; as a means to gain power and control; and because human flesh tastes particularly good (Askenasy 1994; Bell 2007). In this article I focus on cannibalism by men as a means to dominate and gain control over women and "other" men (i.e., homosexual and ethnic minority men) and therefore only examine those who presumably exercised human agency and freely elected to engage in cannibalism. Each of these instances of consumption serves as a means of control.

There are differences as well as similarities among the three types of cases I study. While some participants in tribal ceremonies may have seen their cannibalism as an obligation rather than a free choice, they still presumably consumed human flesh to fulfill collective/tribal responsibilities related to the domination and control of these bodies. Medieval nuns and priests seldom consumed flesh; however, saintly bodies were often "guarded, feared, fought for and sometimes even stolen from fellow Christians to be eaten later" (Bynum 1992:183). While it is true that these priests and nuns were not described as cannibals at the time, and that the body's meaning has changed greatly over the centuries, their reasons—to be closer to God, to invoke the spirit of Christ, and to become sacred—were similar to those described by ethnographers examining "primitive" cannibalistic tribes and modern cannibalistic killers.

Moreover, in this article I argue that the actual agentic act of eating bodies (usually specific body *parts*) is highly gendered in that the consumption of these bodies has largely been done in order to dominate and control the women and men traditionally categorized as "other" (i.e., women, children, ethnic minorities, and sexual minorities) that are paradoxically vulnerable and dangerous. This argument is not unlike those that describe why docile bodies have been produced throughout Western history (Bartky 1997; Bordo 1989, 2004; Butler 1993; Foucault 1977; Ussher 2006). For instance, Bordo (1989) reported that little has changed in this regard since the 1940s; women's bodies are still regulated so that they conform to gendered societal standards, because anything else would threaten men's masculinity. Also, Bartky explained that due to the "inegalitarian system of sexual

subordination" (1997:143) prevalent throughout Western societies (in law, family, and the media), "feminine movement, gesture, and posture must exhibit not only constriction, but grace as well, and a certain eroticism restrained by modesty; all three" (1997:135). As a result of these expectations, women and men learn to control these feminine bodies.

Men's bodies are also controlled, but with very different means and ends. For instance, Bordo (1999) explained that men in modern Western cultures are expected to have strong, masculine bodies. This means that they are supposed to show control through their appearance as well as their behaviors. For example, Bordo described media depictions of men that include dominant and aggressive poses, which are directly opposite to women's submissive poses. However, Bordo also noted that race, class, and sexuality play large roles in how men are depicted in the media and expected to behave in their daily lives; minorities are depicted as "living more fully in their bodies, with a taste for flashy clothes that marks them as déclassé" (1999:199). In patriarchal societies, these "fallen" men also become objects of control, because like women they represent a challenge to traditional masculinity that must be dominated and controlled.

Even the bodies of feminine animals are dominated. In *The Sexual Politics of Meat: A Feminist-Vegetarian Critical Theory,* Adams (2004) argued that men eat meat in order to gain strength from subordinate animal bodies. She also claimed that meat-eating reflects men's power in three different ways: 1) historically, men's "duties" are to kill the animals that women then must clean and cook, 2) the myth that men need protein in order to gain strength has largely made men the carnivore in patriarchal societies; and 3) the animals most often used to produce food (e.g., milk and eggs) and most often eaten *as* food (e.g., meat) are female. Thus, meat-eating is very much a gendered act that reflects sex/gender dimorphism and the active/passive split. Similarly, I argue in this article that masculine men in patriarchal cultures have targeted feminized and "othered" bodies for consumption. Moreover, these men consume "others" as an act of male aggression and dominance: first by objectifying these bodies, or regarding and treating them as objects (Nussbaum 1995),

and then by dominating them, or using, abusing, invading, and destroying them through literal consumption. Even when women become the consumers, as is discussed later in this article, their acts are less about aggression and dominance of the "other" and more about their self-control, although objectification still exists for the purpose of making the "other" edible.

Objectification and Flesh Consumption

Adams described the objectification of the body as an essential step in the process of making the feminized body edible. In regard to animals, their bodies are objectified via the "absent referent" (Adams 2004:53), in which the oppressors "view another being as an object" to be consumed (2004:58). For instance, Adams explained how Westerners use language to objectify the animal's body simply by stating that they are eating "meat" rather than eating a "corpse." Creating an alternate, and perhaps less violent, term for consumers' actions helps them come to terms with violating the animal. "Without its referent point of the slaughtered, bleeding, butchered animal, meat becomes a free floating image" (2004:59). Similarly, Medieval European saints identified the human flesh they ate as a "relic" or "flesh of Christ," rather than the actual body part they consumed (Bynum 1992). Also, male cannibalistic killers and tribal chiefs often identified their victims as objects of desire or "others" rather than beings with identities. As noted above, female animals are not the only beings objectified through language and literally consumed as objects; this has also been the case with human beings, both women and men. Adams argues that Western society has objectified women to such an extent that to some their bodies resemble meat—they can be butchered and eaten like any other animal in the slaughterhouse. For cannibals, women's and sometimes "other" men's bodies *are* "meat" to be dismembered and consumed.

Jack the Ripper, who butchered several women in the late 19th century, is a prominent example of a man treating women's bodies like meat. As sex workers in the 19th century, the women Jack the Ripper butchered were already objectified beings in a patriarchal society; it therefore took little for him to slaughter

these women like the butcher might slaughter an animal. He often utilized precise techniques of dismemberment that the police thought only a skilled person such as a butcher could have. Jack the Ripper would sexually mutilate the women he killed, sometimes taking their uteruses. Some police described the crimes as something that would happen only to animals, but modern theorists noted that the literal butchering of these women was not far from the metaphorical butchering of women in the media (Adams 2004). In patriarchal societies, viewing women and "othered" men as "pieces of meat" or objects creates a situation in which consumers feel it is their right and sometimes duty to dominate these individuals through literal consumption, like pieces of meat.

"Others" objectified in patriarchal societies become consumable, both metaphorically and literally. Metaphorically, these individuals exist as things to be viewed and desired in the media (Bordo 1999). And, because heterosexual men control the media, society has given men, in particular, "cultural permission to be a voyeur" and to consume the images of feminized bodies (Bordo 1999:169). Some men have taken this permission to a pathological extreme, as is evidenced by murderers such as Jack the Ripper, Albert Fish, Andrei Chikatilo, Edward Gein, and Jeffrey Dahmer. The major difference between these individuals and the cannibals of Medieval Europe and tribal clans is that the former exhibited culturally prohibited behaviors/pathologies whereas the latter two engaged in cannibalism that was culturally encouraged and/or required. For instance, tribal cannibals often ate their victims during ceremonies that required sacrifices to their god(s), although some ate enemies from opposing tribes (Poole 1983). In any case, the differences among the three groups do not invalidate the similarities that these groups have: namely that each group's cannibalism is an outgrowth of a violent patriarchal system in which the bodies of objectified "others" are consumed in order to dominate and control them.

Cannibalistic Tribes

The earliest known cannibals were members of tribes in which cannibalism was the norm; they mostly ate their rivals

and neighbors, and have often been described as "primitive" and even "barbaric," despite cannibalism's widespread occurrence across the world. Most "primitive" tribes engaged in cannibalism for ritualistic/religious reasons involving myth and tradition.[1] For example, "the Lessa chiefs of Central Africa 'always' consume certain female parts to better perform their marital obligations, as do the Isabel of the Solomon Islands and the Nissan (a tribe on the Solomon Islands, who also discard the male genitalia as useless)" (Askenasy 1994:112). This act in itself is gendered: "female parts" were associated with characteristics historically attributed to females and femininity, namely the ability to reproduce. In order for the consumption to occur, the chiefs first objectified women's sexual organs; believing they were body parts that held specific characteristics separate of the beings from which they came facilitated the belief that those characteristics could be controlled if consumed by men.

In the above examples, the women's body parts were consumed so that the chiefs could control a characteristic that they found valuable, whereas most often "others'" body parts have been associated with impurity and pollution (Douglas 1966) that needs to be conquered and dominated. Several tribes specifically associated female parts with negative characteristics. For example, the Bimin-Kuskusmin tribes of Papua New Guinea believed that men and women have both male and female "substances." "The cannibalistic consumption of male parts of either male or female corpses [consisting of muscle and bone marrow] is believed to strengthen the hard, strong, internal, ritually significant 'male anatomy' of either men or women" (Poole 1983:9). However, the consumer risked weakening his "male anatomy" and therefore weakening his body if he ate female parts (flesh and fat). Poole claims that Bimin-Kuskusmin warriors very rarely ate female parts of slain men because they did "not value the ritual strength of the bodily substance of these beings under most circumstances" (1983:11). In addition, male sorcerers consumed both male and female substances, but they "transformed" female substances into male substances "in order to ensure the efficacy of ritual endeavors, fertility, propagation, and growth as they affect both humans and ritually significant crops and game"

(1983:14). It is clear from these descriptions of Bimin-Kuskusmin ceremony that feminized (and not just women's) bodies/body parts were deemed undesirable, since they were both weak and polluting. The men in this same tribe were said to have female substances within their own bodies that were only valued once these men conquered the female substances, or purified them through ritual.

This paradoxical relationship between pollution and purity is different from what Douglas (1966) explained as the non-conflation of cleanliness and sacredness for pre-modern civilizations. Douglas suggested that pre-modern civilizations did not conflate cleanliness with sacredness; instead, some viewed pollution as a resource for showing respect. However, in the example provided above, the Bimin-Kuskusmin clearly viewed female substance as polluting and problematic. Moreover, they believed women and children were closer to nature and therefore "more susceptible to the kind of behavior found beyond the buffer zone of humanity" (Reeves Sanday 1986:87). Women, therefore, were represented as having uncontrollable cannibalistic impulses while men were said to control their own urges and also control the women who could not control themselves. As a result, only women who had taken positions as elders in the tribe were allowed to participate in their cannibalistic ceremony, the "Great Pandanus Rite," because according to the Bimin-Kuskusmin, all individuals are born androgynous and return to androgyny in later life.

Although the Bimin-Kuskusmin believed all individuals were born androgynous, a sex/gender dimorphism is clearly evident in their fertility ceremony, the Great Pandanus Rite, held once in every generation. For the first half of this ceremony, the Bimin-Kuskusmin captured a male victim (an "other") from an opposing tribe, and the tribal elders consumed his male substances to show their dominance over the other tribe. The Bimin-Kuskusmin also captured a female victim for the second part of the Great Pandanus Rite, and the male tribal elders ate her female substance raw (versus the cooked male victim in the first part of the rite), in order to destroy "her malevolent female substance." However, these men were required to do so in disguise as sorcerers (who were free from pollution) and then to cleanse themselves by sub-

sequently consuming her male substance in addition to the male substance of wild boars, a masculinized animal in the eyes of the Bimin-Kuskusmin. Female ritual elders were also allowed to participate in the Great Pandanus Rite (Reeves Sanday 1986). They consumed the female victim's ritually purified uterus and vagina in order to gain the victim's physical strength; since women ritual elders were viewed as androgynous, their powers prevailed over the victim's and did not require male substance to decontaminate their bodies.

According to Reeves Sanday, female substances represented decay, death, and pollution whereas male substances represented birth, genesis, and fertility; "thus, defilement and purity map gender-consciousness" for the Bimin-Kuskusmin (1986:91). In other words, this particular tribe, as well as others (e.g., the Lessa of Central Africa and Nissan of the Solomon Islands) that participated in gendered cannibalism, understood feminized and "othered" bodies and substances as polluting dangers, which the men believed they could control through ritual cannibalism. Even though men also had female substances, they were regarded as having more control over their own bodies and impulses, again reinforcing the active/passive and male/female dichotomy. And, while the Bimin-Kuskusmin believed in androgyny at birth and toward the time of death, their tribal ceremonies worked to create a sex/gender dimorphism in which male substances were associated with strength and purity while female substances were paradoxically associated with both weakness and a potency that could only be conquered with masculine substances.

Although female substances at times represented pollution and danger (or femininity and fertility), male substances represented purity, strength, and masculinity. However, even male substances were consumed for reasons suggested at the beginning of this article: to dominate and control the victim, and to reinforce the active/passive dichotomy. For instance, Askenasy (1994) states, "On the New Hebrides … the penis and testicles of fallen enemies are a favorite dish of the chiefs," largely because these body parts represented the failed masculinity of their enemies. Also:

> To gain courage and strength the Menado-Alfuren cook a bouillon made of their slain enemies' heads; the Ife make a stew of man, antelope, and some medicine; as late as 1895 the Chames of Cochin-China drank brandy mixed with the gall of their dead opponents; in northern Australia the eyes and cheeks are eaten; in the middle and south of the continent kidney fat is preferred; the Wabondei of East Africa choose the liver; the Ovambo of Angola cook their enemies' hearts; and so on. (1994:111)

It seems reasonable to speculate that most, if not all, of these tribes' warriors were male and that their opponents were also male warriors. Thus, historically, cannibalism, although sometimes enacted by both men and women, has largely been a phenomenon done *by* men *to* other men. However, as described above, women and "other" men with feminized flesh were those consumed, which worked to reinforce sex/gender and active/passive dimorphisms: individuals consumed women so they could conquer their pollution whereas individuals consumed men so that they could humiliate their enemies. In each instance, men ate "othered" bodies to exert their domination over these individuals and groups. In addition, when women actually consumed flesh, it was less to control others and more to control their own bodies, as is more evident in the next section on Medieval European cannibals.

Medieval European Saints

The ritual consumption of feminized bodies also occurred in cultures that identified themselves as "more civilized" than the "primitive" tribes discussed above. In Medieval Europe, bodies were the "locus of the sacred" (Bynum 1992:184). In other words, the more "saintly" one's body was, the closer to God that person became. For instance, saints used their own bodies to try and be closer to God by either eating the pus from sick bodies or by having the sick eat/drink from their own bodies. This is one culture that Douglas (1966) explained did not conflate cleanliness with sacredness.

