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9

DYING ALONE: THE SOCIAL PRODUCTION OF URBAN ISOLATION

Eric Klinenberg

There is a file marked "Heat Deaths" in the recesses of the Cook County morgue. The folder holds hundreds of hastily scribbled death reports authored by city police officers in July 1995 as they investigated cases of mortality during the most proportionately deadly heat wave in recorded American history.[1] Over 700 Chicago residents in excess of the norm died during the week of 13th to 20th of July (Whitman et al., 1997),[2] and the following samples of the official reports hint at the conditions in which the police discovered the decedents.

> Male, age 65, black, July 16, 1995:
>
> R/Os [responding officers] discovered the door to apt locked from the inside by means of door chain. No response to any knocks or calls. R/Os . . . gained entry by cutting chain. R/Os discovered victim lying on his back in rear bedroom on the floor. [Neighbor] last spoke with victim on 13 July 95. Residents had not seen victim recently. Victim was in full rigor mortis. R/Os unable to locate the whereabouts of victim's relatives . . .
>
> Female, age 73, white, July 17, 1995:
>
> A recluse for 10 yrs, never left apartment, found today by son, apparently DOA. Conditions in apartment when R/Os arrived thermostat was registering

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> over 90 degrees f. with no air circulation except for windows opened by son [after death]. Possible heat-related death. Had a known heart problem 10 yrs ago but never completed medication or treatment . . .

Male, age 54, white, July 16, 1995:

> R/O learned . . . that victim had been dead for quite awhile. . . . Unable to contact any next of kin. Victim's room was uncomfortably warm. Victim was diabetic, doctor unk. Victim has daughter . . . last name unk. Victim hadn't seen her in years. . . . Body removed to C.C.M. [Cook County Morgue].

Male, age 79, black, July 19, 1995:

> Victim did not respond to phone calls or knocks on victim's door since Sunday, 16 July 95. Victim was known as quiet, to himself and, at times, not to answer the door. X is landlord to victim and does not have any information to any relatives to victim. . . . Chain was on door. R/O was able to see victim on sofa with flies on victim and a very strong odor decay (decompose). R/O cut chain, per permission of [landlord], called M.E. [medical examiner] who authorized removal. . . . No known relatives at this time.

These accounts rarely say enough about a victim's death to fill a page, yet the words used to describe the deceased—"recluse," "to himself," "no known relatives"—and the conditions in which they were found—"chain was on door," "no air circulation," "flies on victim," "decompose"—are brutally succinct testaments to forms of abandonment, withdrawal, fear, and isolation that proved more extensive than anyone in Chicago had realized, and more dangerous than anyone had imagined. "During the summer heat wave of 1995 in Chicago," the authors of the most thorough epidemiological study of the disaster explained, "anything that facilitated social contact, even membership in a social club or owning a pet was associated with a decreased risk of death" (Semenza et al., 1996: 90). Chicago residents who lacked social ties and did not leave their homes regularly died disproportionately during the catastrophe.

Three questions motivate this article. First, why did so many Chicagoans *die alone* during the heat wave? Second, to expand this question, why do so many Chicagoans, particularly older residents, *live alone* with limited social contacts and weak support during normal times? What accounts for the social production of isolation? Third, what social and psychological processes organize and animate the experiential make-up of aging alone? How can we understand the lives and deaths of the literally isolated?

↑ Researchquestions

DYING ALONE

If "bowling alone," the social trend reported by Robert Putnam and mined for significance by social critics and politicians of all persuasions (Putnam, 1995), is a sign of a weakening American civil society, dying alone—a fate few Americans can confidently elude—carries even more powerful social and symbolic meaning. For while in advanced societies the normative "good death" takes place at home, it is even more crucial that the process of dying is collective, shared by the dying person and his or her community of family and friends.[3] When someone dies alone and at home the death is a powerful symbol of social abandonment and failure. The community to which the deceased belonged, whether familial, friendship-based, or political, is likely to suffer from stigma or shame as a consequence, one which it must overcome with redemptive narratives and rituals that reaffirm the bonds among the living (Seale, 1995).

The issues of aging and dying alone are hardly limited to Chicago. In Milwaukee, where a similar proportion of city residents died during the 1995 heat wave (US Centers for Disease Control and Prevention, 1996), 27 percent of the decedents, roughly 75 percent of whom were over 60, were found alone more than one day after the estimated time of death (Nashold et al., n.d.). Most older people in Western societies, and particularly in the United States, place great value on their independence, a characteristic of sufficient cultural and psychological importance that people for whom independence is objectively dangerous are often willing to risk its consequences in order to remain self-sufficient. The number of older people living alone is rising almost everywhere in the world, making it one of the major demographic trends of the contemporary period. According to the US Census Bureau, the total

individualism

number of people living alone in the United States rose from 10.9 million in 1970 to 23.6 million in 1994 (Wuthnow, 1998); and, as Tables 9-1 and 9-2 show, the proportions of American households inhabited by only one person and of elderly people living alone have soared since the 1950s. Dramatic as these figures are, they are certain to rise even higher in the coming decades as societies everywhere age.

maybe b/c people living longer.

Ethnographers have done little to document the daily routines and practices of people living alone,[4] but a recent study in the *New England Journal of Medicine* (Gurley et al., 1996) suggests that their solitary condition leaves them vulnerable in emergency situations and times of illness. Researchers in San Francisco, a city about one-quarter the size of Chicago, reported that in a 12 week period emergency medical workers found 367 people who lived alone and were discovered in their apartments either incapacitated or, in a quarter of the cases, dead. The victims, as in the Chicago heat wave, were disproportionately old, white and African American, with older black men most over-represented. Many of them, the researchers reported, suffered tremendously while they waited to be discovered in their homes, suffering that could have been reduced by earlier intervention but was exacerbated by the victims' isolation (Gurley et al., 1996).

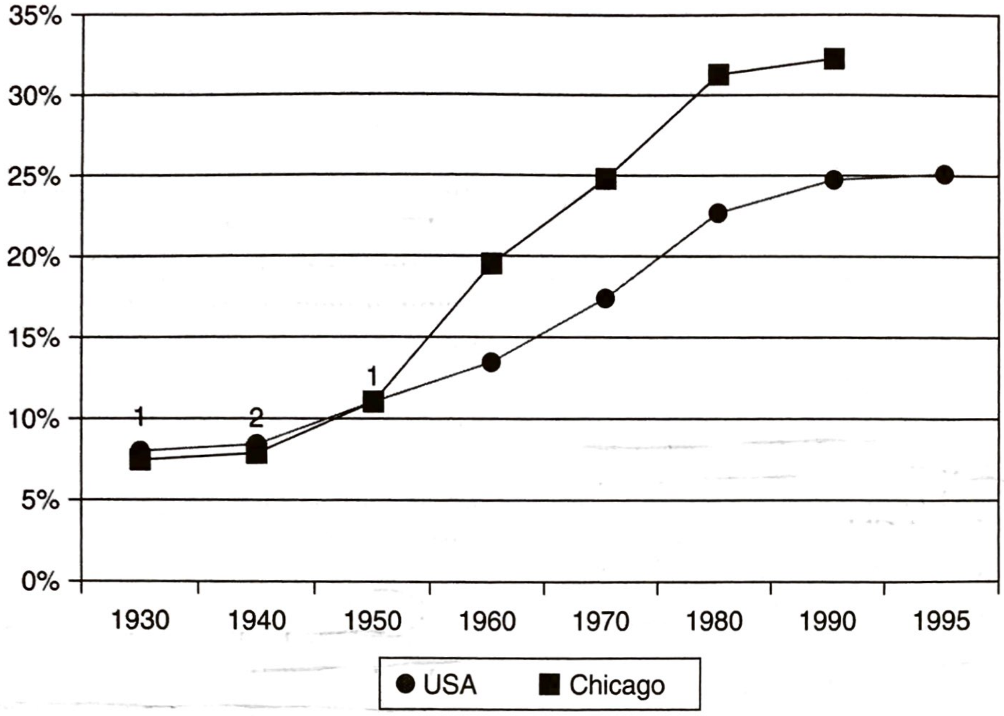
Old white + AA

In this article I examine the lived experiences of isolated Chicago residents, placing them in the context of the changing demography and ecology of the city and paying special attention to the ways in which migration patterns, increasing lifespans and changes in urban social morphology have altered the structural conditions of social and support networks. I also consider the impact of the spreading *culture of fear* that has transformed the nature of social life and community organization as well as the physical and political structure of cities. To illustrate how city residents experience these conditions and depict how they impact on the social life of the city, I return to the streets and neighborhoods of Chicago, drawing upon ethnographic research to flesh out the haunting spectre of dying alone in the great metropolis. Although we cannot speak with those who perished during the heat wave, we can look closely at the conditions in which they died and then follow up by examining the experiences of people in similar conditions today. Thus my focus moves outward from the heat wave to the years immediately following when I conducted fieldwork alongside seniors living alone in Chicago.