Another path to sacredness was through the metaphorical cannibalism of Christ's flesh and blood: "Eucharistic reception became symbolic cannibalism," in which those eating the Eucharist were granted access to the sacredness of the body being eaten (Bynum 1992:185). The hope for many Christians eating the Eucharist was to invoke the spirit of Christ. One, Catherine Benincasa, described her consumption of Christ as how a child might suckle from a mother's breast. She explained, "That day he showed me from far away his holy side, and I cried with great desire to place my lips on the most sacred wound" (Bell 1985:30). Benincasa conflated the Eucharist with Christ's body to such an extent that she ultimately restricted her diet to only the Eucharist in order to be closer to Christ. She claimed, "When I cannot receive the Sacrament, it satisfies me to be nearby and to see it; indeed, even to see a priest who has touched the Sacrament consoles me greatly, so that I lose all memory of food" (1985:26). These cases of "holy anorexia" were relatively common at this time (Bell 1985).

Bell (1985:xii) explains, "A historically significant group of women exhibited an anorexic behavior pattern in response to the patriarchal social structures in which they were trapped." These same women who were starving themselves in order to "be closer to Christ" often explained their behaviors as related to their need to be closer to purity, which in the other cultures described above has meant masculinity. Bell, however, suggests that being closer to Christ was unique in that it meant being more like Christ, who represented femininity. In Medieval Europe, women's bodies, more so than men's bodies, were linked to Christ's own body, partially because women experienced changes (e.g., stigmata, levitation, seizures, and trances) significantly more often than men, and these changes symbolized the events in Christ's life (Bynum 1992). The fact that women menstruated monthly only testified to Medieval Europeans that these women were closer to Christ, since he bled on the cross. "Women mystics often simply became the flesh of Christ, because their flesh could do what his could do: bleed, feed, die and give life to others" (Bynum 1992:222). In this case, feminized bodies "offer[ed] a means of access to the divine," although their social standing in

Medieval Europe was still beneath that of men; as suggested by Bynum, the "body was inferior to soul" largely because the body ages and decomposes while the soul (associated with maleness) is immortal (1992:235-236).

Despite the feminization of Christ, women were expected to control their own femininity through self-denial, much like modern-day anorexics (Bordo 1989): "Toward others the holy girl is docile and uncomplaining, even servile, and yet in her spiritual world her accomplishments are magnificent" (Bell 1985:20). This also worked toward guaranteeing the regulation of feminized bodies. According to Bordo, the social construction of femininity requires that a woman's appetite for food (as well as for control, independence, and sexual gratification) is restricted and contained. The only appetite the holy anorexics allowed themselves to have was for the Eucharist, which interestingly was also deemed feminine in Medieval Europe because it was thought to represent Christ's body (Bynum 1992).

The Medieval European's view of the body was very different from the views of early cannibalistic tribes; the Medieval European female or feminized body had positive characteristics that allowed the saints to consume the metaphorical flesh of the feminized Eucharist without becoming contaminated or being associated with negative human characteristics. Although these feminized bodies had positive characteristics, the act of consumption worked to reinforce patriarchal sex/gender systems in two ways: 1) it created a situation in which women refused to eat anything except for the Eucharist in order to be "more like Christ," although they ended up being more like Christ's bride (Bell 1985) who exhibited a quintessential femininity through self-denial and subservience, and 2) it emphasized the links between femininity/body/inferiority and masculinity/soul/superiority and also suggested that the only way to transcend the inferior feminine body was by both consuming and controlling it so that one could eventually access the superior masculine soul. As I will discuss next, these same ideas about sex/gender dimorphism in modern patriarchal societies create the possibility for other, more deviant, forms of gendered consumption.

Modern Cannibalistic Killers

Modern cannibalistic killers have been known to consume mostly women's bodies, but as I explain later, they have also consumed the bodies of "others" that have also been feminized in Western cultures. One of the earliest U.S. killers found to have eaten his victims was Albert Fish during the 1920s. According to Bell (2007:5), Fish was classified as a "sexual cannibal" because he "claimed to have experienced enormous sexual pleasure when he imagined eating a person or when he actually indulged his fantasies." Although Fish murdered several girls and boys and molested over 100 in twenty-three states, he was best known for his abduction and consumption of ten-year-old Grace Budd. Fish claimed not to have molested Grace; rather he "stripped her naked … choked her to death, [and] then cut her in small pieces so [he] could take [her] meat to [his] rooms." He consumed her buttocks and wrote in a letter to her parents six years later, "How sweet and tender her little ass was roasted in the oven" (Bardsley 2007:9). Fish also admitted to eating a young boy in similar fashion. Although several of the children Fish consumed were boys, it is clear that Fish did so with a similar goal: to dominate and control these vulnerable, less-than-fully male individuals in an act of patriarchal violence (Kaufman 1998).

Two other cannibals, Andrei Chikatilo and Edward Gein, also murdered and consumed their victims with goals similar to those of Fish. Chikatilo "admitted to having butchered at least twenty-one women, twenty-one boys, and ten girls between 1978 and 1990" while Gein killed at least three people (two of whom were women). Chikatilo suffered from impotence and "would often mutilate and then consume the flesh of his victims, including the breasts, genitalia and internal sex organs, as well as other body parts" in order to restore his "manhood" (Bell 2007:5). And, inside of Gein's house, police found:

> chair seats made of human skin, a box of preserved female genitalia, another box containing four women's noses, a belt made of nipples, a heart in a bag near the stove, the crania from several skulls, intestines in the refrigerator, preserved death masks taken off nine women, a fe-

> male skin vest complete with genitals, a face and scalp with black hair … [a victim's] head between two mattresses, and a pair of lips hanging from a string. (Ramsland 2006:55)

Although Gein did not kill all fifteen women from whom he retrieved body parts—he instead stole parts from the cemetery—he did eat parts of these women, as well as wear their skin, to achieve sexual gratification, like Fish and Chikatilo. These men needed to first control their victims' bodies by abducting and murdering them[2], then they objectified and mutilated the bodies, and finally the men consumed their bodies for sexual satisfaction. Also, these men chose bodies thought to be particularly "weak," "vulnerable," and "passive" in patriarchal cultures that link these concepts to feminine women and "others." Egger suggests, "Most victims of serial killers are persons who are vulnerable—those individuals who are perceived as powerless or lacking in prestige by most of society" (2003:47). For instance, Fish claimed of the African American child he murdered, "the police did not pay much attention when they were hurt or missing" (Bardsley 2007:20). He, like the other serial killers, deemed these feminized bodies appropriate for domination, control, and consumption.

Similarly, one of the most notorious murderers in the United States, Jeffrey Dahmer, sought "vulnerable" victims to dominate and consume. Although all of his victims were male, he targeted mostly homosexual, African American men and young boys. Within a racist, heterosexist society, Dahmer's victims were particularly vulnerable because "people who are deemed inferior for whatever reason are represented as feminized, controlled, and subordinate" (Moore 1994:145). It is within this society that, like Fish, Dahmer was very much aware that his victims' lack of status in society (particularly as homosexuals) would allow him to lure them in to his car/house without expecting much effort from police to find these missing individuals. The extra time that he was allowed before anybody even noticed these individuals were gone "provided more time for the control and the kill" (Egger 2003:190). It even allowed Dahmer to have sexual intercourse with many of his victims pre- and post-death and to ritualistically save their body parts in plastic bags, bar-

rels, freezers, and boxes as trophies. "Investigators found skulls, bones, rotting body parts, bloodstained soup kettles, and complete skeletons' in Dahmer's apartment" (Ramsland 2006:105). Dahmer also admitted to "tenderizing and sautéing parts of the hearts, biceps and thigh muscles of several victims *out of curiosity*" (Lester 1995:171).

Once Dahmer was eventually captured, he admitted in an interview with *Dateline* that he "just wanted to have the person under [his] complete control" (Askenasy 1994: 207). He even mentioned to police, "My consuming lust was to experience their bodies. I viewed them as objects, as strangers" (Egger 2003:195). According to Kaufman (1998:7), in a male-dominated (i.e., patriarchal) society, a man "embraces the project of controlling himself and controlling the world … Masculinity is a reaction against passivity and powerlessness" Tithecott (1998:57) claims, "The serial killer is someone who attempts to overcome his insecurities about his gender by killing what he perceives to be a threat to his manhood." Clearly, Dahmer viewed his victims as feminized objects that were at once vulnerable but also dangerous: he needed to control his own homosexual urges, and the only way he saw fit was to control the feminized bodies of homosexual men via objectification, mutilation, and consumption.

In addition to these previously noted sexual serial killers, Issei Sagawa shot and killed a Dutch friend, after which he cut up her body to consume her breast and buttocks. Sagawa was mostly associated with epicurean cannibalism, although he also related his taste for flesh to his taste for beautiful bodies. Sagawa admitted, "I still adore the sight and the shape of young Western women, particularly beautiful ones. I was a premature and unhealthy baby, I am ugly and small, but I indulge in fantasies about strong healthy bodies. I'm essentially a romantic" (Askenasy 1994:204). Here Sawaga excused his deviant behaviors by attesting to his own lack of masculine qualities while also revealing that his victims served to reassert his masculinity by allowing him to control and consume their feminine bodies.

Like the cannibalistic serial killers mentioned above, Sagawa engaged in gender consumption when he specifically chose feminine victims and ate some of their mostly feminine body parts

(e.g., breasts and buttocks).[3] And, his acknowledgement that he may be less-than-masculine served as both justification for his actions and reassertion that in a patriarchal society, only masculine men will do. Sagawa "surmised that being acutely self-conscious of his shortcomings might have fueled his obsession with 'the perfect woman,'" or perhaps more to the point, destroying the feminine woman that reminded him of his shortcomings with masculinity (Ramsland 2007:1). Of Sagawa's first victim, Ramsland states, "He found these Nordic women overpowering, and even as he claimed he loved them, he wanted to posses and destroy them" (2007:6). Sagawa needed to destroy women who were too powerful; a feminine object is less dangerous when controlled and dismembered (see also Adams 2004).

In stark contrast to modern male cannibals, the few known modern female cannibals were not serial killers, and they appear to have consumed their victims for reasons other than sexual gratification (i.e., aggression or psychosis). More specifically, Omeima Nelson and Anna Zimmerman each killed, mutilated, and consumed a male romantic partner. In 1991 Nelson stabbed her husband with scissors, cut him into pieces, and cooked him. She testified to castrating her victim, skinning his body, and cooking his ribs in barbecue sauce, although later in her testimony she denied having eaten her victim (Askenasy 1994:39). In 1981 Zimmerman murdered her boyfriend and froze his body parts in order to thaw and consume them over time (Bell 2007).

To reiterate, these two instances of female cannibalism represent unique cases, since in most cannibalism, men do the consuming. However, these cases also highlight the differences in intensity and rationale for gendered consumptions. Nelson and Zimmerman each had one male partner victim whereas the men mentioned above abducted, dismembered, and consumed many feminized, non-partner victims. Moreover, both Nelson and Zimmerman accused their partners of abuse and admitted to murdering them out of anger, revenge, and self-defense. Rather than wanting to control their victims and use them for sexual gratification, then, these women wanted to assert the self-control that they had lost to their abusive partners. Similar to the holy anorexics, then, these women cannibals ate flesh for different reasons

than the men wanting to dominate and control dangerous female substances and weak feminized bodies.

Conclusion

In essence, gendered cannibalism is a practice of masculinity in which males exert patriarchal control over feminized bodies (both male and female) through their metaphorical and literal consumption. The examples provided above serve as a reminder that the objectification of both women's and men's bodies has many consequences, including the ritualized objectification, mutilation, and cannibalism of these bodies. In addition, it is evident that cannibalism largely operates in positive terms for consuming men, while being detrimental to consuming women and the consumed. For instance, the male cannibalistic tribal elders and the modern, male cannibalistic killers either reinforced their notions of hegemonic masculinity (i.e., domination and control), or they at least gained sexual pleasure from their gendered consumptions. The women, on the other hand, experienced very different effects; the female Medieval European saints did not gain control over their lives once they dedicated their lives to the metaphorical cannibalism of Christ; rather, they ended up surrendering their control to the church. Similarly, the modern female cannibalistic killers did not explain their behaviors in terms of sexual gratification or control; rather, they killed and contemplated consuming abusive partners for vengeance. Based on these examples, cannibalism appears patriarchal in that it reinforces sex/gender dimorphisms in which men control the bodies of the "others" who threaten their hegemonic masculinity.

Reeves Sanday (1986) made similar conclusions in her book on the cultural politics of cannibalism. She claimed that cannibalism is a means for destroying the negative characteristics associated with those consumed. She states, "the victim is cast as the living metaphor for animality, chaos, and the powers of darkness—all those things people feel must be tamed, destroyed, or assimilated in the interest of an orderly social life" (1986:6). Reeves Sanday also mentions that cannibalism for many tribes is the "ultimate act of domination" that can be imposed on the enemy. For example, enemy women are consumed during the second

part of the Bimin-Kuskusmin Pandanus Rite in order to diminish their sorceress qualities or to improve the elders' sexual faculties. Interestingly, Reeves Sanday identified male aggression against women as a significant variable related to cannibalism in more complex societies, or societies with political heterogeneity and social orders and structures that are often hierarchically based. In other words, patriarchal societies are primed for gendered consumptions, and even when gender is not hierarchically ordered, it still exists as a means of control. She states, "Male aggression is a reaction to stress as males seek to dominate controlling material forces by dominating the bodies of women and female reproductive functions" (1986:13). This reaction to stress most often occurs in societies that have a high investment in the idea that men have the power to (re)create—sperm is valued over the egg, the mind over the body, and thus the masculine over the feminine. In these societies the "female bodily substances (such as menstrual blood and fertile fluids)" (Reeves Sanday 1986:37) are negatively encoded in order to differentiate between male and female. Reeves Sanday suggests that when this dichotomy occurs, "the consciousness of the social other is experienced in terms of the subject's dread of pollution by the bodily substances of others" (1986:37). From this dread springs the desire to control and destroy/consume the "othered" body. Consequently, cannibals experience the paradox of consumption within patriarchal systems in which they seek to maintain their masculine identities, but at times do so by consuming negatively encoded substances (i.e., female substances). Kaufman (1998:8) aptly describes situations such as these as "an expression of the fragility of masculinity" in which men turn towards violence in an attempt to claim a masculinity that they may never fully possess. It is also within this paradox that feminized and othered individuals are trapped and become objects of violence and consumption.