It is important to make distinctions between *living alone, being isolated, being reclusive,* and *being lonely.* I define alone as residing without other people in a household; being isolated as having limited social ties; being reclusive as largely confining oneself to the household; and being lonely as the subjective state of feeling alone.[5] Most people who live alone, seniors included, are neither lonely nor deprived of social contacts.[6] This is significant because seniors who are embedded in active social networks tend to have better health and greater longevity than those who are relatively isolated. Being isolated or reclusive, then, is more consequential than simply living alone. But older people who live alone are more likely than seniors who live with others to be depressed, isolated, impoverished, fearful of crime and removed from proximate sources of support.[7] Moreover, seniors who live alone are especially vulnerable to traumatic outcomes during episodes of acute crisis because there is no one to help recognize emerging problems, provide immediate care or activate support networks.

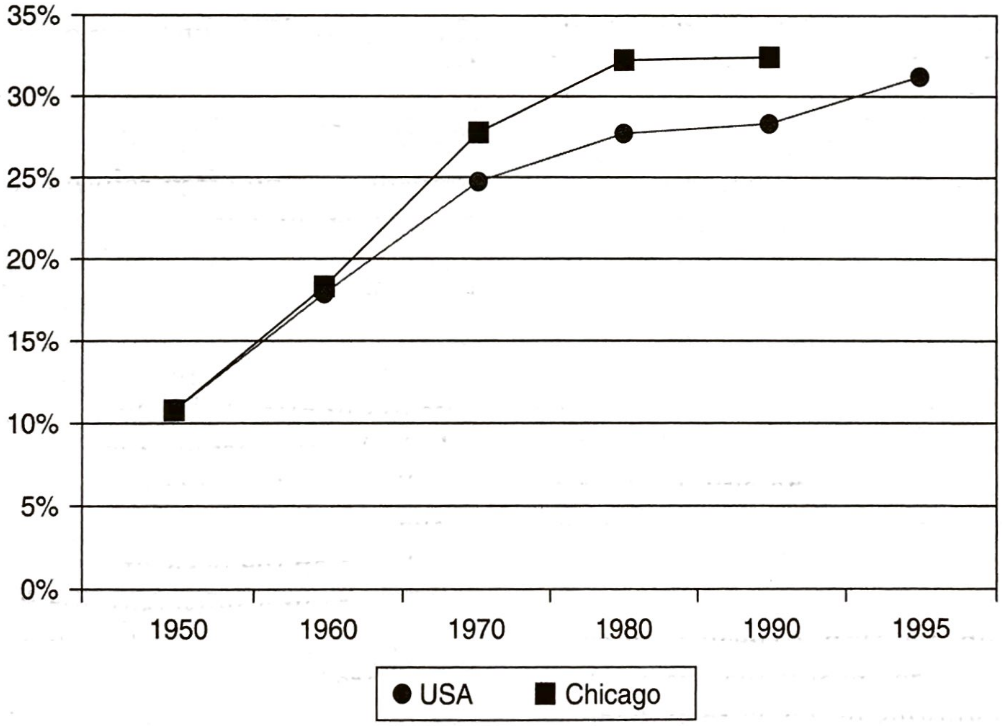
It is difficult to measure the number of people who are relatively isolated and reclusive because they have few ties to informal or formal support networks or have little exposure to researchers. In surveys and censuses, isolates and recluses are among the social types most likely to be uncounted or undercounted because those with permanent housing often refuse to open their doors to strangers and are unlikely to participate in city or community programs through which they can be tracked. In academic research it is common to underestimate the extent of isolation or reclusion among seniors because most scholars gain access to samples of elderly people who are already relatively connected. One recent book about loneliness in later life, for example, makes generalizations about the prevalence of isolation and loneliness on the basis of a survey of seniors who participate in a university for the aged (Gibson, 2000) and even medical studies of isolation and health are likely to exclude people whom medical doctors and research teams never see or cannot locate. . . .

Table 9-1. Proportion of American households with one inhabitant.



Source: *The Statistical Abstract of the United States* (1980, 1989, 1999), US Census Bureau.

Table 9-2. Proportion of American elderly (65+) living alone.



Source: *The Statistical Abstract of the United States* (1980, 1989, 1999), US Census Bureau.

What social conditions produce isolation?

What social conditions produce isolation? And how can we understand the lived experience of isolation itself? The heat wave mortality patterns pointed to places in the city where isolation proved to be especially dangerous and suggested sites where similarly situated isolates who survived the disaster but remained alone and vulnerable to the problems stemming from reclusiveness were concentrated. In addition, the disaster illuminated a set of demographic, cultural and political conditions that are associated with isolation, forming the broader social context in which social isolation emerges.

4 conditions contribute to social isolation

There are four key social conditions that contribute to the production of literal and extreme social isolation: first, the aging of the urban population, particularly the increases in the population of African American, Latino and Asian seniors; second, the fear of crime stemming from the violence and perceived violence of everyday life—in extreme forms this fear can result in the retreat from public life altogether and the creation of urban burrows, "safe houses" where the alone and the afraid protect themselves from a social world in which they no longer feel secure; third, the degradation and fortification of public spaces in poor urban areas and specific residential facilities (such as senior public housing units and some single-room-occupancy hotels); fourth, the transformation in the nature of state social services and support systems such as health care, public or subsidized housing and home energy subsidies. The interaction of these conditions with poverty and the daily deprivations it entails renders poor seniors who live alone vulnerable to a variety of dangers whose consequences can be severe.

Our focus on social isolation should not obscure the fact that literal isolation is an uncommon condition. As Claude Fischer has shown, the overwhelming majority of city dwellers are integrated into personal networks that provide them with support during normal times as well as times of crisis (Fischer, 1982, 1984[1976]). There is, by now, compelling evidence that Wirth's general theory of urbanism—the thesis that city living will break down most forms of solidarity, destroying social groups and creating an anomic society and alienated, isolated individuals—is simply not true; nor is there evidence that city residents on the whole are any less socially integrated than residents of rural areas. Whether urbanites remain with their traditional ethnic groups or form new subcultural groups on the basis of shared interests and experiences (Fischer, 1975), decades of research have shown that, despite the common experience of feeling alone in crowded urban areas, in private life most city dwellers have rich and rewarding relationships and social networks (Fischer, 1982). What I want to show here, however, is that literal social isolation arises in certain situations which, although historically unusual, are becoming more common in American cities today.

"THE CLOSEST I'VE COME TO DEATH"

The first of the conditions producing extreme urban isolation and its experiential correlates is the general aging of American society and the willingness of seniors to live alone. For cities there are three specific pre-disposing factors: first, the rise in the number of seniors living alone, often after outliving their social contacts and seeing their children migrate to the suburbs or other regions of the country altering their neighborhood populations so that they feel culturally or linguistically differentiated; second, the rapid increase in the population of "very old" seniors, 85 and above, who are more likely to be both alone and frail, sick, and unable or unwilling to enter into a public world in which they often feel vulnerable and who are, in fact, an historically new group, older than all previous cohorts and subjected to a distinct set of physical constraints; and third, the increase in the population of black and Latino seniors, who are more likely than their white counterparts to live in poverty and be at risk of the related forms of vulnerability, including illness and inadequate access to health care (Ford, et al., 1992; Lawlor et al., 1993). There is a fourth implication for metropolitan areas (as distinct from central cities) which is the growth of the elderly population in the suburban ring which in general lacks the appropriate housing stock and support systems for aged and aging residents.

By 1990, one-third of Chicago's elderly population, roughly 110,000 seniors, lived alone. When a group of researchers from the Heartland Center on Aging, Disability and Long Term Care at Indiana University surveyed Chicago seniors in 1989 and 1990, they found that 48 percent of Chicagoans over 65, and 35 percent of suburbanites over 65, reported having no family members available to assist them (Fleming-Moran et al., 1991).

Pauline Jankowitz is one of the recluses I got to know during my fieldwork in Chicago.[8] Her story helps to illustrate some of the fundamental features of life alone and afraid in the city. I first met Pauline on her 85th birthday, when I was assigned to befriend her for a day by the local office of an international organization that supports seniors living alone by linking them up with volunteers who are willing to become "friends" and inviting them to the organization's center for a birthday party, Christmas and a Thanksgiving dinner every year. A stranger before the day began, I became her closest companion for the milestone occasion when I picked her up at the uptown apartment where she had lived for 30 years.

Pauline and I had spoken on the phone the previous day and she was expecting me when I arrived late in the morning. She lived on a quiet residential street dominated by the small, three and four-flat apartment buildings common in Chicago. The neighborhood, a key site of departure and arrival for suburbanizing and new urban migrants, had changed dramatically in the time she had lived there, and her block had shifted from a predominately white ethnic area in which Pauline was a typical resident to a mixed street with a sizable Asian and increasingly Mexican population. Uptown remained home to her, but she was less comfortable in it because the neighbors, whom she was eager to praise for their responsibility and good character, were no longer familiar to her. "They are good people," she explained, "but I just don't know them." Her situation is similar to that of thousands of Chicago residents and millions of seniors across the country who have *aged in place* while the environment around them changes.

The major sources of her discomfort were her physical infirmities which grew worse as she aged, a bladder problem that left her incontinent and a weak leg that required her to walk with a crutch and drastically reduced her mobility, and her real terror of crime, which she heard about daily on the radio and television shows that she likes. "Chicago is just a shooting gallery," she told me, "and I am a moving target because I walk so slowly." Acutely aware of her vulnerability, Pauline reorganized her life to limit her exposure to the threats outside, bunkering herself in a third-floor apartment (in a building with no elevator) that she had trouble reaching because of the stairs, but which "is much safer than the first floor. . . . If I were on the first floor I'd be even more vulnerable to a break-in." With a home-care support worker, meals-on-wheels and a publicly subsidized helper visiting weekly to do her grocery shopping and help with errands, Pauline has few reasons to leave home. "I go out of my apartment about six times a year," she told me, and three of them are for celebrations sponsored by the support organization.