Acknowledgements

The author would like to thank Professors Joanne Belknap and Isaac Reed, both of the Sociology Department at the University of Colorado-Boulder, for comments on earlier drafts of this article, as well as the Southwestern Women's and Gender Studies Association (SWGSA) for

the 2010 Virginia Currey Best Student Paper Award. The author is responsible for any shortcomings in this article.

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Endnotes

1. After briefly describing the different tribes that prefer eating female flesh to male flesh, Askenasy (1994:131) stated, "it seems that the consensus went something like this: women and children are better than men; blacks are better than whites … and in general the young are tastier than the old." And perhaps an even stronger claim would be that women's *breasts* were preferred over other forms of human flesh.

2. Gein was an exception, in that he did not abduct and murder his victims; however, he did choose dead victims because he gained satisfaction from manipulating their docile bodies.

3. Other serial killers known to eat women's breasts and buttocks include: Robin Gecht and the Ripper Crew who severed women's breasts, used them for sexual gratification, and then consumed them; and Joachim Kroll who stalked women and girls and ate their body parts, mostly cut from the buttocks (Ramsland 2007).

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Rutgers Journal of Sociology
Volume 1, 2011

http://sociology.rutgers.edu/RJS.html

WEIGHT SELF-CONCEPT: FORMATION, STABILITY, AND CONSEQUENCES

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This theoretical review develops weight self-concept (defined as self-assessed degree of thinness or overweight) as a dimension of self-concept and distinguishes it from body image (affective evaluation of one's body) which is a dimension of self-esteem. It proposes that weight self-concept and body image might resemble other dimensions of self-concept and self-esteem in that they coalesce after the instability of adolescence and are thereafter resistant to change. Therefore, in considering the determinants of weight self-concept and body image, this article reviews the literature on those aspects of the adolescent experience which influence weight self-concept and body image, particularly pubertal timing. This article also addresses the implications that weight self-concept might have for understanding identity formation and identification with stigmatized groups (such as the overweight). The conclusion discusses the importance of interventions during pre-adolescence to prevent the development of a stigmatized, overweight self-concept and negative body image.

Introduction

This article develops weight self-concept, defined as self-assessed degree of thinness or overweight, as a dimension of global self-concept. Weight self-concept is a cognitive self-assessment, not a reflection of one's emotional state or self-esteem, and as such it does not denote an affective judgment of one's body. Thus, it is not equivalent to body image, the perception of one's physical adequacy and physical attractiveness, which is a dimension of self-esteem and is inherently evaluative. Prior literature has generally not distinguished between weight self-concept and body image, instead treating weight self-concept as an indicator of body image (e.g., Levinson et al. 1986). This ap-

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proach is problematic because it imputes an invariant affective self-evaluation to self-assessed body weight. But assessing one's body weight is not in itself an emotive evaluation, and moreover, when affective evaluations are attached to body weight they vary systematically by race, gender, and cultural context (e.g., Lovejoy 2001; Ogden and Thomas 1999). In its review of prior literature, this article treats measures of self-assessed body weight as indicators of weight self-concept while treating measures of body satisfaction as indicators of body image. Thus, although weight self-concept is a new theoretical concept, prior literature addressing it nonetheless exists: this literature has generally confused weight self-concept with body image by using self-assessed weight as a measure of body image.

This article proposes that weight self-concept and body image resemble other dimensions of self-concept and self-esteem in that they are formed or reformed in adolescence and thereafter become resistant to change. Accordingly, this article critically reviews literature addressing the relationship between pubertal timing, weight self-concept, and body image in adolescence and into adulthood. It begins by discussing the emergence of a socially-informed weight self-concept and body image in adolescence and by reviewing those aspects of the adolescent experience which influence weight self-concept and body image, including pubertal timing. Next it addresses the influence of race, socioeconomic status, and social context on the development of weight self-concept and body image. After discussing the formation of weight self-concept and body image, this article addresses their temporal stability and argues that this stability has broad implications for understanding identification with stigmatized groups. Finally, the conclusion emphasizes the importance of weight self-concept and body image for mental health and suggests intervention in early adolescence to improve youths' body image and assuage the stigma associated with feeling overweight.

This article defines weight self-concept as the degree to which one thinks one's body is underweight, about right, or overweight. Weight self-concept is not a simple reflection of "objective" clinical classifications; perceptions of one's body size depend on one's social location (Levinson et al. 1986). In fact, in a large, nation-

ally representative survey just over half of adolescents (58%) and young adults (51%) have an accurate weight self-concept by clinical standards[1]. One reason that weight self-concept is interesting is that weight is a major dimension of body dissatisfaction among adolescents. But weight self-concept is also interesting because weight identities are imbued with social meaning. In particular, adopting an overweight self-concept implies self-identifying with a highly stigmatized group (Carr and Friedman 2005; Crandall 1994; Laslett and Warren 1975; Puhl and Brownell 2001). Thus, it would be especially interesting if an overweight self-concept is a stable characteristic over the life course, even among those no longer (or never) clinically overweight.

Weight self-concept does not necessarily imply (dis)satisfaction with one's body: one might be satisfied with a body one evaluates as underweight or dissatisfied with a body one evaluates as about the right weight. Thus, weight self-concept is not equivalent to body image, which is inherently evaluative and reflects one's general satisfaction with one's appearance and physical self. This distinction between physical self-concept (including weight self-concept) and body image is consistent with understanding physical self-concept as a dimension of self-concept and body image as a dimension of self-esteem; not all authors distinguish between self-concept and self-esteem (e.g., Marsh et al. 1983), but those who do argue that self-esteem involves affective judgment of the self whereas self-concept simply characterizes the self (Calhoun and Morse 1977; Germain 1978; King 1997; Watkins 1989) . Consistent with this distinction, McClintock (2010) finds that self-esteem is a strong predictor of body image, but not of weight self-concept. In other words, weight self-concept is primarily a cognitive self-assessment, influenced by social context and social comparison, whereas body image is an affective self-judgment, influenced by one's emotional and psychological state. However, both are largely subjective: like weight self-concept, body image cannot be explained by objective measures. For example, there is substantial variation in body image among overweight adolescent girls (Van den Berg and Neumark-Sztainer 2007).

The Emergence of Weight Self-Concept

Although weight self-concept and body image may be evident among pre-pubertal children, it is only in adolescence that they begin to be significantly correlated with others' evaluations (Marsh 1989; Marsh and Craven 1991; Marsh et al. 1998). It seems that adolescents respond to the newly-imposed social importance of the body by incorporating the evaluations and standards of significant others into their own physical self-concept and body image. Additionally, the changes in self-concept that occur during puberty involve an increasing emphasis on the physical body (Ge et al. 2001), plausibly as a result of the physical changes to the body during puberty and the increasing sociosexual importance of the body in this period. Thus, it is in adolescence that individuals develop a socially-informed weight self-concept and body image, and in this same period both gain importance as components of self-concept and self-esteem, respectively.

Presumably because of the newly-imposed social importance of their bodies, adolescents evaluate their physical selves through reflected self-appraisals (Milkie 1990) and through social comparisons, using other individuals or groups—such as classmates—as the base of reference (Jones 2004; Krayer et al. 2008) . Thus, if girls believe that their peers have internalized the cultural preference for thin women (Milkie 1990)[2], it is not surprising that adolescent females negatively evaluate the body fat associated with normal sexual development (Dornbusch et al. 1984; Duncan et al. 1985; Ge et al. 2001). On the other hand, if boys believe that their peers are influenced by media images of men, then for boys the theory of reflected self-appraisals predicts that puberty would improve body image: boys' pubertal development moves their bodies closer to the ideal male body type, which is muscular and of normal to slightly heavy weight (Cohn and Adler 1992; Korn and Lerner 1972; Leit et al. 2001; Li and Kenrick 2006). Consistent with this expectation, boys are less likely than girls to feel overweight in response to pubertal body changes (Ge et al. 2001), and adolescent boys report greater satisfaction with their body and weight, compared to girls (Richards et al. 1990).

In general, individuals rely most heavily on social comparisons when more objective means of evaluation are unavailable

(Festinger 1950, 1954). In the case of weight self-concept, body mass index (BMI) provides an alternative, clinical evaluation of body weight, including thresholds separating underweight, normal weight, overweight, and obese. But BMI can be misleading for individuals with an unusually high or low percentage of body fat (Flegal et al. 2009; Ode et al. 2007). BMI may be especially unreliable during puberty. It is normal and healthy for BMI to increase during puberty, but age-adjusted BMI does not account for differential pubertal timing. Additionally, rapid changes in height and weight may prevent adolescents from knowing their current BMI. Perhaps most important, the sociosexual importance of the body during adolescence may make clinical classifications less relevant than (perceived) peer evaluations. For all of these reasons, it is not surprising that adolescents rely on social comparisons despite the existence of a more objective measure. As a result, adolescents' weight self-concept is only partly a reflection of their clinical weight status and is largely influenced by their social location and by the (perceived) evaluations of significant others (Levinson et al. 1986).

Because adolescents evaluate their bodies by comparing themselves to peers, the effects of puberty may be amplified by its timing.[3] Specifically, early-maturing girls are likely to be particularly sensitive to pubertal increases in body fat because the majority of their peers still manifest the thin, adolescent ideal. Early-maturing boys are likely to be especially benefited by increases in height, body size, and muscle because these changes are more obvious when compared to their pre-pubertal peers. Consistent with this argument, most studies indicate that for girls it is early pubertal timing that is most troubling whereas boys are harmed by late pubertal development (Blyth et al. 1985; Duncan et al. 1985; Ge et al. 1996; Ge et al. 2001; Graber et al. 1997; Martin 1996; Rosenblum and Lewis 1999; Siegel et al. 1999; Simmons et al. 1979; for an exception to this pattern, see Zehr et al. 2007). For girls, the relationship between pubertal timing, body image, and weight self-concept is further amplified by the developmental effect of weight on pubertal timing: being overweight has hormonal effects that trigger girls' earlier pubertal transitions (Anderson et al. 2003; Biro et al. 2005; Jasik and Lustig 2008; Kaplowitz et al.

2001). Thus, overweight girls who are already at risk of developing a poor body image and an overweight self-concept are subjected to the additional stress of experiencing early puberty.

Race, Class, and Context

Although being overweight is widely stigmatized, the social meaning of being overweight or underweight may vary across characteristics such as race and socioeconomic status (in addition to gender). For example, despite their greater frequency of obesity (Shafer 2010), Black women and men report being more satisfied with their bodies and general appearance compared to their White counterparts (Kelly et al. 2005; Lovejoy 2001; Miller et al. 2000; Russell 2002; Russell and Cox 2003; Parker et al. 1995). There is also evidence that the pubertal transition is less distressing for non-White female adolescents (Hayward et al. 1999). These findings imply that weight self-concept is less closely linked to body image for Black Americans. In other words, Black women and men may be less likely to assume that an overweight body is innately unattractive, so they enjoy generally more positive body image and less concern about body weight. Indeed, BMI is an indicator of social physique anxiety (excessive anxiety over other's evaluations of one's body) for White men but not for Black men (Russell 2002) and perceived body weight discrepancy (perceived distance between one's actual and ideal weight) is an indicator of social physique anxiety for White women but not for Black women (Russell and Cox 2003).

These racial differences in affective evaluations of overweight bodies may be explained in part by differences in the body standards that adolescents imagine are held by their peers. For example, Milkie (1990) finds that despite being personally critical of media representations of thin women in teen magazines, White girls' body image and self-esteem suffer because they believe that their peers accept these media images as the standard for evaluating girls' bodies. In contrast, Black adolescent girls do not believe their peers to be influenced by representations of women in magazines that they feel are meant for White girls, and are thus unaffected by these media images (Milkie 1990). By rejecting the White standard, Black girls are free to develop a body

image less dependent on weight self-concept, enabling girls of various body sizes to feel attractive.

But whether minority women are protected from White beauty standards may depend on their degree of racial socialization and integration: Black women are more vulnerable to body dissatisfaction when they identify socially with non-Black women (Sabik et al. 2010) whereas Black women taught to value and identify with their African American heritage have a more positive body image (Grandberg 2006). Like Black women, Latina women distinguish between mainstream cultural standards applied to White women's bodies (as expressed in media images) and the body standards they and Latino men support (Poran 2002; Viladrich et al. 2009). Still, despite this sense of a unique, Latina ethnic body aesthetic that values curvaceous bodies, their body image is negatively influenced by exposure to White media and positively influenced by exposure to Black media (Schooler 2008). It may be because they are more integrated into White culture that non-Black racial minorities such as Hispanic, Asian, and Native American women express similar body dissatisfaction as White adolescents (Averett and Korenman 1995; Miller et al. 2000; Neumark-Sztainer et al. 2002). In addition to increasing the perception that others hold them to White standards of thinness, integration into White culture may increase women's propensity to identify as overweight and to evaluate their "overweight" body negatively. Indeed, when asked to identify the silhouette most resembling their current and ideal bodies, White and Asian women selected a larger current size and a smaller ideal size than Black women, controlling for actual BMI (Kronenfeld et al. 2010).

Racial differences in weight self-concept and in body image may be exaggerated by racial differences in social tolerances regarding evaluation of one's physical self. While there is strong evidence that White girls and women are expected to engage in "fat talk" (a social ritual of denigrating one's body as overweight and therefore unattractive), this practice is less common among African American girls and women (Nichter 2000). In contrast, Black women are expected to be emotionally strong and physically large (Beauboeuf-Lafontant 2003). The cultural expectation of large Black female bodies and the strong cultural pressure to

express high body satisfaction may silence Black women who are personally dissatisfied with their weight (Baturka et al. 2000). Additionally, Black women may be less likely to be diagnosed with anorexia or bulimia not because they are at lower risk for developing eating disorders but because they are instead prone to compulsive overeating (Beauboeuf-Lafontant 2003; Lovejoy 2001). Thus, Black women's seemingly resilient body image may mask underlying body dissatisfaction and disordered eating. Conversely, White women's criticism of their bodies may reflect social norms rather than (or in addition to) actual body dissatisfaction.

The effects of race may also be confounded by those of social class: girls from higher socioeconomic backgrounds report more concerns over their bodies and greater drive to be thin (Ogden and Thomas 1999), despite being thinner on average than their less advantaged peers (Kimm et al. 1996). In addition to race and social class, adolescents' social context might influence the body standard that they use in evaluating their bodies and the norms that encourage them to express body (dis)satisfaction. For example, girls' weight control efforts depend upon the weight control efforts used by similarly-sized girls in their school (Mueller 1980). Thus, an overweight girl is more likely to engage in weight control behaviors when many other overweight girls at her school are engaging in these behaviors. Similarly, girls' preoccupation with weight and weight-loss behaviors depend on the attitudes and behaviors of their peer group (Mackey and La Greca 2008). These findings suggest that girls' propensity to identify their bodies as overweight and the degree to which an overweight self-concept results in emotional distress and a negative body image may depend on their social environment. More research is needed to identify other contextual factors (such as urbanicity, region, or school racial composition) that might influence weight self-concept and body image.

The Stability of Weight Self-Concept

The stability of global self-concept and self-esteem has long been an object of scholarly research, but little research has yet addressed whether the physical self-concept and body image formed in adolescence is stable into adulthood (Eisenberg et al.

2006). Except during major life course transitions such as pubertal development, self-concept and self-esteem are considered fairly stable personality traits (Calhoun and Morse 1977; Marsh et al. 1983; Trzesniewski et al. 2003). Thus, it is plausible that the physical self-concept formed during the turmoil of adolescence will become fixed, enduring into adulthood even when it does not accurately characterize one's body. Likewise, the body image formed in adolescence might tend to endure into adulthood.

It is somewhat counterintuitive that a negative body image or an overweight self-concept would be stable traits even when these self-perceptions are inaccurate; presumably, individuals have an incentive to distance themselves from stigmatized identities. But social psychological theories of the self provide competing motivations that may outweigh the disadvantages of holding a stigmatized identity. For example, temporal comparison theory proposes that individuals have an incentive to maintain a coherent sense of personal identity over time (Albert 1977), and this desire for a temporally stable sense of self may motivate them to maintain even stigmatized identities such as an overweight self-concept.

Individuals may also fail to recognize a leaner body as no longer overweight because their vision of themselves as slender assumed that thinness would transform many dimensions of their lives (Grandberg 2006). The theory of possible selves proposes that individuals imagine elaborate possible selves associated with potential achievements (Markus and Nurius 1986). Thus, a once-overweight individual may not shed her overweight self-concept because she has not achieved the possible self she associated with thinness (e.g., a happier, romantically successful, wealthier self). The pain of relinquishing the hope that becoming thin will transform one's life might be greater than the discomfort of imagining a continuing discrepancy between one's current (overweight) self and one's ideal (thin) self (Higgins 1987). In fact, the appeal of an idealized possible self to be attained by weight loss (and the hope this provides) might be strong enough to cause a never-overweight individual to develop and maintain an overweight identity.

Empirical tests of these theories are scarce. Most studies addressing the stability of physical self-concept or body image

have been limited to fairly brief periods of time (at most a year) during which actual changes in body size or shape would rarely be large (e.g., Fortes et al. 2004; Raudsepp et al. 2004). However, at least two studies have examined stability or change in physical self-concept across life course stages. In one of these studies, McClintock (2010) used a large, nationally representative sample to examine stability in weight self-concept over a period of about eight years. The author found that the weight self-concept formed in adolescence tends to endure into young adulthood, net of similarity in clinical weight classification. In other words, weight self-concept tends toward stability even when it is inaccurate and even when actual clinical weight classification has not been stable. A second longitudinal study of physical self-concept that spans adolescent and adult life stages focused on the factors that predict change in body image (Eisenberg et al. 2006); because it examines only the predictors of change, this study does not indicate whether change or stability is the dominant trend.

There is also some indirect evidence that the adolescent experience influences adult weight self-concept and body image, which is suggestive of stability across life course stages. For example, among obese adult women, those who were obese as adolescents report more negative body image, net of current BMI (Wardle et al. 2002). It is also suggestive that in high school, girls who recall their pubertal transition as occurring earlier report more eating problems, particularly chronic eating problems (Graber, et al. 1994; Swarr and Richards 1996). Similarly, in college, women and men recalling earlier pubertal transitions report more disordered eating (Zehr et al. 2007). But, for girls at least, early puberty is associated with greater risk of being clinically overweight (Harris et al. 2008; Kivimaki et al. 2008; Pierce and Leon 2008); this may result in a spurious relationship between pubertal timing and eating problems such that the apparent effect of pubertal timing on adult physical self-concept may be entirely explained by differences in actual weight. Against this, a study that controlled for clinical weight classification in adolescence and in adulthood (McClintock 2010) found that pubertal timing has an independent, direct effect on adult weight self-concept.

Implications for Psychological Distress

The theory of reflected appraisals suggests that feeling overweight and physically unattractive would negatively influence global self-esteem. Many adolescent girls and boys are prejudiced against overweight peers, seeing overweight as an undesirable and blamable condition (Davison and Lipps Birch 2004; Greenleaf et al. 2006), and similar attitudes are expressed by college students of both genders (Crandall 1994). Similarly, individuals attribute many positive characteristics (e.g., intelligence, friendliness) to physically attractive individuals while attributing negative characteristics to the physically unattractive (Dion and Berscheid 1972; Eagly et al. 1991; Langlois et al. 2000; Rosenblat and Mobius 2006). The theory of reflected appraisals argues that individuals come to see themselves as they imagine others see them (Owens 2003). Thus, if an individual believes that she is overweight or unattractive, she may internalize the negative appraisals she believes her peers associate with being overweight and with being unattractive, possibly resulting in low self-esteem or depressed mood.

There is also considerable evidence that social comparison processes contribute to self-esteem: individuals who compare unfavorably on a salient dimension (such as socioeconomic status or physical attractiveness) suffer lower self-esteem (Rosenberg and Pearlin 1978). Importantly, self-esteem is only influenced by social comparison when the reference group used for the comparison exhibits substantial variation on the relevant dimension (Rosenberg and Pearlin 1978). As discussed earlier, Latina and Black women report lower body image when they are exposed to White friends and White media (Sabik et al. 2010; Schooler 2008); this may be because these women compare their bodies to a wider range of images, including the unattainably slender bodies reified in White culture. Given the salience of physical attractiveness and weight among adolescents, self-esteem is likely to be strongly affected by comparisons to peers, and it is plausible that this effect would be greater for adolescents in physically-heterogeneous peer groups.

Indeed, weight self-concept and body image influence many important social and psychological outcomes. Girls and boys who identify as overweight are at greater risk of depressed mood,

somatic complaints, and lower self-esteem, regardless of clinical overweight status (Ge et al. 2001; Jansen et al. 2008). The negative effect of an overweight self-concept is stronger for White adolescents than for their Hispanic or Black peers (Ge et al. 2001), possibly because it is the White adolescents who are most likely to attribute negative characteristics to the overweight and to translate an overweight self-concept into a negative body image. (Non-White adolescents are more accepting of heavier body types.) In other words, believing one's body is overweight is only harmful when being overweight is thought to be physically unattractive and socially undesirable. Existing studies have not distinguished the effects of weight self-concept and body image, but given their relationship[4], examining the effects of one without controlling for the other may bias results.

More research is also needed to understand the causal relationships between self-esteem, body image, weight self-concept, and depression. Global self-esteem and depressed mood are likely to influence affective self-evaluations such as body image. But as one of its component dimensions (Scalas and Marsh 2008), body image also contributes to global self-esteem, potentially creating a reciprocally causal relationship. Similarly, depressed mood might alter individuals' affective evaluations of their body, but it is equally plausible that feeling overweight or unattractive might contribute to depressed mood. Indeed, one study found that depressed college students see themselves as less physically attractive and are less satisfied with their bodies, compared to non-depressed students, but the cross-sectional design prevented the authors from establishing the direction of causality (Noles et al. 1985).

Conclusion

Despite the large number of articles addressing weight self-concept and body image—a recent search of literature on the importance of body image produced over 7,000 articles (Menzel et al. 2010), important questions remain unanswered. For one thing, further research and theorizing is needed to distinguish body image and weight self-concept and to evaluate their independent effects on social and psychological outcomes, such as substance abuse and depressed mood. Current research also

does not fully investigate contextual differences that may make adolescents more or less vulnerable to negative body image and distorted weight self-concept in adolescence, such as the school and neighborhood environments. Additionally, research is needed to clarify the relationships between pubertal timing, self-esteem, body image, and depression. Finally, research is needed to test the stability of weight self-concept and body image over the life course and to investigate the possible mechanisms that might influence stability and change, such as temporal comparison theory and the theory of possible selves.

This article has argued that weight self-concept and body image, as dimensions of global self-concept and self-esteem, are fairly stable personality traits, at least after they are formed or reformed during the tumultuous pubertal transition. There is some support for this hypothesis in regard to weight self-concept (McClintock 2010), but it has yet to be tested with regard to body image. Given that being overweight is highly stigmatized, it is intriguing that an overweight self-concept developed in adolescence continues into adulthood: it is not unusual for normal-weight adults continue to self-identify as overweight, retaining the stigmatized identity they adopted as adolescents (McClintock 2010). Identity control theorists have shown how individuals work to maintain positive identities (Burke 2006) and have hypothesized conditions under which individuals may also seek to maintain stigmatized identities (Cast and Burke 2002). As mentioned above, temporal comparison theory and the theory of possible selves provide alternative accounts for the maintenance of an overweight self-concept, even among the non-overweight. Further research is needed to explicate the psychological processes that result in stable weight self-concept. But by providing an empirical example of a stigmatized identity that endures even when the individual is not objectively a member of the stigmatized group, weight self-concept might be useful in investigating identity formation more generally.

As discussed above, feeling overweight or physically unattractive is associated with depressed mood and low self-esteem. An overweight weight self-concept or negative body image can also result in unhealthy eating behaviors, substance abuse, risky sexual behavior, or even suicide (Anderson et al. 2006; Cafri et

al. 2006; Gillen et al. 2006; Graber et al. 1994; Parkes et al. 2008; Rogriguez-Cano et al. 2006). Clearly, many of these behaviors have long-term implications for health outcomes and life course trajectories. While the exact causal relationships between weight self-concept, body image, depressed mood, and low self-esteem are not fully understood, it is theoretically plausible that overweight self-concept and negative body image result in depressed mood and low self-esteem. If this is the case, and if weight self-concept and body image are indeed inflexible after being formed during puberty, interventions in early adolescence are vital.

Given that adolescent females judge themselves against the ultra-slim images of women in mainstream media that they believe that their peers endorse, despite personally rejecting these images (Milkie 1990), a potentially fruitful intervention might be to educate adolescents about their peers' true standards. Realizing that their peer group holds the more reasonable body standards that girls themselves privately endorse might alleviate the pressure they feel to achieve an unfeasibly slim physique. It might also be useful to address the negative stereotypes about being overweight or physically unattractive: developing an overweight self-concept may be harmful primarily because adolescents believe that their peers attribute negative characteristics to the overweight, and by seeing themselves through their peers' (perceived) evaluations, adolescents come to attribute these negative characteristics to themselves.

Acknowledgements

This research uses data from Add Health, a program project designed by J. Richard Udry, Peter S. Bearman, and Kathleen Mullan Harris, and funded by a grant P01-HD31921 from the National Institute of Child Health and Human Development, with cooperative funding from 17 other agencies. Special acknowledgment is due Ronald R. Rindfuss and Barbara Entwisle for assistance in the original design. Persons interested in obtaining data files from Add Health should contact Add Health, Carolina Population Center, 123 W. Franklin Street, Chapel Hill, NC 27516-2524 (addhealth@unc.edu).

Thanks are due to Emily Fitzgibbons Shafer, Shelley J. Correll, and two anonymous *RJS* reviewers for their helpful comments on this article.

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Notes

1. Author's calculations from the National Longitudinal Study of Adolescent Health, Wave I (1994-5) & III (2001-2).

2. As discussed later, the ideal of thin female bodies may apply less strongly to non-White and working-class girls.

3. For the purposes of this article, pubertal timing refers to the timing of observable physical pubertal changes, relative to peers. For example, these changes include weight gain, breast development, and growth of facial hair.

4. Weight self-concept relates to body image because certain weight identities are more often translated into positive or negative body images, depending on race and gender. For example, for White adolescent females, identifying as overweight likely contributes to a negative body image. But this relationship is imperfect: a non-trivial proportion of overweight girls report high body satisfaction (Van den Berg and Neumark-Sztainer 2007).

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Rutgers Journal of Sociology
Volume 1, 2011

http://sociology.rutgers.edu/RJS.html

LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND QUEER ADOLESCENT DATING VIOLENCE: A REVIEW AND DISCUSSION OF RESEARCH AND THEORY

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This article reviews the limited body of scholarship pertaining to dating violence among lesbian, gay, and bisexual adolescents. Although recent research suggests that rates of dating violence among these populations approximate rates for heterosexual adolescents, sociological research has only begun to explore how the experiences, dynamics, and outcomes for lesbian, gay, bisexual, transgender, and queer (LGBTQ) adolescents may be qualitatively different from those of their heterosexual and cisgender counterparts. Utilizing an intersectional framework, this review synthesizes literature specific to same-sex adult intimate partner violence and heterosexual adolescent dating violence in order to identify factors and dynamics that may be unique to populations that exist at the intersection of these two groups. This review concludes by sketching a provisional intersectional framework for LGBTQ adolescent dating violence research, and highlighting the need for empirical research on dating violence within this population.