It is, I would learn, a challenge for service providers and volunteers to help even the seniors with whom they have contact. Pauline and I made it to the birthday celebration after a difficult and painful trip down her stairway, during which we had to turn around and return to the apartment so that she could address "a problem" that she experienced on the stairs. Pauline's grimaces and sighs betrayed the depth of the pain the walk had inflicted, but she was so excited to be going out, and going to her party, that she urged me to get us to the center quickly.

During one visit, Pauline, who knew that I was studying the 1995 heat wave, told me that she wanted to tell me her story. "It was," she said softly, "the closest I've come to death." She has one air conditioner in her apartment which gets especially hot during the summer because it is on the third floor. But the machine "is old and it doesn't work too well," which left her place uncomfortably, if not dangerously warm during the disaster. A friend had told her that it was important for her to go outside if she was too hot indoors, so she woke up very early ("it's safer then") on what would become the hottest day of the heat wave and walked towards the local store to buy cherries ("my favorite fruit, but I rarely get fresh food so they're a real treat for me") and cool down in the air conditioned space. "I was so exhausted by the time I got down the stairs that I wanted to go straight back up again," she recounted, "but instead I walked to the corner and took the bus a few blocks to the store. When I got there I could barely move. I had to lean on the shopping cart to keep myself up." But the cool air revived her and she got a bag of cherries and returned home on the bus.

"Climbing the stairs was almost impossible," she remembers. "I was hot and sweaty and so tired." Pauline called a friend as soon as she made it into her place and as they spoke she began to feel her hands going numb and swelling, a sensation that quickly extended into other parts of her body, alarming her that something was wrong. "I asked my friend to stay on the line but I put the phone down and lied down." Several minutes later, her friend still on the line but the receiver on the floor, Pauline got up, soaked her head in water, directed a fan towards her bed, lay down, and placed a number of wet towels on her body and face. Remembering that she had left her friend waiting, Pauline got up, picked up the phone to report that she was feeling better and to thank her buddy for waiting before she hung up. Finally, she lay down again to cool off and rest in earnest. Before long she had fully recovered.

"Now," she ended her story, "I have a special way to beat the heat. You're going to laugh, but I like to go on a Caribbean cruise," which she does alone and, as she does nearly everything else, without leaving her home.

> I get several wash cloths and dip them in cold water. I then place them over my eyes so that I can't see. I lie down and set the fan directly on me. The wet towels and the wind from the fan give a cool breeze, and I imagine myself on a cruise around the islands. I do this whenever it's hot, and you'd be surprised at how nice it is. My friends know about my cruises too. So when they call me on hot days they all say, "Hi Pauline, how was your trip?" We laugh about it, but it keeps me alive.

Social ecological conditions stemming from migration patterns and the widespread abandonment of urban regions have created new barriers to collective life and social support, particularly for the elderly. In *When Work Disappears* William Julius Wilson noted the significance of depopulation in poor black neighborhoods for both formal and informal social controls (Wilson, 1996: 44–5). Most scholars who have analyzed urban social support systems have focused on provision for children, but the changing demographics of the city suggest that it is increasingly important to consider how these systems work for older neighborhood residents as well. The problems are not exclusive to black and Latino communities. Since the 1950s, many white ethnic groups have experienced a sweeping suburbanization that has undercut the morphological basis for cross-generational support, leaving thousands of white seniors estranged in neighborhoods that their families and friends had left behind, out of reach during times of need but also during everyday life. As the concentration of heat wave deaths among seniors in the traditionally Polish and Slav neighborhoods on the southwest side of Chicago suggests, many of the older Italians, Slavs and Poles whose communities appeared so resilient in the work of Kornblum (1974) and Suttles (1968) have been separated from their children and extended family ties. These patterns are becoming more prevalent in Latino and African American communities as they join the suburban exodus, leaving behind older and poorer people for whom the loss of proximity to family and friends will be compounded by the relatively high rates of poverty and illness in America's so-called minority groups.

In addition to the fraying lines of social support from families experiencing generational rifts due to migration, the changing nature of friendship networks has also undermined the morphological basis of mutual assistance. For decades, community scholars have shown that many communities are no longer place-based, but organized instead around common interests and values. Advanced technology, including the telephone and the internet, ease the process of establishing connections with people in disparate places and therefore increase the probability that new social networks will develop without much regard for spatial proximity. Yet, as much research has established, certain forms of social assistance, particularly emergency care and frequent visitation, are more likely when members of a network are physically close to one another. Indeed, after the heat wave, epidemiologists found that older Chicagoans who had died during the disaster were less likely than those who survived to have had friends in the city (Semenza et al., 1996: 86). Spatial distance, in other words, imposes real barriers to social support for friends as well as family. Proximity is a life and death matter for some people, particularly for the elderly who suffer from limited mobility.

"I'LL TALK THROUGH THE DOOR"

Although old age, illness and spatial separation from her family and friends established the grounding for Pauline Jankowitz's condition, her isolation became particularly extreme because of her abiding fear of being victimized by crime. Pauline's perception of her own extreme vulnerability heightens her fear, but her concerns are in fact typical of city dwellers throughout the United States at a time when a veritable culture of fear and a powerful cultural industry based on crime have come to influence much of the organizational, institutional and political activity within the country as well as the thought and action of Americans in their everyday lives. By the late 1990s, fear of crime has taken on a paradoxical role in American urban life, on the one hand pushing people to dissociate from their neighbors and extend their social distance from strangers, and on the other hand becoming one of the organizing principles of new collective projects, such as neighborhood watch groups and community policing programs. Regardless of the form it takes, "coping with crime," as Wesley Skogan and Michael Maxfield put it in the title of their book (Skogan and Maxfield, 1981), has become a way of life for Americans in general and for residents of notably violent cities such as Chicago.

Throughout Chicago and especially in the most violent areas, city residents have reorganized their daily routines and behaviors in order to minimize their exposure to crime in an increasingly Hobbesian universe, scheming around the clock to avoid driving, parking or walking on the wrong streets or in the wrong neighborhoods, seeing the wrong people and visiting the wrong establishments and public places. In Chicago, as in most other American cities, "wrong" in this context is associated with blacks in general and young men in particular, especially now that the massive dragnet cast by the drug warrior state has captured so many young blacks and labeled them as permanent public enemies (Wacquant, 2001). Yet doing fieldwork in even the most objectively dangerous streets of Chicago makes it clear that the common depiction of city residents, and particularly those who live in poor and violent aras, as constantly paranoid and so acutely concerned about proximate threats that they can hardly move, is a gross misrepresentation of how fear is managed and experienced. "It's caution, not fear, that guides me," Eugene Richards, a senior citizen living in North Lawndale explained to me during a discussion of managing danger in the area. Eugene will walk a few blocks during the day, but he refuses to go more than four blocks without a car. Alice Nelson, a woman in her 70s who lives in the Little Village, walks during the day and carries small bags of groceries with her. "But I won't go out at night," she told me. "And if someone comes to the door I won't open it. I'll talk through the door because you never know . . ."[9]

Preying on the elderly, who are presumed to be more vulnerable and easier to dupe, is a standard and recurrent practice of neighborhood deviants and legitimate corporations, mail-order businesses and salespersons alike. Several of my informants said that turning strangers away at the door was part of their regular routine, and complained that they felt besieged by the combination of local hoodlums who paid them special attention around the beginning of the month when social security checks were delivered as well as outsiders who tried to visit or call and convince them to spend their scarce dollars. In the United States, where guns are easy to obtain and levels of gun-related violence are among the highest in the world, roughly one-quarter of households are touched by crime each year, and about one-half of the population will be victimized by a violent crime in their life-time (Miethe, 1995). The nature of the association between fear and vulnerability is enigmatic because it is impossible to establish that the lower levels of victimization are not at least partially attributable to fear which causes people to avoid potentially dangerous situations and, in the most extreme cases, pushes people to become recluses, "prisoners of their own fear," as one social worker I shadowed calls them. Nonetheless, many scholars of crime have argued that fear of crime is irrational because of the often-cited finding that the elderly and women, who are the least likely to be victimized, are the most fearful of crime. Yet ethnographic observation and more fine-grained surveys of fear can show what grounds these concerns.

First, community area or neighborhood characteristics influence levels of fear. Just as city residents tend to be more concerned about crime than residents of suburban and rural areas, African Americans and other ethnic groups who live in areas with higher levels of crime are more likely than whites to report fear of crime in surveys (Joseph, 1997; Miethe, 1995). Signs of neighborhood "disorder," such as abandoned buildings, vandalism, litter and graffiti, instill fear in local residents, whereas, as Richard Taub and his colleagues found in Chicago, neighborhood resources, such as stores, safe public spaces, and active collective life provide incentives for city dwellers to overcome their fears and participate in public activities (Joseph, 1997; Miethe, 1995; Skogan, 1990; Taub et al., 1984). Second, as Sally Engle Merry concluded from her study of a high-crime, multi-ethnic urban housing project, once residents of a particular area grow fearful of crime a vicious cycle begins: fear causes people to increase the amount of time they spend at home and reduces their willingness to socialize with their neighbors; reclusiveness increases the social distance between residents and their neighbors creating a community of strangers who grow even more fearful of each other; heightened fear leads to heightened reclusiveness, and so on (Merry, 1981).