Introduction

Intimate partner violence (IPV) in adult heterosexual relationships has been the subject of much social, political, and academic debate over the past several decades (Anderson 1997; Gelles 1997, 2003; Hagemann-White 2003; Loskee 2005; Strauss 1991; Walker 1979). The Center for Disease Control and Prevention (CDC), defines intimate partner violence in the following way:

> Intimate partner violence occurs between two people in a close relationship ... includ[ing] current and former spouses and dating partners. IPV

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> exists along a continuum from a single episode of violence to ongoing battering [and] includes four types of behavior: physical violence ... sexual violence ... threats of physical or sexual violence ... [and] emotional abuse. (CDC 2011)

Topics ranging from the prevalence of violence between intimate partners, potential causes and solutions, and even the terminology and definitions used to describe intimate partner violence[1] have undergone rigorous scrutiny in both the public sector and scientific communities. However, research on this topic remains as relevant and necessary as it was almost half a century ago, when the grassroots efforts of the battered women's movement and family sociology researchers first identified IPV as a social problem (Anderson 1997). Intimate partner violence has certainly not been eradicated, and many aspects of this issue remain un- or under-examined due to the systemic marginalization of minority populations. Variations in the experience and context of intimate partner violence among racial and ethnic minorities (Crenshaw 2010; Hamby 2005; West 2004), immigrants (Klevens 2007; Narayan 1995), heterosexual adolescents (Hall 2000; Lloyd 1999), and adult same-sex couples (Allen and Leventhal 1999; Cruz 2003; Hassouneh and Glass 2008), have been established, highlighting the need for substantive and culturally competent research within these populations.

This article reviews intimate partner violence research specific to lesbian, gay, bisexual, transgender, and queer (LGBTQ)[2] adolescent populations. Because queer adolescent dating violence[3] is truly an emerging area of sociological inquiry, the literature is extremely limited in scope. Research on the topic almost exclusively focuses on lesbian, gay, and bisexual-identified youth, (Freedner et al. 2002), youth reporting same-sex romantic or sexual partners (Halpern et al. 2004), or youth reporting different and/or same-sex sexual partners (Pathela and Schillinger 2010). It appears transgender or otherwise gender non-conforming youth are excluded from the intimate partner violence literature. Despite a dearth of research, recent studies that do focus on LGB adolescent intimate partner violence suggest that it occurs at rates approximating those of heterosexual adolescent popula-

tions (Freedner et al. 2002; Halpern et al. 2004). The omission of this population from sociological intimate partner violence research is likely a result of a combination of factors; it is probable that the marginalization and delegitimation of same-sex relationships and transgender populations in the larger society is mirrored in social scientific research, and there are methodological challenges related to access and measurement (Saewyc 2011; Waldner-Haugrud 1999), which are further compounded for research with adolescent populations (D'Augelli and Grossman 2006). Additionally, it has been hypothesized that queer individuals may be especially reluctant to acknowledge that intimate partner violence occurs in their communities due to the added stigma it may place on an already stigmatized population (Allen and Leventhal 1999; Donovan and Hester 2010). The paucity of research on queer adolescent dating violence is troubling, however, as the more established body of literature focusing on risk behaviors and health outcomes for this population indicates that many queer youth have unique experiences, needs, and outcomes as compared to other adolescent populations. For recent, comprehensive reviews of queer adolescent health research, see Coker, Austin, and Schuster (2010) and Saewyc (2011).

Much of what we know about dynamics of intimate partner violence among heterosexual adult couples can be applied to same-sex IPV (Cruz 2003; Giorgio 2002; Girshick 2002; Kulkin et al. 2007); however, it is clear that the experiences of many queer adult survivors of intimate partner violence are impacted by the heterosexist[4] and homo/bi/transphobic[5] context of our society (Allen and Leventhal 1999; Giorgio 2002; Girshick 2002). Additionally, scholarship on heterosexual teen dating violence has recently begun to explore qualitative differences challenging the applicability of adult frameworks of intimate partner violence to heterosexual adolescent populations (Mulford and Giordano 2008). Utilizing an intersectional framework, this review synthesizes scholarship on intimate partner violence among same-sex adult couples and heterosexual adolescents in an attempt to highlight factors and social conditions that may be pertinent to the generation of future research and theory about LGBTQ adolescent dating violence. Due to the common elision of gen-

der non-conforming and sexual-minority youth in popular and academic discourses, this review presents a framework intended to be applicable to LGBTQ adolescent populations. This review seeks to trace existing scholarship on LGBTQ adult populations and heterosexual adolescent populations to where LGBTQ identity and age intersect, in an attempt to highlight the gap in literature and break the pervasive silence around the issue of queer adolescent dating violence. However, it is important to note that no one "community" encompasses all queer youth. Queer adolescents, like non-queer adolescents, enjoy varying levels of access to resources and are differentially influenced by expectations and experiences with dating and sexual relationships based on their race, class, gender, and sexual identity. A limited focus on the intersection of LGBTQ positionality and age in this review foregrounds the need to account for multiple identities when considering the role of social location in intimate partner violence research.

Intersectionality and Intimate Partner Violence Research

Contemporary intersectionality theorists posit that structurally-based inequalities relating to race, class, gender, and sexuality result in shifting and varied experiences with marginalization, subordination, and oppression (Collins 1991; Crenshaw 2010; Hooks 1994; McCall 2005).[6] Intersectionality theory has its roots in Black feminist thought of the 1960s and 1970s, which challenged both feminist attempts to explain sexism without due attention to race, and anti-racist politics that prioritized race over gender (Collins 1991; The Combahee River Collective 1997; Lorde 1984). Black feminist thought produced the grounding concept of contemporary intersectionality theory, which is that race, class, gender, and sexuality are experienced simultaneously within interlocking systems of oppression (Collins 1991). While intersectionality theory does engage with dominant assumptions that categories such as race, class, gender, and sexuality are discrete, it does not suggest that identity categories are mutually exclusive. Instead, intersectionality is intended to function as "a methodology that will ultimately disrupt ... tendencies to see [identity categories] as exclusive or separable" (Crenshaw 2010:483). The

strength of an intersectional framework is that it has the potential to highlight commonalities of experience within marginalized groups, while recognizing that diversity within groups may result in different manifestations of common themes (Collins 1991:37).

Many contemporary scholars have used intersectional frameworks to discuss intimate partner violence (Bograd 1999; Bowleg 2008; Crenshaw 2010; Josephson 2005; Sokoloff and Dupont 2005; West 2004). In her seminal work on intersectionality and violence against women of color, Crenshaw addresses theories, practices, and politics dichotomizing the identities of women of color as either "woman" or "person of color," and argues that such conceptualizations relegate the identities and experiences of women of color to "a location that resists telling" (2010:482). To this effect, Crenshaw presents an intersectional framework to:

> advance the telling of that location by exploring the race and gender dimensions of violence against women of color ... consider[ing] how the experiences of women of color are frequently the product of intersecting patterns of racism and sexism ... hop[ing] to capture, at least in part, how prevailing structures of domination shape various discourses of resistance. (2010: 482)

While the intersection of identity is an important component of this framework, attention to the structural dynamics of oppression is of equal importance. Sokoloff and Dupont foreground a structural approach in their use of intersectionality, which recognizes and seeks to analyze "the hierarchies and systems of domination that permeate society and… systematically exploit and control people" (2005:40). This is best illustrated by Josephson's use of intersectionality in her work on domestic violence among welfare recipients, where Josephson discusses how existing social hierarchies, state forms of social control, and the control exerted by intimate partners intersect in the lives of poor women (2005). Josephson concludes that poor women are at once objects of these forms of control, but also exert subjective agency and may respond to various types of control in multiple ways. Josephson's conclusion speaks to another key component in intersectional frameworks of intimate partner violence, which

simultaneously recognizes the victimization and agency of all battered people and remains attentive to the ways victimization and agency may operate differently depending on historical and social circumstances (Sokoloff and Dupont 2005:55). This is born from an underlying recognition that a singular focus on victimization—especially for minority groups—can function as yet another mechanism of social control.

Intersectionality theory holds promise for research on queer adolescent dating violence as it allows for exploration of the ways identity and social context mediate experiences with intimate partner violence. However, research produced from within this framework has not been immune to the failure of sociological scholarship as a whole to recognize IPV in sexual-minority and gender non-conforming populations, specifically adolescent populations. There is a demonstrated need for research and theories of intimate partner violence that do not rely on normative assumptions about (socially-constructed) sex/gender categories, and that can transgress the notion that identity categories are fixed within a specific system of power and meaning in society. This review uses an intersectional framework to identify the dynamics and factors that may impact groups whose identities are shaped by both age and gender non-conformity/sexual-minority status, to "advance the telling of that location" (Crenshaw 2010: 482). Attention to the systemic nature of inequality, as well as individual agency and community-level protective factors, will also be discussed.

Limiting focus to the intersection of gender non-conformity/sexual-minority status and age does not imply that these are the only elements of identity relevant to this population. Although this intersection is certainly a space that has thus far resisted articulation, it is likely that within-group differences do exist. This review will not address such differences in a substantial way due to space limitations. Future research is encouraged to move beyond the limitations posed by the narrow focus of this review. The next section reviews the limited body of scholarship on queer adolescent dating violence, but first reviews intimate partner violence research on same-sex adult couples and heterosexual adolescents to lay the groundwork for an intersectional framework for queer adolescent IPV.

Intimate Partner Violence Research

Intimate Partner Violence among Same-Sex Adult Couples

Intimate partner violence between same-sex couples cannot be understood outside of the specific social, historical, and political context in which it occurs. While the consensus seems to be that "the dynamics surrounding same-gender abuse mimic heterosexual domestic violence" in terms of the cyclical nature of abuse patterns (Kulkin et al. 2007), the psychological effects of abusive control and manipulation (Kuehnle and Sullivan 2003), and the use of certain battering tactics (Allen and Leventhal 1999), the interrelationship between inequalities present on the individual, interpersonal, and structural levels of society cause intimate partner violence to differ in significant ways for many LGBTQ individuals.

Heterosexism and Homo/Bi/Transphobia

Oppression and inequality are perpetuated by heterosexist and homo/bi/transphobic social institutions, the effects of which are experienced on every level of society. The complex relationship between 1) violence within LGBTQ communities in the form of intimate partner violence and 2) violence enacted at institutional levels is explained in the following way by Allen and Leventhal (1999):

> The domestic violence within our communities has everything to do with the hostility and condemnation directed against them. Such a climate encourages self-loathing, separates us from one another and from the straight world, creates a false sense of safety and security within the confines of our communities, and leaves us in fear of the consequences of "airing our dirty laundry" in public. GLBT batterers can use the conditions created by homo/bi/transphobia and heterosexism to wield highly effective weapons against their partners. (1999:76)

Social institutions that are antagonistic to or silent about LGBTQ issues create an environment hospitable to violence. Such a climate is conducive to the internalization of homo/bi/transphobia,

isolation, and perpetuation of myths that obscure the presence of interpersonal violence. Other forms of structurally based oppression, such as inequalities upheld by the legal system through discriminatory domestic violence laws and homophobia in the courts and legal profession (Fray-Witzer 1999), fear of revictimization by law enforcement (Hassouneh and Glass 2008; Kuehnle and Sullivan 2003), and the lack of widespread and comprehensive protection against discrimination (Girshick 2002), can easily be manipulated by individual perpetrators to further victimize and silence their partners.

Community and Cultural Norms

Community and cultural norms specific to queer communities also support LGBTQ battering in a variety of ways. The most common manifestations of this are informal and covert, and may include a hesitancy or refusal to acknowledge and address intimate partner violence (Allen and Leventhal 1999; Girshick 2002). The ubiquity of stereotypes and cultural narratives that overwhelmingly portray victims of intimate partner violence as white, female, and heterosexual may in part explain research indicating that many queer survivors fail to label or conceptualize their experiences of intimate partner violence as IPV or domestic abuse (Allen and Leventhal 1999; Girshick 2002).

The silence in many LGBTQ communities around the issue of intimate partner violence has resulted in the absence of what Girshick refers to as *definitional dialogues* for LGBTQ victims of violence (2002). Not only are survivors unable to fully express their experiences of pain, but also the person who inflicts pain can deny that the pain exists, causing the survivor to question whether their experiences really count as abuse (Allen and Leventhal 1999; Girshick 2002). For some queer folks, the inability of language to even adequately capture the basic elements of their partnership (like the actors' relationships with one another) has consequences. On a broader level, the lack of a shared language may undermine attempts to gain political representation (Girshick 2002).

Another result of heterosexism and homo/bi/transphobia is the absence of complex representations of queer individuals and

relationships (Cruz 2003). The effect of this is a lack of relationship scripts for LGBTQ relationships; the implications for intimate partner violence are explained by Cruz, who theorizes that:

> the issues of naiveté or inexperience with same-sex relationships are interesting to explore, as the gay community seemingly does not have comparable relationships to emulate. Without public or widespread social support, gays and lesbians who are successfully coupled are not necessarily as visible as they can be so that positive relationship styles and modes for coping in a same-sex relationship are generally hidden from view. This is unique to same-sex relationships, as examples of "positive" heterosexual relationship models are replete, within our culture. (2003:6)

The absence of definitional dialogues around intimate partner violence, and the lack of complex representations of queer relationships and relationship scripts may be of particular importance in regard to the issue of queer adolescent dating violence.