In interviews and casual conversations conducted during my fieldwork, Chicago seniors provided their own explanations for the fear that so many criminologists and city officials seem unable to understand. Many of the seniors I got to know said that although they knew that they were unlikely to be robbed or attacked, their heightened concern about victimization stemmed from their knowledge that if they were victimized, the consequences, particularly of violent crime, would be devastating in ways that they would not be for younger people. At the economic level, seniors living on fixed and limited incomes feared that a robbery or burglary could leave them without sufficient resources to pay for such basic needs as food, medication, rent or energy. In Chicago, where hunger, under-medication, homelessness, displacement and energy deprivation are not uncommon among seniors, these are not unfounded concerns. At the physical level, seniors, for whom awareness of bodily frailty is one of the defining conditions of life, are afraid that a violent attack could result in permanent disabilities, crippling and even death. The elderly make it clear that their fears of crime are directly related to their concerns about the difficulty of recovering from crime and that their sensitivities to danger were rational from their points of view.

DEAD SPACE

A cause and consequence of this culture of fear is the degradation and fortification of urban public spaces in which city dwellers circulate. The loss of viable public space is the third condition that gives rise to literal social isolation undermining the social morphological foundations of collective social life and so giving rise to sweeping insecurity in everyday urban life. The real and perceived violence of the city has pushed Chicago residents to remake the sociospatial environment in which they live.[10] In Chicago the degradation of public space has been most rampant in the city's hyperghettos, where the flight of business, the retrenchment of state supports, the out-migration of middle-class residents, the rise of public drug markets, and the concentration of violent crime and victimization have radically reduced the viability of public spaces (Wacquant, 1994). Despite the real decreases in crime that Chicago experienced in the mid-1990s, the overall crime rate in Chicago is falling at a slower pace than in all of the other major American cities. According to the Chicago Community Policing Evaluation Consortium, a major research project directed by Wesley Skogan at Northwestern University, "the largest declines [in crime] have occurred in the highest-crime parts of the city," and "the greatest decline in gun-related crime has occurred in African-American neighborhoods" (Chicago Community Policing Evaluation Consortium, 1997: 6–8). Nonetheless the levels of violent crime concentrated in poor black areas of the city remain comparatively high, making it difficult for residents to feel safe in the streets. A study by the Epidemiology Program at the Chicago Department of Public Health showed that in 1994 and 1995 the overall violent crime rate as reported to the Chicago Police Department, a likely underestimation of the true victimization levels, was 19 violent crimes for every 100 residents of Fuller Park, the community area that had the highest mortality levels during the heat wave. Other community areas with high heat wave mortalities had similar crime levels: Woodlawn, with the second highest heat mortality rate, reported 13 violent crimes per 100 residents; Greater Grand Crossing reported 11 per 100; Washington Park, Grand Boulevard, and the near south side, all among the most deadly spots during the disaster, listed rates above 15 crimes per 100 residents as well, suggesting, as did the Illinois Department of Public Health, an association between the everyday precariousness of life in these neighborhoods and vulnerability during the heat wave (City of Chicago, 1996). In contrast, Lincoln Park, the prosperous community on the near north side, reported two violent crimes for every 100 residents, and a heat wave mortality rate among the lowest in the city (City of Chicago, 1996).

But the conditions of insecurity are hardly confined to the Chicago ghettos, and constant exposure to images and information about violence in the city has instilled genuine fear in communities throughout the city. Moreover, the depacification of daily life that is concentrated in the city's ghettos has emerged on a smaller scale in other parts of Chicago, affecting a broad set of buildings, blocks, and collective housing facilities as well as neighborhood clusters. Several studies have documented the erosion of the sociospatial infrastructure for public life in low-income barrios and ghettos, therefore I will focus here on showing the ways in which spatial degradation and public crime have fostered reclusiveness in settings, such as senior public housing units, where many of the heat wave deaths occurred.

In the four years leading up to the heat wave conditions in the city's senior public housing facilities bucked all of Chicago's crime trends. Residents of these special units experienced a soaring violent crime rate even as the overall crime levels in the Chicago Housing Authority (CHA) family projects and the rest of the city declined, forcing many residents to give up not only the public parks and streets that once supported their neighborhoods, but the public areas within their own apartment buildings as well. In the 1990s the CHA opened its 58 senior buildings, which house about 100,000 residents and are dispersed throughout the city although generally located in safer areas than the family public housing complexes, to people with disabilities as well as to the elderly. The 1990 Americans with Disabilities Act made people with substance abuse problems eligible for social security insurance and the CHA welcomed them into senior housing units as well. Unfortunately this act of accommodation has proven disastrous for senior residents and the communities they had once established within their buildings: the mix of low-income substance abusers, many of whom continue to engage in crime to finance their habits, and low-income seniors, many of whom keep everything they own, savings included, in their tiny apartments, creates a perfect formula for disaster in the social life of the housing complex.

In March of 1995, just a few months before the heat wave, the Chicago Housing Authority reported that from 1991 to 1994 the number of Part I crimes (in which the US Justice Department includes homicide, criminal sexual assault, serious assault, robbery, burglary, theft and violent theft) committed and reported within CHA housing increased by over 50 percent. "The elderly in public housing," a group of CHA tenants and advisers called the Building Organization and Leadership Development (BOLD) group reported, "are more vulnerable than seniors in assisted or private housing in that they are being victimized in many cases by their neighbors." Moreover, BOLD showed that thefts, forcible entry, armed robbery, "and other crimes of violence are substantially higher in those developments housing a large percentage of non-elderly disabled. . . . The reality appears to be that disabled youth are victimizing seniors" (BOLD, 1995).

Elderly residents of senior buildings throughout the city now voice the same complaint: they feel trapped in their rooms, afraid that if they leave they might be attacked or have their apartment robbed, and the most afraid refuse to use the ground floor common rooms unless security workers are there. The fortification of public space that contributes to isolation all over the city is exacerbated here. Most residents, to be sure, do manage to get out of their units, but they have to limit themselves to secure public areas, elevators and halls. Unable to reduce the structural conditions of insecurity in the buildings, workers at the Chicago Department on Aging recently initiated a program to help residents develop building watch groups in the senior complexes. True to its mission to enable as well as provide, the city has increased the security services in the buildings but has also encouraged the elderly and poor CHA residents to arm themselves with flashlights, cellular phones and badges to patrol their home turf. Yet while one branch of the city government prepares the seniors for a feeble battle against the conditions that another branch of the city has created, the most worried and disaffected residents of the senior buildings respond by sealing off their homes with home-made security systems designed to ward off invaders.

Concern about the proximity of younger residents and their associates who are using or peddling drugs is ubiquitous in Chicago's senior housing complexes. During an interview in her home, one woman, a resident of a CHA building on the near west side, expressed remorse that a formerly pleasant and popular patio on the top floor had been vandalized and looted by younger residents and their friends. The group had first taken the space over and made it their hangout spot, then decided to take some of the furniture and even the fire extinguishers for themselves. Some older residents, she explained to me, did not want to make a big deal out of the problem because they worried that their young neighbors would learn who had informed security and then retaliate. The fear of young people and the demonization of drug users common in contemporary American society rendered the situation more difficult, as many building residents presumed that the younger residents would cause trouble and were scared to approach them. Ultimately, the seniors have been unable to fix up the area or win it back. "Now," she sighed, "no one uses that space. It's just empty, dead."

"I NEVER HAVE ENOUGH TIME TO SEE THEM"

The current array of programs and services is insufficient to provide primary goods such as adequate housing, transportation, energy assistance, reliable health care and medication for the elderly poor, leaving private agencies and numerous charities to address gaps that they have no means to fill. Local welfare state agencies in American cities historically have lacked the resources necessary to meet the needs of impoverished and insecure residents, but in the 1990s the rise of entrepreneurial state programs that required more active shopping services from consumerist citizens created additional difficulties for the most isolated and vulnerable city residents. Studies of Chicago's programs for the poor elderly had warned officials about the dangers of residents falling through gaps in the withering safety net. After conducting a major study of Chicago's support programs and emergency services, social service scholar Sharon Keigher concluded that "city agencies are not equipped to intervene substantially with older persons who do not ask for help, who have no family, or who do not go to senior centers and congregate at meal sites. Yet, increasingly these persons—who tend to be very old, poor and living alone—are in need of multiple services" (Keigher, 1991: 12). Published as both an official city report (in 1987) and a scholarly book (in 1991), Keigher's findings were known to city agencies responsible for serving vulnerable seniors long before the heat wave. But the city government lacked both the resources and the political priorities necessary to respond to them sufficiently, and its agencies were poorly prepared for assisting needy seniors in either the heat disaster of 1995 or the struggles they take on regularly.