Same-sex or otherwise-queer intimate partner violence is not only overlooked within queer communities; it also goes unrecognized in dominant society. It is likely that a contributing factor is the continued stigmatization of same-sex relationships and relative invisibility of transgender populations in mainstream society. Another contributing factor may be the fact that normative, gender-based relationship scripts do not easily match up with the participants and patterns of queer relationships (Allen and Leventhal 1999). The rootedness of gender ideologies and the institutionalization of heterosexuality provide the basis for claims that society does not know how to deal with aggression occurring in queer relationships (Girshick 2002; Hassouneh and Glass 2008). Focusing on the specific issue of female-on-female sexual assault, Girshick (2002) points out that woman-on-woman rape is oftentimes taken less seriously because of culturally-based notions that a woman cannot sexually assault another woman (or man, for that matter). Women who are sexually assaulted by another woman, then, often have trouble conceptualizing their assault as a legitimate sexual assault, and may harbor legitimate fears that

they will not be taken seriously or that services will be inadequate or denied (Girshick 2002). Cruz (2003) juxtaposes the minimal amount of support that female victims of male-perpetrated IPV receive with the even greater lack of support for gay male survivors, asking, "where women receive no support, what could be said for gay men and the [lack of] formal and structured support for their relationships? It is vital to study this because there is very little informal and virtually no formal socio-legal support for the maintenance of gay relationships" (Cruz 2003:10).

Gender Norms, Expectations, and Gender Role Stereotyping

Gender role stereotyping and the internalization of dominant gender scripts are two dynamics that researchers identify as significant to same-sex IPV, albeit in different ways than in the dominant IPV literature. Gender roles and gender role stereotyping function to diminish the significance and reality of same-sex intimate partner violence (Allen and Leventhal 1999). For example, the positioning of aggressive and even violent behavior as natural and appropriate within the confines of hegemonic masculinity may function to dissuade people from recognizing intimate partner violence in gay male relationships. Additionally, if men are typically socialized to express anger and aggression via physical means, some gay men might categorize incidents of IPV as prescribed and gender-typical behaviors (Cruz 2003:1). Similarly, the cultural myth that women are inherently nonviolent has the potential to obscure violence that may be occurring in lesbian relationships not only from those outside the relationship, but also from the battered lesbians themselves (Hassouneh and Glass 2008:316). This theory is supported by trends among lesbian survivors of sexual assault, who overwhelmingly fail to label their experiences as rape and often have much difficulty conceptualizing what happened to them as sexual assault because the perpetrator was gender-atypical, according to societal discourses (Girshick 2002). Also stemming from the myth that women are inherently nonviolent is the erroneous belief that fights between women are less serious and dangerous than male-perpetrated acts of aggression or abuse. Research with lesbian women speaks to this issue, as some lesbian women reported that even when

friends witnessed the violence, some did not take it seriously (Hassouneh and Glass 2008:320). The implication of this myth for transgender individuals may be that the ability of one to inflict serious physical harm is in some way less plausible or likely than in a heterosexual domestic dispute. Variations of themes pertaining to gender-role stereotyping and myths about queer intimate partner violence can be found in much of the available literature on the subject (Allen and Leventhal 1999; Cruz 2003; Girshick 2002; Hassouneh and Glass 2008).

Myths that minimize or deny the possibility of intimate partner violence for any LGBTQ population are clearly harmful to queer communities and individuals who experience intimate partner abuse. Another myth perpetuated about same-sex IPV is that the abuse is mutual. This perspective is sometimes referred to as "common couple violence," which can be summarized as the belief that intimate partner violence takes the form of mutual fighting (Allen and Leventhal 1999). The centralization of gender asymmetry as the root cause of power imbalances underlies stereotypic assumptions that same-gender relationships must be equal. Rejecting the notion that queer IPV reflects the same power and control dynamics that are known to characterize heterosexual IPV minimizes the severity of the problem and diverts attention from the actions of the batterer. Because many LGBTQ adolescents probably do not live with their partner, the source of power inequality and the way batterers manipulate existing power imbalances to maintain control may be even less apparent than for co-habiting queer adults. The myth that same-gender relationships are inherently devoid of power imbalances and immune to abuses of power may seem even more valid for some queer adolescents who may not share tangible markers of status such as home ownership or monetary wealth.

Literature on the social construction of violence discusses the gendered nature of IPV in terms of societal acceptance of masculine aggression and the enactment of violence against women. One theory explaining queer IPV reframes this perspective by pointing out that queer folks are subject to the same socialization regarding (unequal) relationship dynamics as heterosexuals (Allen and Leventhal 1999). Prioritizing the role of socialization while

taking a broader look at the way gender and power shape intimate relationships may be a useful strategy for exploring the way gender manifests in queer adolescent relationships, as the negotiation of gender-specific and gender non-conforming behavior is a key element of individual and social development for teens.

Power, Control, and Same-Sex Intimate Partner Violence

Allen and Leventhal (1999) point to the rootedness of power inequality in the institutions of gender and heterosexuality, not the qualitative differences in gender role scripts, in their assessment of how differential amounts of power are patterned into same-sex relationships. The authors begin by noting that heterosexual battering often occurs in a gendered context in which men and women have unequal amount of power, and while gendered power disparities do not manifest in same-sex relationships in the same way, queer individuals are socialized into a culture where normative relationship patterns are hierarchical. Miller (2005), who also identifies power as an important factor in same-gender relationships, suggests that power differences in queer relationships can result from unequal status due to differences in education, social class, employment, ethnicity, earning potential, immigration status, and age, instead of gender (2005:26).

The general patterns of abusive use of power and control that characterize intimate partner violence seem to be consistent across diverse populations, suggesting that some elements of IPV may be universal (Cruz 2003; Giorgio 2002; Girshick 2002; Kulkin et al. 2007). For example, many of the tactics used by heterosexual male batterers are also utilized by perpetrators of same-sex intimate partner violence (Cruz 2003). However, status as a heavily stigmatized minority group changes the dynamic of the relationship between the batterer, the survivor, and socially instituted forms of oppression, raising additional issues and identifying new areas of concern for researchers. One tactic employed by some queer batterers may be to undermine their partner's sense of pride and identity. This can take on a variety of forms, including the exploitation of internalized oppression, or questioning a transgender person's gender identity. Reflecting on her research with lesbian women, Giorgio asserts that in male/female abusive rela-

tionships, a typical occurrence is the denigration of a female for not possessing good feminine abilities as a mother, sex partner, or housewife; in lesbian relationships, this may take the form of attacks on the survivor's identity as a lesbian, "evok[ing] both self-surveillance and jealousy from the victim" (Giorgio 2002:1244). Denying that abuse exists is another related tactic—blaming a trans person's hormone treatments for resulting in emotional "overreactions" or convincing them that they just bruise more easily than other people are two examples of the enactment of this dynamic (Allen and Leventhal 1999). Utilizing heterosexism and homo/bi/transphobia to their advantage, batterers may also attempt to manipulate the system by misleading emergency responders, misusing and invading domestic violence shelters or agencies, and relying on stereotypes to transfer blame to the non-offending partner (Allen and Leventhal 1999; Giorgio 2002).

This section provided an overview of existing theories and empirical research specific to adult same-sex couples, with attention to the ways this information may inform scholarship on LGBTQ adolescent dating violence. The next section will add to this discussion by focusing on elements of the heterosexual teen dating violence literature that may further inform a discourse on LGBTQ adolescent IPV.

Intimate Partner Violence among Heterosexual Adolescents

While reported rates of heterosexual dating violence differ due to variations in the conceptualization and measurement of dating violence, research suggests that approximately one in three high school students have been or will be involved in an abusive relationship (Levy 2006). Despite such high reports of victimization, the issue of teen dating violence among different-sex partners has only recently started to receive attention as a social and public health problem. Thus, researchers and practitioners have relied heavily on frameworks of intimate partner violence developed for adults to conduct and analyze research on teens (Mulford and Giordano 2008). Utilizing adult frameworks to research and conceptualize adolescent IPV is less than ideal, as such frameworks may not prioritize or measure the different factors, dynamics, and conditions that make adolescent expe-

riences with dating violence unique. Specifically, this emerging body of research is criticized for its heavy reliance on national survey data and measures that do not account for the specific context in which violent behavior occurs (Halpern et al. 2004; O'Keefe 2005).

In a recent review of heterosexual teen dating violence, Mulford and Giordano (2008) argue for the use of a gender-based developmental perspective that considers differences in the social context of heterosexual teen dating relationships as well as developmental factors pertaining to adolescent youth. The three key differences between heterosexual adult intimate partner violence and heterosexual teen dating violence identified in Mulford and Giordano's review are perceptions of relationship equality, (in)experience with dating relationships, and the role of peers. The key elements of Mulford and Giordano's gender-based developmental perspective will be discussed and negotiated in light of additional scholarship pertinent to queer adolescent dating violence. The remainder of this section will explore the following themes: perceptions of equality in adolescent relationships, gender and power, developmental factors and peer-centrality, and adolescent dating violence discourse.

Perceptions of Equity in Relationships

There is some evidence that the use of physical violence in adolescent relationships may be mutual, although the motivation and effects of such violence seem to differ among adolescent women and men (Mulford and Giordano 2008; O'Keefe 2005). There is evidence of a gendered dynamic whereby adolescent girls are differentially impacted by the violence enacted against them (Levy 2006; Mulford and Giordano 2008; O'Keefe 2005). However, some research suggests that heterosexual teenagers do not feel their relationships are unequal, and the majority of teens report having "equal say" in their relationships (Mulford and Giordano 2008). Teenage relationships lack elements traditionally associated with greater male power: females are typically not financially dependent on their partners and are less likely to have children to protect and provide for, so it is possible that gender-based inequality is either less prevalent or under-acknowledged

(Mulford and Giordano 2008). While it seems unclear how heterosexual adolescent perceptions of power in relationships relate to actual power inequalities, it seems that the assertion of power and enactment of dating violence likely manifest in different ways for heterosexual adolescents than for heterosexual adults.

Gender and Power

Adelman and Hea Kil present a unique theory pertaining to gender and power in heterosexual adolescent dating relationships, asserting that:

> young people are typically wed to dominant forms of masculinity and femininity that inform dating violence. Subverting gender conformity and the heterosexual imperative that underlie dating violence may prove difficult or risky to youths striving to fit in among their peers. The pressure to conform is particularly troubling because when young people do seek help with dating violence they rely heavily, though not exclusively, on their friends and peers for advice and information. (Adelman and Hea Kil 2007:1298)

Dominant forms of masculinity and femininity position control, dominance, and violence as masculine-typical behaviors, while submissiveness, deference, and passivity are feminine-typical behaviors. Adelman and Hea Kil do not argue that youths simply mimic the gendered patterns of heterosexual adult relationships marked by gender inequality, but instead suggest that gender performance and the negotiation of gender roles is a normative element of adolescent development and peer socialization. However, heterosexual adolescents' typical adherence to traditional gender norms may serve to normalize controlling or violent behaviors and likely influences friends' perceptions and interventions in dating conflicts. Based on the varied ways that dominant gender ideologies manifest in queer adult IPV, it is highly probable that gender will be an important factor in LGBTQ adolescent dating violence as well, although further research is needed to explore exactly how. There is a demonstrated need for empirical research on the ways power and perceptions of relationship

equality relate to dating violence among both heterosexual and queer adolescents.

Developmental Factors and the Importance of Peers

An element unique to adolescent dating violence is the role of psycho-social development and the centrality of peers in adolescent dating relationships. Heterosexual adolescent dating violence research theorizes that a relative lack of dating experience and underdeveloped communication skills may result in the use of poor coping strategies (such as verbal and physical aggression) to address relationship issues (Mulford and Giordano 2008:38). Relatedly, sociological research on youth conflict suggests that friends and peer groups play a central role in heterosexual dating conflicts; the role of peers is a variable that differentiates heterosexual adolescent experiences with dating violence from the experience of heterosexual adult IPV (Adelman and Hea Kil 2007). Mulford and Giordano's review lends support to the idea that friends play a central role in (heterosexual) teenage dating relationships, noting:

> conflict over how much time is spent with each other versus with friends, jealousies stemming from too much time spent with a friend of the opposite sex, and new romantic possibilities are all part of the social fabric of adolescence … navigating such issues can cause conflict, and for some adolescents, lead to aggressive responses and problematic coping strategies, such as stalking, psychological or verbal abuse, and efforts to gain control. (2008: 38)

Exploring possible differences between LGBTQ and heterosexual adolescents' friendships and interactions with peers may prove beneficial in this respect.

Adolescent Dating Violence Discourse

Research with heterosexual adolescents indicates that teenagers define dating violence differently from their adult counterparts, oftentimes including acts such as avoidance or being ignored; threats to one's reputation or the disclosure of

information to other peers/friends; and turning friends against a former dating partner (Adelman and Hea Kil 2007:1298). Adelman and Hea Kil conclude the "peer-centered meaning of dating violence is not surprising" due to the centrality of peer groups during this stage of adolescence (2007:1298). The peer-centered meaning of dating violence appears to extend into the help-seeking realm as well. A study about help seeking and Latino teens suggests that this population is less likely to seek support from organizations than go to their friends for help in a teen dating violence situation (Ocampo et al. 2007). This finding is mirrored in research with other heterosexual adolescent populations (Adelman and Hea Kil 2007) and queer adolescent populations (Freedner et al. 2002).

The significance of seeking help from peers is contested, however. Some researchers purport that adolescents are reluctant to intervene in dating violence situations and therefore are of less help (Ocampo et al. 2007). Other researchers have a much more positive assessment of the ability of teenagers to address and assist with conflict situations (Adelman and Hea Kil 2007:1298). The role of peer groups during adolescence is undoubtedly significant for youth, regardless of their sexual or gender identity. Thus, exploring how peer groups may impact queer youths' conceptualization of dating violence or influence factors such social support and help seeking is a necessary component of LGBTQ adolescent dating violence research.