Government policies and procedures that limited the capacity of residents to enter programs and obtain resources they need is the fourth condition that produces literal isolation. These changes have been disproportionately destructive for the city's most impoverished residents, who have had to struggle to secure the basic resources and services necessary for survival that a more generous welfare state would provide. In a political context where private organizations provide most of the human services to elderly city residents, research must shift from state agencies and agents to include the private offices and employees through which local governments reach their constituents. Spending time alongside social workers and home care providers for Chicago seniors, it became clear that the city's incapacity to reach isolated, sick or otherwise vulnerable seniors during the heat wave was by no means an anomaly created by the unusual environmental conditions. Under-service for Chicago's poor elderly is a structural certainty and everyday norm in an era where political pressures for state entrepreneurialism have grown hand-in-hand with social pressures for isolation. Embedded in a competitive market for gaining city contracts which provides perverse incentives for agencies to underestimate the costs of services and overestimate their capacity to provide them, the agencies and private organizations I observed had bargained themselves into responsibilities that they could not possibly meet. "Most entrepreneurial governments promote *competition* between service providers," David Osborne and Ted Gaebler wrote in *Reinventing Government* (Osborne and Gaebler, 1992: 19), but competition undermines the working conditions of human service providers if it fosters efficiency but compromises the time and human resources necessary to provide quality care. "My seniors love to see me," Mandy Evers, an African-American woman in her late 20s who was on her fourth year working as a case manager, told me. "The problem is I never have enough time to get to them."

Stacy Geer, a seasoned advocate of Chicago seniors who spent much of the 1990s helping the elderly secure basic goods such as housing and energy, insists that the political mismatch between more entrepreneurial service systems and isolated seniors contributed to the vulnerability of Chicago seniors during the heat wave. "The capacity of service delivery programs is realized fully only by the seniors who are most active in seeking them out, who are connected to their family, church, neighbors, or someone who helps them get the things they need." In some circumstances, the aging process can hinder seniors who have been healthy and financially secure for most of their lives. Geer continues, "As seniors become more frail their networks break down. As their needs increase, they have less ability to meet them. The people who are hooked into the Department on Aging, the AARP, the senior clubs at the churches, they are part of that word of mouth network and they hear. I know, just from doing organizing in the senior community, that you run into the same people, and the same are active in a number of organizations."[11] Seniors who are marginalized at the first, structural level of social networks and government programs are then doubly excluded at the second, conjunctural level of service delivery because they do not always know of—let alone know how to activate—networks of support. Those who are out of the loop in their daily life are more likely to remain so when there is a crisis. This certainly happened during the heat wave, when relatively active and informed seniors used official cooling centers set up by the city while the more inactive and isolated elderly stayed home.

During the 1990s, however, not even the best-connected city residents knew where to appeal if they needed assistance securing the most basic of primary goods: home, energy and water. In Chicago, the combination of cuts to the budget for the federally-sponsored Low Income Home Energy Assistance Program (LIHEAP) and a market-model managerial strategy for punishing consumers who are delinquent on their bills has placed the poor elderly in a permanent energy crisis. Facing escalating energy costs (even before prices soared in 2000), declining government subsidies and fixed incomes, seniors throughout the city express great concern about the cost of their utilities bills and take pains to keep their fees down.[12]

Poor seniors I got to know understood that they would face unaffordable utilities costs in the summer if they used air conditioners. Epidemiologists estimate that "more than 50 percent of the deaths related to the heat wave could have been prevented if each home had had a working air conditioner," arguing that surely this would be an effective public health strategy (Semenza et al., 1996: 87). Yet the elderly who regularly struggle to make ends meet explain that they could not use air conditioners even if they owned them because activating the units would push their energy bills to unmanageable levels. But their energy crisis was pressing even during moderate temperatures. The most impoverished seniors I visited kept their lights off during the day, letting the television, their most consistent source of companionship, illuminate their rooms. Fear of losing their energy altogether if they failed to pay the bills has relegated these seniors to regular and fundamental forms of insecurity and duress. Yet their daily crisis goes largely unnoticed.

THE FORMULA FOR DISASTER

The four conditions highlighted here impose serious difficulties for all seniors. But they are particularly devastating for the elderly poor who cannot buy their way out of them by purchasing more secure housing in safer areas, visiting or paying for distant family members to visit, by obtaining private health insurance supplements or by using more expensive and safe transportation such as taxis to get out of the house or the neighborhood. Each one of the key conditions described in this article contributes to the production of the forms of isolation that proved so deadly during the heat wave and that continue to undermine the health and safety of countless older Chicagoans. But in many cases Chicago residents are subjected to all of the conditions together, and the combination creates a formula for disaster that makes extreme social, physical and psychological suffering a feature of everyday life. If aging alone, the culture of fear, the degradation and fortification of public space and the reduction of redistributive and supportive state programs continue at their current pace, more seniors will retreat to their "safe houses," abandoning a society that has all but abandoned them. Collectively producing the conditions for literal isolation, we have made dying alone a fittingly tragic end.

ACKNOWLEDGMENTS

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NOTES

1. For a synthetic sociological account of the conditions that helped produce the historic mortality rates, see Klinenberg (1999); for an epidemiological account, see Semenza et al. (1996).
2. Roughly 70 Chicagoans died on a typical July day during the 1990s. "Excess deaths" measures the variance from the expected death rate. In assessing heat wave mortality, forensic scientists prefer the excess death measure to the heat-related death measure, which is based on the number of deaths examined and recorded by investigators, because many deaths during heat waves go unexamined or are not properly attributed to the heat (Shen et al., 1998).
3. Sherwin Nuland is among the more recent writers to discuss the modern version of the *ars moriendi*. Describing a man dying of AIDS, Nuland writes, "During his terminal weeks in the hospital, Kent was never alone. Whatever help they could or could not provide him at the final hours, there is no question that the constant presence of his friends eased him beyond what might have been achieved by the nursing staff, no matter the attentiveness of their care" (Nuland, 1993: 196).
4. There is, of course, a brighter side to the extension of the life span, which is itself a sign of significant social and scientific progress. Aging alone, as Robert Coles and Arlie Hochschild have argued, can be a rich personal and social experience, albeit one filled with challenges. In *The Unexpected Community*, Hochschild documents the active social lives of a group of Bay Area seniors who, as she emphatically stated, "were not isolated and not lonely" but instead "were part of a community I did not expect to find" (Hochschild, 1973: xiv), one that worked together to solve the problem of loneliness that proves so troublesome for the elderly. There are vital communities of older people and Hochschild's research shows how these groups come into being, portraying them once they are made. But too often readers of Hochschild are so eager to celebrate the community she describes that they forget that she chose to study Merrill Court precisely because the residents there were an exceptional case. The opening lines of her epilogue explain the goal of her project much better than do many of her interpreters. She wrote, "The most important point I am trying to make in this book concerns the people it does not discuss—the isolated. Merrill Court was an unexpected community, an exception. Living in ordinary apartments and houses, in shabby downtown hotels, sitting in parks and eating in cheap restaurants, are old people in various degrees and sorts of isolation" (Hochschild, 1973: 137). Hochschild leaves it to others to render the social worlds of the isolated

as explicit as she makes the world in Merrill Court.

5. This conception of social isolation breaks from both sociological definitions of the term, which generally refer to relations between groups rather than people, and from conventional gerontological definitions of isolation, which define isolation as being single or living alone. There are, however, an increasing number of social network studies and gerontological reports that classify social integration or isolation by relative levels of social contact. Fischer and Phillips, for example, define social isolation as "knowing relatively few people who are probable sources of rewarding exchanges" (Fischer and Phillips, 1982: 22); Rubinstein classifies social integration and activity on a scale ranging from "very low range" to "high range" (Rubinstein, 1986: 172–9); and Gibson lists four types of loneliness: "physical aloneness," "loneliness as a state of mind," "the feeling of isolation due to a personal characteristic," and "solitude" (Gibson, 2004: 4–6).
6. See Gibson (2000) for a review of studies showing that most seniors who live alone are not lonely.
7. Thompson and Krause find that not only do people who live alone report more fear of crime than those who live with others, but also that "the greater sense of security among those who live with others appears to permeate beyond the home because they report less fear of crime than their counterparts" (Thompson and Krause, 1998: 356).
8. All personal names of Chicago residents have been changed.
9. Yet, as Alex Kotlowitz and teenage journalists LeAlan Jones and Lloyd Newman have shown in their accounts of growing up in Chicago's West and South Side housing projects, even young residents of the most violent urban areas are subjected to so much brutality, death and suffering that they have learned from their infancy how to organize their daily routines around the temporal and seasonal variations of the criminal economy (Jones et al., 1997; Kotlowitz, 1991). For Jones and Newman, managing fear and avoiding violence is such a fundamental part of their everyday lives that they decided to introduce and organize their book around it. "They used to shoot a lot in the summertime," Jones begins. Lloyd continues ominously, especially in light of the heat wave, "That's why I stayed in my house most of the time" (Jones et al., 1997: 31).
10. In 1995 Chicago ranked 6th in robbery and 5th in aggravated assaults among all United States cities with a population of over 350,000; in 1998 the city was the national leader in homicide, with the annual figure of 698 exceeding New York City's by about 100 even though Chicago is roughly one-third as populous; and throughout the 1990s its violent crime rate decreased much more slowly than any of the eight largest American cities (New York City, Los Angeles, Chicago, Houston, Philadelphia, Phoenix, San Diego, Dallas).
11. Internal pressures within state agencies and advocacy organizations push social workers and organizers to reward the most entrepreneurial clients with special attention. Overwhelmed with problem cases and operating in an environment where agencies must show successful outcome measures to garner resources from external funders who expect tangible results, the social workers I observed engaged in what Lipsky called "creaming," the practice of favoring and working intensively on the cases of people "who seem likely to succeed in terms of bureaucratic success criteria" (Lipsky, 1980: 107).
12. While the average Illinois family spends roughly 6 percent of its income on heat-related utilities during winter months, for low-income families the costs constitute nearly 35 percent (Pearson, 1995).