Intimate Partner Violence among Queer Adolescents

The existing literature on the topic of intimate partner violence among queer adolescents is extremely sparse. While there is little data establishing how dating violence may vary between heterosexual and queer youth, recent research using a nationally representative sample of adolescents indicates that almost 25 percent of youth with same-sex dating or sexual partners have experienced some form of physical or psychological victimization within the past 18 months, with eleven percent reporting physical violence, and thirteen percent reporting psychological violence alone (Halpern et al. 2004). Other quantitative studies suggest that rates of IPV among this population are either equivalent

to (Freedner et al. 2002) or greater than (Pathela and Schillinger 2010) those reported in heterosexual adolescent relationships.

There is some evidence that the prevalence of certain types of intimate partner violence varies among lesbian, gay, and bisexual youths. In a nationally representative study of adolescents aged 12–21, females with same-sex romantic or sexual partners reported higher rates of victimization than males with same-sex romantic or sexual partners (Halpern et al. 2004:128). In a community-based sample of gay, lesbian, bisexual, and heterosexual youth, bisexual males reported higher odds of experiencing any abuse (defined in this study as "control," "emotional," "scared for safety," "physical," and "sexual") than heterosexual males, and bisexual females reported greater odds of experiencing sexual abuse (Freedner et al. 2002:471). Data from a regionally representative sample suggests that males with both-sex sexual partners report significantly higher rates of intimate partner violence than other male subgroups, and both male and female respondents with both-sex partners reported experiences with partner violence and with forced sex, at a rate which the authors note is three times the national estimates for these measures (Pathela and Schillinger 2010:883). For this review, the author was unable to find any research reporting on dating violence among transgender youth populations.

All of the studies located by the author focus on prevalence rates, which dispel any myths that intimate partner violence is not occurring in same-sex adolescent relationships. These studies provide a very limited picture of queer adolescent dating violence, as they yield little information regarding the social context and dynamics that may be specific to this population. Freedner et al. provides one exception, discussing data gathered about disclosure rates (2002). Freeder et al.'s data from a community-based sample indicates that of the young men who experienced some form of abuse, more than one quarter did not tell anyone; similarly, about 31% of females who had experienced abuse did not report it (2002:472). There were no statistical differences across sexual orientation groups; however, among both males and females who disclosed abuse, almost everyone disclosed to a friend, and less than one-sixth reported their abuse to an adult

(Freedner et al. 2002:473). Freedner et al. also found that nearly half of the lesbians reporting abuse had been abused by a male partner, prompting the authors to highlight the importance of distinguishing between behavior and identity (2002:473). While it is likely that there are some universals in terms of the dynamics of dating violence and the conditions that may engender abuse, it is also likely that LGBTQ adolescents may face unique challenges due to their social location in larger systems of oppression. The next section draws on the previous reviews of adult same-sex intimate partner violence and heterosexual adolescent dating violence to locate possible places where age and LGBTQ identities intersect. Adopting an intersectional approach, the next section provides a preliminary framework for investigating the topic of queer adolescent dating violence.

An Intersectional Approach to Queer Adolescent Intimate Partner Violence

Structural and Political Intersectionality in Queer Adolescent Dating Violence

Intersectional frameworks foreground interlocking systems of domination in analyses of intimate partner violence. Institutionalized heterosexism, homo/bi/transphobia, and ageism intersect in the lives of queer adolescents, and their experiences with dating violence are necessarily mediated by these structural factors. For example, heterosexism and homo/bi/transphobia have been correlated with elevated health risk behaviors and outcomes for queer youth (Bontempo and D'Augelli 2002; Coker, Austin, and Schuster 2010; Saewyc 2011), and a general culture that is dismissive and sometimes antagonistic to LGBTQ populations increases the likelihood that queer adolescents may face harassment, rejection, isolation, and violence, both at school and at home (GLSEN 2009; Russell, Franz, and Driscoll 2001). In light of these trends, it is plausible that queer adolescent experiences with dating violence are subject to the multidimensional effects of heterosexism and homo/bi/transphobia. In addition, adolescent romantic relationships generally seem to be perceived as less serious than adult relationships, and adolescents in violent relationships have access to varying levels of structural support

compared to adults. The lack of structural support may be even more pronounced among LGBTQ adolescents, whose relationships are further delegitimized (or at the very least, under-acknowledged and under-accounted for) due to heterosexist ideologies and homo/bi/transphobia.

One manifestation of the intersection of heterosexism, homo/biphobia, and age in current political discourse is embodied in a 2009 amendment to H. 3543, South Carolina's teen dating violence prevention bill.[7] The proposed amendment specified that "dating partners" refer only to *heterosexual* dating partners; the amendment would also bar any mention of same-sex relationships in school-sponsored educational programming for middle and high school students. The passage of this bill has been held up due to debate around the proposed amendment, highlighting the potential for tensions that can manifest for groups that exist at the intersection of varying political interests. In this case, the interests are not markedly different (it is likely that queer activists as well as domestic violence activists are interested in educating youth about healthy dating relationships), but the greater social context of heterosexism and homo/biphobia create a political landscape that could engender contention.

Relationship (In)experience and Queer Social Scripts

The unavailability of a language that can be used to communicate experiences with intimate partner violence is also rooted in structural inequalities that converge at the intersection of queer and adolescent positionalities. A survivor's failure or reluctance to identify their experience with relationship violence as abuse is likely a universal issue, but for queer populations this dynamic may be magnified due to historically rooted cultural ideologies positioning white, middle-class, heterosexual adult women as the "typical" survivors of intimate partner violence. Failing to conceptualize abuse in their relationships (or their friends' relationships) as dating violence may influence the likelihood that queer survivors will seek help or locate and gain access to appropriate support.

Another issue that may arise at the intersection of LGBTQ and adolescent positionalities relates to the absence of healthy relationship models involving LGBTQ people, and developmental

issues as they pertain to adolescent dating experiences. A lack of experience engaging in intimate relationships combined with the marginalization of queer relationships in dominant society may contribute to a context in which unhealthy, violent, or abusive behavior may not seem out of place for some queer adolescents. Further, queer adolescents who do experience relationship conflicts or violence may not have developed the necessary skills for healthy conflict resolution. Allen and Leventhal identify this as an issue especially pertinent to LGBTQ adult experiences with intimate partner violence, asking, "[H]ow, particularly if you are battered in your first relationship after coming out, do you separate the experience of being queer from the experience of being battered?" (1999:79). Referencing inexperience as a key factor in heterosexual adolescent dating violence, Lloyd and Emery make a similar argument about the significance of relationship (in)experience; they add that self-blame, due primarily to inexperience with dating relationships, is one of the mechanisms through which young women rationalized and excused the abusive behavior perpetrated against them (2000:125). It is plausible that inexperience with dating, as well as a lack of social scripts for queer relationships, may play a connected role in intimate partner violence among queer adolescents.

Gender Performativity

The negotiation of gender-specific and gender non-conforming behavior is a key element of individual and social development for adolescents. Because sexual behavior and identity are linked to gender and gender performativity, it is possible that lesbian, gay, bisexual, transgender, and queer youth have qualitatively different relationships with socially sanctioned gender roles and ideologies. Research on heterosexual adolescent negotiations of dating violence that suggests adolescents are particularly dedicated to enacting traditional gender norms highlights the performative nature of gendered behaviors, although how this manifests or informs dating conflict and violence remains unclear. Based on the varied ways that dominant gender ideologies manifest in queer adult IPV, it is highly probable that gender will be an important factor in LGBTQ adolescent dating violence.

Due to developmental factors such as dating inexperience, as well as the general marginalization of queer individuals, bodies, and identities that permeates our culture and social institutions, it is possible that many queer youth may replicate heterosexual relationship patterns in their relationships. While there is some indication that the replication of heterosexual relationship patterns creates relationships imbued with power (Allen and Leventhal 1999), research on heterosexual teen dating violence suggests that adolescent relationships lack the traditional elements associated with unequal power dynamics (Mulford and Giordano 2008). Because it is unknown what effect (if any) this may have for queer adolescent dating relationships and violence, it seems prudent to leave room for emerging and undefined dynamics in any research or theory pertaining to this population.

Queer Adolescent Peer and Family Relationships

The role of peer groups during adolescence is undoubtedly significant for all youth, regardless of their sexual or gender identity, although exploring possible differences between LGBTQ and heterosexual adolescents' friendships and interactions with peers may prove relevant to queer dating violence research. While there seems to be a finite amount of research on the topic, one study focusing on the relationship patterns of heterosexual and queer adolescents during early and late adolescence suggests that the dynamics of friend relationships and networks may vary among heterosexual and sexual-minority youths (Diamond and Lucas 2004). Further, differences in perceived levels of sexuality-related support from sexual-minority versus non-sexual-minority friends may be a significant factor as well (Doty et al. 2010). Finally, the generally hostile climate of many schools across the nation is a factor that cannot remain unaddressed in discussions of queer adolescent peer relationships (GLSEN 2009; Russell, Franz, and Driscoll 2001). As a result of heterosexism, it is likely that for some LGBTQ adolescents, the development of a queer identity will involve communicating to friends, family, institutions, etc. that their identity deviates from what is considered normative. Thus, for queer adolescent populations in

particular, it is possible there are peer dynamics impacting adolescent dating relationships that have yet to be examined.

It also seems plausible that some queer adolescents have had to cultivate and rely on informal support networks composed of friends and peers due to a lack of adequate structural support. Thus, friend relationships in particular may serve as an important protective factor for some queer youth. Alternately, it is possible that friend relationships may function as informal support networks in certain instances—such as when facing harassment at school—and not in others, such as dating violence situations where both partners share the same network of friends.

Recent research on lesbian, gay, and bisexual youth's perceptions of support indicate that for LGB youth, sexual-minority friends provide the most support around sexuality stressors, whereas family and heterosexual friends provide less support for sexuality stress than they provide for other stressors (Doty et al. 2010). This speaks to a unique condition related to the social location of queer adolescents. For some minority communities, the family is a place where individual family members can come together and find strength and refuge from dominant society. Many queer adolescents' immediate family members are not LGBTQ-identified, and levels of support around gender/sexual-minority status varies significantly. Additionally, most LGBTQ adolescents must rely on their families to meet their basic needs, so even a perceived threat of homo/bi/transphobia in the family of origin may limit youth's willingness to communicate about problems in dating relationships.

Community Norms and Community as a Protective Factor

There is evidence that many LGBTQ adolescents face an increased risk of marginalization and isolation, which could function to exacerbate dating violence (Kosciw, Diaz, and Greytak 2008). At the same time, some queer youths may benefit from protective factors such as informal peer networks and involvement with LGBTQ school or community groups. Research suggests that sexual-minority students who attend schools with gay-straight alliances experience positive benefits due to increased levels of social support (Walls et al. 2009). In addition to providing

a space where youth can feel supported, queer-specific organizations may create space for dialogue around LGBTQ adolescent relationships and possibly strengthen youths' ability to recognize and address unhealthy or abusive relationship dynamics (see Merrill (1999) for a discussion of dating violence prevention groups targeting LGBT youth). The possibility of unique protective factors sustained by community ties should not be overlooked by researchers and theorists.

The nature of the relationship between individual queer adolescents and the larger LGBTQ culture, or community, in all probability varies significantly. Thus, the level of protection afforded by community affiliation as well as the salience of "community norms," such as a culture of silence around LGBTQ battering, is not a dynamic that remains fixed across all LGBTQ communities. While cultural discourses often seem to suggest that LGBTQ adolescents join the queer community when they come out, it is probable that some LGBTQ youth feel disconnected from queer communities, some form their own communities, and some queer youth may not have access to (or interest in) LGBTQ communities at all. As a result, queer youth are socialized into community norms, such as silence around intimate partner violence, to different degrees. This is not to suggest that community norms around dating relationships and violence are less important for queer youth than for queer adults, but instead, that existing norms and trends may shift in form and importance both over time and among different queer populations.

To effectively provide culturally competent services for queer adolescents, cultural and developmental differences need to be taken into account on both the individual and interpersonal levels. The cultural and structural needs of the community as a whole must be addressed in addition to the needs of individuals. In reference to the latter, advocates should prioritize not only legislation that legitimizes same-sex marriage, for example, but also endeavors such as school-based comprehensive health education programs that recognize the existence of queer adolescent relationships. Research and service provision should also be attentive to potential sources of resilience in addition to focusing on the unique and unmet needs of queer adolescent populations.

Conclusion

Existing research on queer adolescent romantic relationships in general—and dating violence specifically—is extremely limited. The omission of this population from the generation of sociological research and theory is troubling, as it is likely that queer youth populations have different experiences, needs, and outcomes than other populations.

The extensive theoretical and empirical scholarship on intimate partner violence provides a strong grounding for IPV research with queer adolescent populations. However, recent research suggests frameworks generated for adult IPV may have only a limited applicability to heterosexual teen dating violence (Mulford and Giordano 2008). Similarly, scholarship on adult same-sex partner violence (Allen and Leventhal 1999) indicates that frameworks generated for heterosexual adolescent dating violence may be inadequate for LGBTQ youth due to pervasive heterosexism and homo/bi/transphobia. In addition, the developmental status and social experiences of adolescent populations likely influence the way conflict and violence are conceptualized and negotiated in dating relationships (Collins, Welsh, and Furman 2009). This review utilized an intersectional framework prioritizing the role of structural-level oppressions while recognizing that experiences may vary within LGBTQ youth populations due to these individuals' unique social location in regard to age and gender non-conformity/sexual-minority status.

This review focused on literature specific to queer adult intimate partner violence and heterosexual adolescent dating violence in order to identify factors or dynamics that might be pertinent to populations that exist at the intersection of these two groups. While such an exploration may be useful insofar as it brings to the forefront both the lack of research available on the topic as well as the different issues queer youth populations may face, it is only a starting point. Substantive analysis of the way, for example, lesbian, gay, and bisexual experiences may differ from one another, and from those of transgender youths, is needed.