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10

GREATER EQUALITY: THE HIDDEN KEY TO BETTER HEALTH AND HIGHER SCORES

Richard Wilkinson and Kate Pickett

Let's consider the health of two babies born into two different societies. Baby A is born in one of the richest countries in the world, the United States, home to more than half of the world's billionaires. It is a country that spends somewhere between 40 and 50 percent of the world's total spending on health care, although it contains less than 5 percent of the world's population. Spending on drug treatments and high-tech scanning equipment is particularly high. Doctors in this country earn almost twice as much as doctors elsewhere and medical care is often described as the best in the world.

Baby B is born in one of the poorer of the western democracies, Greece, where average income is not much more than half that of the United States. Whereas America spends about $6,000 per person per year on health care, Greece spends less than $3,000. This is in real terms, after taking into account the different costs of medical care. And Greece has six times fewer high-tech scanners per person than the United States.

Surely Baby B's chances of a long and healthy life are worse than Baby A's?

In fact, Baby A, born in the United States, has a life expectancy of 1.2 years less than Baby B, born in Greece. And Baby A has a 40 percent higher risk of dying in the first year after birth than Baby B. Had Baby B been born in Japan, the contrast would be even bigger: babies born in the United States are twice as likely to die in their first year as babies born in Japan. As in Greece, in Japan average income and average spending on health care are much lower than in the United States.

If average levels of income don't matter (at least in relatively rich, developed countries), and spending on high-tech health care doesn't make so much difference, what does? We can't say with certainty, but inequality appears to be a driving force. Greece is not as wealthy as the United States, but in terms of income, it is much more equal—so is Japan. There are now many studies of income inequality and health that compare

research question.

Inequality appears to be driving force in health outcomes.

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more egalitarian societies are healthier

countries, American states, or other large regions, and the majority of these studies show that more egalitarian societies tend to be healthier.[1] This vast literature was given impetus by a study by one of us, on inequality and death rates, published in the *British Medical Journal* in 1992.[2] In 1996, the editor of that journal, commenting on further studies confirming the link between income inequality and health, wrote:

> The big idea is that what matters in determining mortality and health in a society is less the overall wealth of that society and more how evenly wealth is distributed. The more equally wealth is distributed the better the health of that society.[3]

The health outcomes↓

Inequality is associated with lower life expectancy, higher rates of infant mortality, shorter height, poor self-reported health, low birth weight, AIDS, and depression. Knowing this, we wondered what else inequality might affect.

To see whether a host of other problems were more common in more unequal countries, we collected internationally comparable data from dozens of rich countries on health and as many social problems as we could find reliable figures for.* The list we ended up with included:

- level of trust
- mental illness (including drug and alcohol addiction)
- life expectancy and infant mortality
- obesity
- children's educational performance
- teenage births
- homicides
- imprisonment rates
- social mobility

Occasionally, what appear to be relationships may arise spuriously or by chance. In order to be confident that our findings were sound, we also collected data for the same health and social problems—or as near as we could get to the same—for each of the 50 states of the United States. This allowed us to check whether or not problems were consistently related to inequality in these two independent settings. In short, they were— and strongly so.

To present the overall picture, we have combined all the health and social-problem data for each country, and separately for each U.S. state, to form an Index of Health and Social Problems for each country and U.S. state. Each item carries the same weight—so, for example, the score for mental health has as much influence on a society's overall score as the homicide rate or the teenage birth rate. The result is an index showing how common all these health and social problems are in each country and each U.S. state. The higher the score on the Index of Health and Social Problems, the worse things are. (Some items, such as life expectancy, were reverse scored, so that on every measure, higher scores reflect worse outcomes.)

We start by showing, in Figure 10-1, that there is a very strong tendency for ill health and social problems to occur less frequently in the more equal countries. With increasing inequality (to the right on the horizontal axis), the score on our Index of Health and Social Problems also increases. Health and social problems are indeed more common in countries with bigger income inequalities. The two are extraordinarily closely related—chance alone would almost never produce a scatter in which countries lined up like this.

To emphasize that the prevalence of poor health and social problems in rich countries really is related to inequality rather than to average living standards, we show in Figure 10-2 the same Index of Health and Social Problems, but this time in relation to average incomes (national income per person). It shows that there is no clear trend toward better outcomes in richer countries.

The evidence from the United States confirms the international picture. Across states, health and social problems are related to income inequality, but not to average income levels.

It is remarkable that these measures of health and social problems in the two different settings tell so much the same story. The problems in rich countries are not caused by the society not being rich enough (or even being too rich), but by the

richer countries don't have
better health outcomes.

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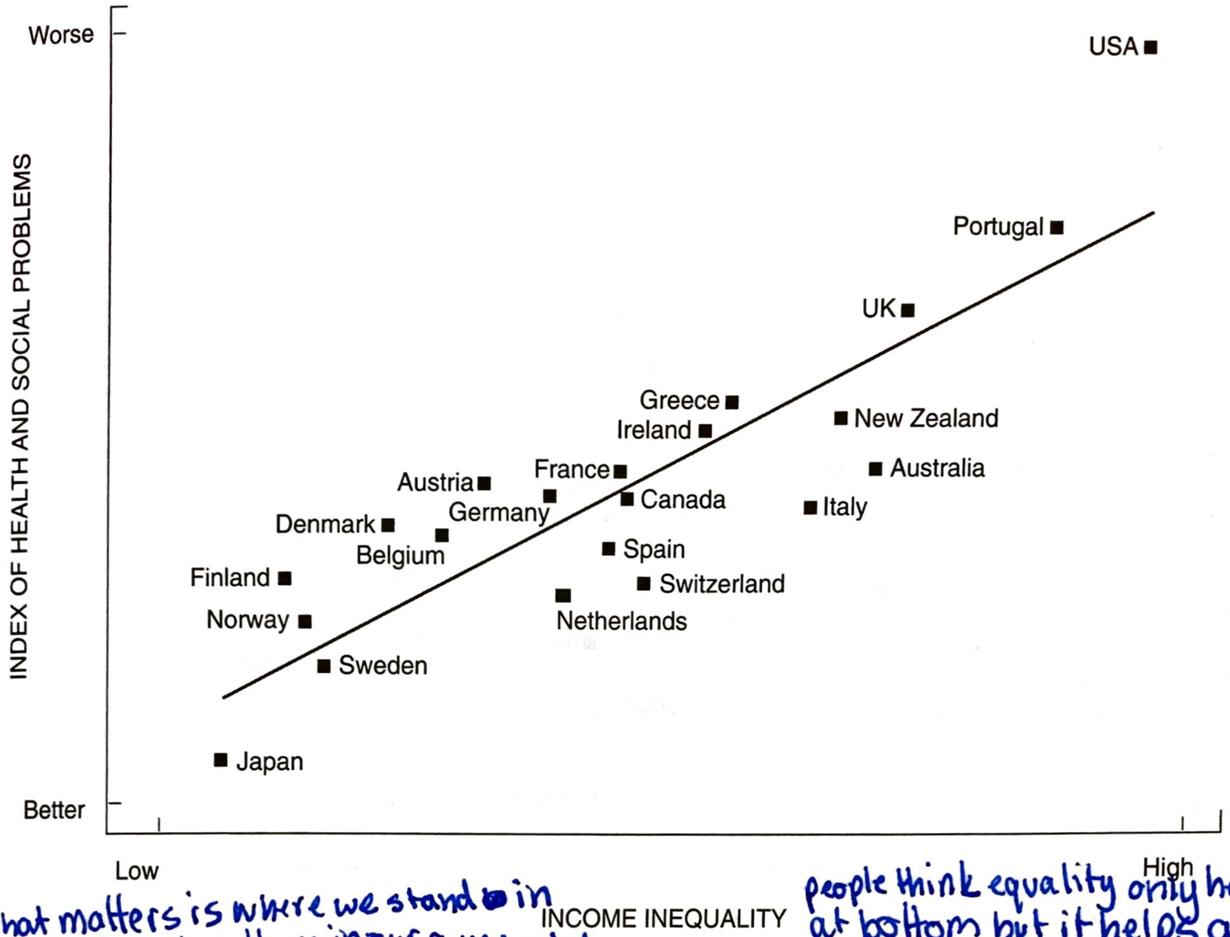
*All the data come from the most reputable sources—from the World Bank, the World Health Organization, the United Nations, and the Organisation for Economic Co-operation and Development, among others.

Figure 10-1. *Health and social problems are closely related to inequality within rich countries.*



what matters is where we stand in relation to others in our own society.

people think equality only helps those at bottom but it helps all.

material differences between people within each society being too big. What matters is where we stand in relation to others in our own society.

The importance of community, social cohesion, and solidarity to human well-being has been demonstrated repeatedly in research showing how beneficial friendship and involvement in community life are to health. Equality comes into the picture as a precondition for getting the other two right. Not only do large inequalities produce problems associated with social differences and the divisive class prejudices that go with them, but they also weaken community life, reduce trust, and increase violence.

It may seem obvious that problems associated with relative deprivation should be more common in more unequal societies. However, if you ask people why greater equality reduces these problems, the most common assumption is that greater equality helps those at the bottom. The truth is that the vast majority of the population is harmed by greater inequality.

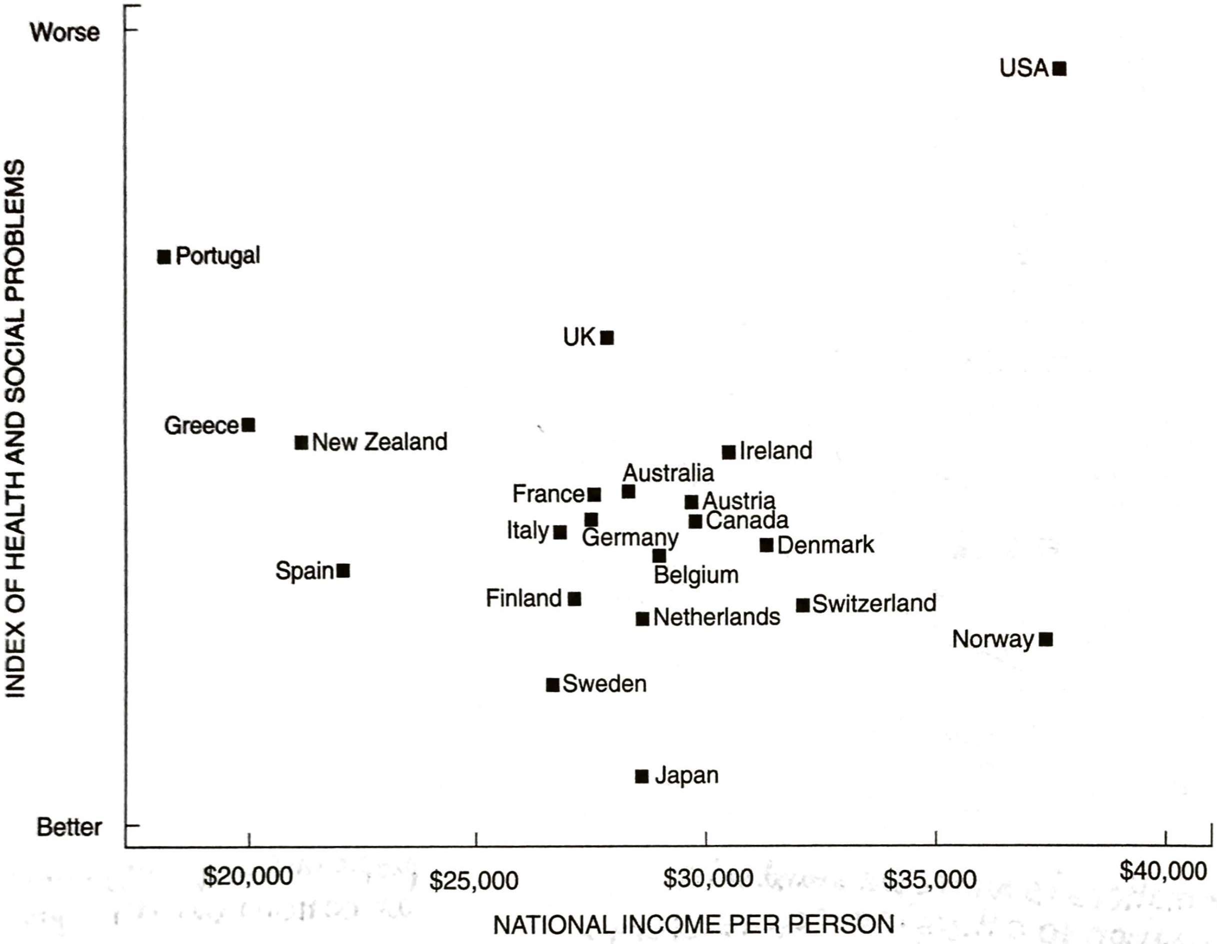
Across *whole* populations, rates of mental illness are three times as high in the most unequal societies compared with the least unequal societies. Similarly, in more unequal societies, people are almost ten times as likely to be imprisoned and two or three times as likely to be clinically obese, and murder rates may be many times higher. The reason why these differences are so big is, quite simply, because the effects of inequality are not confined just to the least well-off: instead, they affect the vast majority of the population. For example, as epidemiologist Michael Marmot frequently points out, if you took away all the health problems of the poor, most of the problem of health inequalities would still be untouched. For a more detailed example, let's take a look at the relation ship between equality and literacy.

mental illness
prison
obesity
murder rate

inequality affects health of whole population

Large inequalities produce divisive class prejudices + weaken community life, reduce trust, + increase violence.

Figure 10-2. *Health and social problems are only weakly related to the national average incomes of rich countries.*

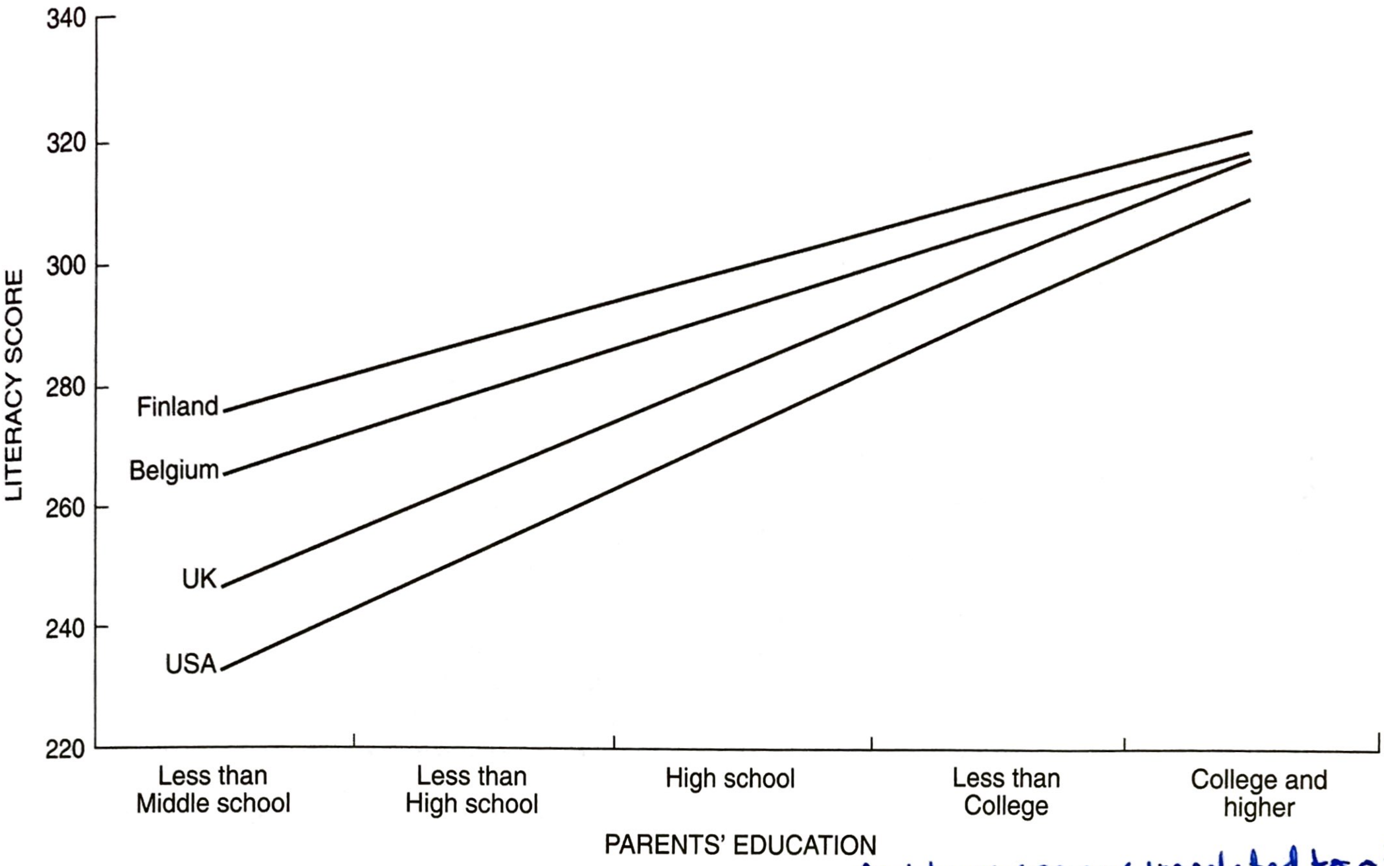


It is often assumed that the desire to raise national standards of performance in fields such as education is quite separate from the desire to reduce educational inequalities within a society. But the truth may be almost the opposite of this. It looks as if the achievement of higher national standards of educational performance may actually depend on reducing the social gradient in educational achievement in each country. Douglas Willms, professor of education at the University of New Brunswick in Canada, has provided striking illustrations of this.[4] In Figure 10-3, we show the relation between adult literacy scores from the International Adult Literacy Survey and their parents' level of education—in Finland, Belgium, the United Kingdom, and the United States.