Future research and theory may also deconstruct and/or expand upon this discussion in ways that illuminate how race and class may mediate the experiences of LGBTQ adolescents. For

example, Giorgio discusses how race and gender performance mediate women's experiences with the criminal justice system, asserting that "women with more cultural capital, feminine gender performance, and unmarked versus marked race successfully misled the police about the violence through her definitional hegemony (the ability to define the moment for outsiders) in an assertion of abusive power" (Giorgio 2002:1243). While this discussion focused on the intersection of age and queer positionality, as a conceptual tool intersectionality leaves room for further exploration of the ways other systemic inequalities mediate experiences with domestic violence. More empirical research with queer youth communities is needed to inform further theorizing.

Author Biography

Leandra M. Smollin is a sociologist who focuses on Health and Health Disparities; Race, Class, Gender and Sexuality; Feminist Theory and Methodology; and Media Studies. She primarily conducts research with sexual-minority and transgender adolescents in the fields of Health and Violence at Northeastern University, where she is a doctoral candidate in the Department of Sociology and Anthropology. Her most recent scholarly work has focused on dating violence among gay, lesbian, bisexual, and transgender (GLBT) adolescents; feminist pedagogy; and depictions of race, class, and sexuality in the media. In 2009, Leandra received the Most Outstanding Graduate Instructor of the Year award and was in the same year granted a $500 Dissertation Support Award. In 2011, Leandra was appointed to the Massachusetts Commission on Gay, Lesbian, Bisexual and Transgender Youth, and she currently coordinates the Heath Education and Outreach Program at the North Shore Alliance of GLBT Youth. Leandra earned a BA in English and Gender Studies from Stonehill College in 2005, and in 2007 earned a MA in Sociology and a Graduate Certificate in Women, Gender and Sexuality Studies from Northeastern University.

Endnotes

1. This review uses the phrase "intimate partner violence" (and acronym "IPV") due to the inclusivity of its definition. Other terms will be used in accordance with theories/researchers who conceptualize and label the phenomenon in other ways.

2. The acronym "LGBTQ" and the term "queer" will be used alternately to represent lesbian, gay, bisexual, transgender, and queer populations.

3. The phrase "dating violence" will be used to reference IPV among adolescents. The CDC defines teen dating violence as "a type of intimate partner violence ... occur[ing] between two people in a close relationship. The nature of dating violence can be physical, emotional, or sexual" (CDC 2011).

4. *Heterosexism* is the attitude that heterosexuality is the only valid or acceptable sexual orientation.

5. *Homo/bi/transphobia* is the irrational fear of lesbian, gay, bisexual, or transgender people; an aversion to LGBT people, their lifestyle or culture; and/or behavior or actions based on this aversion.

6. For recent discussions specific to the methodological considerations and challenges of conducting research using this approach, refer to McCall (2005) and Bowleg (2008).

7. South Carolina General Assembly 2010. H.3543 Session 118. Retrieved April 5, 2011. (*www.scstatehouse.gov/sess118_2009-2010/bills/3543.htm*).

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IVANA BROWN
LECTURER, WOMEN'S STUDIES, GENDER AND SEXUALITY PROGRAM, UNIVERSITY OF HOUSTON

My research interests focus on the sociology of the family and gender, with particular attention to social and gender inequalities involved in the social organization of family life. My current research is dedicated to the study of motherhood and mothering in our society, representations of motherhood in popular culture, and issues of balancing work and family, as well as theoretical and methodological applications of the concept of ambivalence in sociology.

In my dissertation (Rutgers University, 2011) research I explore the concept of maternal ambivalence as a social and structural phenomenon rather than an experience rooted in the relationship between a mother and her child. My work represents the first analysis of maternal ambivalence from a sociological perspective, which emphasizes social roles and expectations toward mothers. Building upon my analysis of motherhood memoirs published at the beginning of the 21st century, I examine social class and race differences in the experience of motherhood ambivalence in a national sample of new mothers, focusing thus on social structural constraints on the motherhood experience. I define maternal ambivalence as the coexistence of positive and negative attitudes about a woman's position as a mother and her relationship toward the institution of motherhood. Based on my

analysis of current motherhood memoirs and review of recent social research on motherhood, I conceptualize and develop measures of ambivalence along four distinct dimensions: 1) ambivalence about being good at mothering, 2) identity, 3) attachment with the baby, and 4) combining work and family.

My findings show that mothers are not just happy or depressed but hold a combination of positive and negative attitudes about motherhood simultaneously along different dimensions of mothering. White middle-class mothers, assumed to experience more ambivalence about motherhood, are indeed more ambivalent about their maternal identities than mothers from other social and racial groups. But this is not the case for the other ambivalence outcomes—i.e., ambivalence about being good at mothering, attachment ambivalence, and ambivalence about combining work and family. Race, education, and income thus do not create a single pathway towards maternal ambivalence. Rather, mothers with diverse social structural positions, and thus different access to resources and different meanings given to motherhood, prioritize distinct aspects of motherhood and evaluate differently how to integrate their mothering with other identities and social roles. My research thus contributes to understanding of the transition to motherhood among mothers of different social backgrounds as well as to the methodological debate about the measurement of opposing attitudes. I suggest that the consideration of both positive and negative aspects simultaneously provides a useful approach for sociologists in general and can help to capture the complexity of social life and provide a more valid representation of social reality and relationships between social actors and social institutions than the standard dichotomous view.

Thus far, I have published eight articles, book chapters, and encyclopedia essays. Among these publications are the first two papers based on the qualitative research in my dissertation project. "Mommy Memoirs: Feminism, Gender and Motherhood in Popular Literature," analyzes the gendered character of motherhood and inequality in parenting and was published in the peer-reviewed *Journal of the Association for Research on Mothering*. The second, "Ambivalence of the Motherhood Experience," which examines representations of motherhood experiences in popular

literature with a focus on maternal ambivalence and its social and cultural context, has recently been published in the edited volume *21st Century Motherhood: Policy, Experience, Identity, Agency* (Columbia University Press, 2010). I am working on additional articles focused on the conceptualization and measurement of maternal ambivalence, and the effects of employment and social support on the relationship between social structural variables and ambivalence outcomes.

JENNIFER R. HEMLER
DOCTORAL CANDIDATE, SOCIOLOGY,
RUTGERS UNIVERSITY

My research interests center on processes of self- and meaning-making in contemporary U.S. society. I spent my early graduate years researching the impact of traumatic events on narratives of selfhood. Combining my interests in mental health and cognitive sociology, I hypothesized that disjunctive narratives resulting from a self-defined major event may be useful to individuals depending on the content and context of this defining event. Following the significant work done in social psychology and sociology of mental illness about traumatic and life events, I also hypothesized that individuals who experience a rupture in their "assumptive lifeworld" are perhaps more harmed by the isolation and separation from their normal routine and community that result from this breach in existential security than they are from the actual event and/or breach in existential security themselves. Indeed, these phenomena are intricately intertwined, but the anomic condition resulting from the isolation/separation from social norms caused by the traumatic event sustains the initial breach in existential security over an extended period of time.

My work on trauma led me to think about ways in which people cope with ruptured existential security and the things they do if they are not able to repair gaps or ruptures completely. I started researching compulsive buying as a social practice used

as an attempt to repair just these kinds of gaps and ruptures. I found that individuals use compulsive buying as a coping mechanism for feelings of fragility and/or deprivation in relation to particular strains, ones I typified as "existential," "ideological," and "experiential/emotional." These strains represent multiple levels on which problems of ontological security, meaning-making, and identity are experienced. I also studied the attempts to "disorder" compulsive buying by media and professional and personal interest groups. I argued that the emerging perception of compulsive buying as a "disorder" by lay and some professional communities is only possible because of larger cognitive and scientific shifts, such as the preeminence accorded to biological explanations of deviant behaviors.

Thinking about medicalization and its impact on how individuals think about themselves, their problems, and their lifeworld, I came to my dissertation project: exploring the ways in which breast cancer survivors think about cancer and chronic disease/illness, incorporate medical interventions into their everyday lives, and perceive the self in relation to these highly medicalized experiences. I plan to interview 60 breast cancer survivors in order to explore how survivors form cognitions of cancer; what kinds of cognitive strategies they employ at different moments for living with chronic illness and dealing with medical interventions into their lifeworlds; and how these cognitions and strategies vary in relation not only to the social location of the survivor but also to the type of treatment facility and level of medical intervention experienced during active treatment and follow-up care.

The driving force behind all my work is an intense desire to understand how factors of "modern life"—ruptures in existential security and processes of medicalization—shape formations of selfhood and influence how people think about and attribute meaning to their lives.

ERIC R. KUSHINS
DOCTORAL CANDIDATE, SOCIOLOGY AND ORGANIZATION MANAGEMENT, RUTGERS UNIVERSITY

I am a fourth-year joint PhD candidate in the departments of Sociology and Organization Management. My work explores the areas of culture and cognition, decision making, and organizations. Specifically, I focus on various types of human resources and business relationship decision making under conditions of limited information and time. To more fully research mental processes involved in these areas, I have completed a Graduate Certificate in Cognitive Science.

My research explores the various triggers that call up cognitive schemas enabling individuals to draw conclusions about others who are physically absent. In many areas of daily life, we must make assumptions about individuals whom we've never met in person. This is of particularly acute importance in organizational settings. Businesspeople routinely participate in phone conversations and make deals with individuals whom they know only by voice, and human resource managers are required to make decisions about whether to interview an applicant based only on a résumé. For these types of decisions, in which bodies are unavailable to signal information, what cues are picked up about individuals from their voices or on paper, and what sorts of conclusions about the physical person are drawn? Furthermore, what

are the possible ramifications of these mental images, and how might these conclusions impact interpersonal interactions that take place upon subsequent meeting?

Voice perception as a trigger for mental imagery is a primary area I am investigating. The brain has extraordinary capacity to extract the social aspects of speech. Certain vocal cues enable us to make snap judgments about a speaker without visual information. When one hears the "disembodied" voice of a business executive in an international conference call, a job applicant during a phone interview, or a masked individual committing a crime, what skin color, facial features, height, frame size, etc. do people conjure in their minds? More importantly, how might this mental image affect the listener's reaction toward the speaker and the perception of the information being conveyed?

Researchers have explored psychological mechanisms of stereotyping and impression management, but few have looked at the specific link between voice and perceived speaker appearance. I have been working on lab experiments to determine whether voice-cued cognitive schemata—organized knowledge frameworks—lead to accurate identification of the physical appearance and biographical background of a speaker. Additionally, I aim to assess how the accuracy of matching one's mental image to the actual speaker affects one's attitude toward the speaker. The specific questions that my experiment aims to investigate are: 1) What vocal cues trigger physical appearance schemata? 2) How do listeners interpret the creation of their mental images and what might this say about unconscious or implicit stereotypes? 3) How might appearance schemata and memory trump actual appearance?

In addition to this research, I am working on other decision-making experiments in collaboration with colleagues in sociology, psychology, and marketing: I am completing a study on perceptions of low-salary job offer acceptance rates when job applicant targets are either black or white; I am researching perceptions of negotiating skills as they pertain to negotiator gender and race; and finally, I am working on a matched-résumé audit study that investigates perceptions of hard and soft skills based on prior self-employment or prior organizational employment. In this fi-

nal study, I am also looking at how these skills might be evaluated when gender and race come into play.

I hope my research, taken together, will have broad application in academia and in the workplace. The sorts of questions to which I believe this research seeks to contribute include: What sort of intervention methods are required to combat the consequences of "voice-profiling" or other practices that may lead to discriminatory hiring practices? How can we anticipate the communication challenges to companies increasing telecommuting and international business? In early candidate evaluation stages, how can companies better ensure they are pursuing the most talented candidates for the job? The increasingly competitive and integrative global economy requires new approaches to employee relations and business management, and I hope to contribute to research in this area as well as to workplace practices.

EIKO SAEKI
DOCTORAL CANDIDATE, SOCIOLOGY,
RUTGERS UNIVERSITY

Broadly, my research centers on the intersection of the sociology of the body, culture, and cognition. Specifically, I am interested in the relationship between the body, personhood, and their margins; that is, how the beginning and the end of life are conceptualized in different cultural and historical contexts.

My dissertation explores the introduction of Western science and modern notions of the body to Japan in the context of modernization, and how this affected ideas surrounding the genesis of life. Existing scholarship suggests that while modern notions conceptualize the body as autonomous and insular, the boundary of the body was considered blurred in Japan prior to the introduction of the Western science. Accordingly, the beginning of life was thought of as an ambiguous process, and infants and young children acquired recognition as a person in a gradual manner, by undergoing a number of rites of passage.

Focusing on the mid-eighteenth to the late nineteenth century—the historical period of modernization, cultural encounters, and the rise of obstetrics in Japan—I investigate how different ideas about the body came into contact and how the differences were negotiated. Specifically, I examine the ways in which scientific knowledge and obstetrical and midwifery practices interacted with other societal factors (i.e., values, policies, and folk prac-

tices) to constitute notions of the genesis of life. An examination of the dynamics surrounding reproduction offers a particularly critical perspective on the body because it challenges the taken-for-granted modern notion of the body, revealing its contradictions and androcentricity. The very process of producing the body involves the destabilization of what is perceived as an individual's bodily boundaries.

My dissertation aims to accomplish the following three goals: 1) to decipher the role of science and technology in the conceptualization of the genesis of life, and personhood and bodily boundaries, more broadly; 2) to contribute to the theorization of the body beyond its modern conceptualization through the prism of reproduction; and 3) to document the process of cultural encounter and knowledge exchange, negotiation, and dissemination.

Having received a Doctoral Fellowship from the Japan Foundation, I am currently conducting archival research in Japan, collecting and analyzing a wide range of materials including anatomical, obstetrical, and midwifery texts, legal documents on abortion and infanticide, Confucian publications on pregnancy and childbirth, as well as letters and diaries written by women.

I hold a BA in Anthropology and an MA in Sociology from the University of Hawaii at Manoa. My Master's thesis examined the relationship between organizational autonomy and democratic practices in civil society, using a case study of a women's organization established in Japan under the U.S. Occupation immediately after World War II. I have also completed the Graduate Certificate in Women's and Gender Studies at Rutgers.

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