This figure suggests that even if your parents are well educated—and so, presumably, of high social status—the country you live in makes some difference to your educational success. But for those lower down the social scale with less well-educated parents, it makes a much larger difference. An important point to note, looking at these four countries, is the steepness of the social gradient—steepest in the United States and the United Kingdom, where inequality is high; flatter in Finland and Belgium, which are more equal. It is also clear that an important influence on the average literacy scores in each of these countries is the steepness of the social gradient. The United States and the United Kingdom have low average scores, pulled down across the social gradient. In contrast, Finland and Belgium have high average scores, pulled up across the social gradient.

Willms has demonstrated that the pattern shown in Figure 10-3 holds more widely—internationally among 12 developed countries, as well as among Canadian provinces and U.S. states.[5]

Figure 10-3. *Adult literacy scores in relation to parents' education in four countries.*



The tendency toward divergence also holds; Willms consistently finds larger differences at the bottom of the social gradient than at the top.

What is most exciting about our research is that it shows that reducing inequality would increase the well-being and quality of life for all of us. Far from being inevitable and unstoppable, the deterioration in social well-being and the quality of social relations in society is reversible. Understanding the effects of inequality means that we suddenly have a policy handle on the well-being of whole societies.

Politics was once seen as a way of improving people's social and emotional well-being by changing their economic circumstances. But over the last few decades, the bigger picture seems to have been lost, at least in the United States, the United Kingdom, and several other rich countries in which inequality has increased dramatically. People are now more likely to see psychosocial well-being as dependent on what can be done at the individual level, using cognitive behavioral therapy—one person at a time—or on providing support in early childhood, or on the reassertion of religious or family values. Every problem is seen as needing its own solution—unrelated to others. People are encouraged to exercise, not to have unprotected sex, to say no to drugs, to try to relax, to sort out their work-life balance, and to give their children "quality" time. The only thing that many of these policies do have in common is that they often seem to be based on the belief that the poor need to be taught to be more sensible. The glaringly obvious fact that these problems have common roots in inequality and relative deprivation disappears from view. However, it is now clear that income distribution provides policymakers with a way of improving the psychosocial well-being of whole populations. Politicians have an opportunity to do genuine good.

We think psycho-social well-being is all about change at individual level.

Problems seen as unrelated to others. needing their own solution.

teach poor to be sensible

Rather than suggesting a particular route or set of policies to narrow income differences, it is probably better to point out that there are many different ways of reaching the same destination. Although the more equal countries often get their

Problems have roots in inequality.

greater equality through redistributive taxes and benefits and through a large welfare state, countries like Japan manage to achieve low levels of inequality *before* taxes and benefits. Japanese differences in gross earnings (before taxes and benefits) are smaller, so there is less need for large-scale redistribution.

What matters is the level of inequality you finish up with, not how you get it. However, in the data there is also a clear warning for those who want low public expenditure and taxation: if you fail to avoid high inequality, you will need more prisons and more police. You will have to deal with higher rates of mental illness, drug abuse, and every other kind of problem. If keeping taxes and benefits down leads to wider income differences, the ensuing social ills may force you to raise public expenditure to cope.

There may be a choice between using public expenditure to keep inequality low, or to cope with social harm where inequality is high. An example of this balance shifting in the wrong direction can be seen in the United States during the period since 1980, when income inequality increased particularly rapidly. During that period, public expenditure on prisons increased six times as fast as public expenditure on higher education, and a number of states have now reached a point where they are spending as much public money on prisons as on higher education.[6]

Not only would it be preferable to live in societies where money can be spent on education rather than on prisons, but policies to support families—such as providing high-quality, publicly funded preschool—would have meant that many of those in prison would have been working and paying taxes instead of being a burden on public funds.[7]

fund schools not prisons.
might have to spend more + tax more.
social ills may force to spend more.
publically funded pre-school instead
of spending $ on prisons

Modern societies will depend increasingly on being creative, adaptable, inventive, well-informed, and flexible, able to respond generously to each other and to needs wherever they arise. Those are characteristics not of societies in hock to the rich, in which people are driven by status insecurities, but of populations used to working together and respecting each other as equals.

ENDNOTES

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11 MORALITY AND HEALTH: NEWS MEDIA CONSTRUCTIONS OF OVERWEIGHT AND EATING DISORDERS

Abigail C. Saguy and Kjerstin Gruys

In 2005, in the wealthy suburbs of Richmond, Virginia, Emily and Mark Krudys' ten-year-old daughter, Katherine, was diagnosed with anorexia, and her parents were desperate for a cure. "Emily and Mark tried everything. They were firm. Then they begged their daughter to eat. Then they bribed her. We'll buy you a pony, they told her. But nothing worked" (Tyre 2005). Finally, Katherine was admitted for inpatient treatment at a children's hospital in another town. During the two months of her daughter's treatment, Emily stayed nearby so that she could attend family-therapy sessions. After Katherine was released, Emily homeschooled her while Katherine regained strength. Considered a success story, *Newsweek* reported that Katherine entered sixth grade in fall of 2005: "She's got the pony, and she's become an avid horsewoman, sometimes riding five or six times a week . . . But the anxiety still lingers. When Katherine says she's hungry, Emily has been known to drop everything and whip up a three-course meal" (Tyre 2005).

Only a short drive away, in Washington, DC, Leslie Abbott, a black single mother, was dealing with a very different food battle. She had lost custody of her son Terrell after months of fighting neglect charges related to his body weight. Known to his friends as "Heavy T," Terrell had recently been released from an inpatient weight-loss program, but—once at home— had gained weight. Leslie explained to a reporter why it was unfair for public authorities to blame her for Terrell's backslide: "This boy is 15, going to be 16 years old. I can't watch him 24 hours a day. They want me to hold his hand, take him to the Y, make him eat salad" (Eaton 2007). Leslie said she would have had to quit her minimum-wage job in order to follow the health regimen suggested by Terrell's doctors. But, as noted by the journalist, "How could she afford that? To her thinking, the healthy food Terrell needed meant she needed more money, not less" (Eaton 2007).

These two news articles discuss topics—anorexia and obesity—in which body size (too thin or too heavy) and eating (too little or too much) are treated as medical risks and/or diseases. The American Psychiatric Association (APA) defines anorexia as the refusal to maintain body weight at or above a minimally "normal weight" for age and height, fear of gaining weight or becoming

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"fat," and denial of the gravity of one's low body weight. The Centers for Disease Control and Prevention (CDC) defines "obesity" among adults as having a body mass index (BMI) (weight in kilograms divided by height in meters squared) equal to or greater than 30, and "overweight" as having a BMI equal or greater than 25 but less than 30.[1] Different measures are used for children and teenagers under 18-years old, which adjust for age.

While anorexia and overweight/obesity are both medical categories related to body weight and eating, they have strikingly different social and moral connotations. In the contemporary United States, being heavy is seen as the embodiment of gluttony, sloth, and/or stupidity (Crandall and Eshleman 2003; Latner and Stunkard 2003), while slenderness is taken as the embodiment of virtue (Bordo 1993). A deep-seated cultural belief in self-reliance makes body size—like wealth—especially likely to be regarded as being under personal control and as reflecting one's moral fiber (Stearns 1997).

?

To what extent does the contemporary American social and moral valence of body size shape how the news media report on overweight/obesity and eating disorders as medical issues? Comparing only the two news media articles above suggests that the news media treats anorexics as *victims* of a terrible illness beyond their and their parents' control, while obesity is caused by bad individual behavior, including, in the case of children, parental neglect. Second, the difference in class and racial profile of these two families is striking. A young white girl from a well-to-do family provides "the face" of anorexia, while a young boy and his low-earning, black single mother are discussed in an article on obesity. If these reflect typical patterns in reporting, then news reports on eating disorders and obesity may reinforce moral hierarchies based on body size, race, and class. That is, they may reproduce stereotypes of young white female victims and irresponsible, out-of-control lower class minorities. Moreover, articles may represent the issues of eating disorders and overweight differently depending on which demographic groups are the focus of the discussion.

To investigate this issue more systematically, we draw on content analyses of 332 articles published between 1995 and 2005 in *The New York Times* and *Newsweek* on the topic of eating disorders or overweight/obesity. We also draw on qualitative analyses of five additional articles published in these publications in 2006 and 2007 that specifically discuss binge eating disorder and were not included in our larger sample. We examine how news reports on these issues assign blame and responsibility as well as how they discuss gender, race, and class. In so doing, we contribute to sociological understandings of how cultural values shape the construction of social problems and, in turn, reproduce social inequalities.

THEORETICAL PERSPECTIVE

Body weight has long been a marker of social status. However, at most times and in most places, where food is scarce, corpulence signals *high* rather than low status. In these cultures, plumpness in women is especially prized. Among elite Nigerian Arabs, for instance, girls are fattened up in early childhood (Popenoe 2005). A young girl's girth is physical evidence of her father's—and later her husband's—wealth. Being so fat that she is immobile signifies that her labor is not needed, making fat women the ultimate "trophy wives." Similarly, up until the early twentieth century, women in the United States and Europe strived to be fat, not thin. There too, food was scarce and plumpness signaled wealth, while thinness suggested illness (Klein 1996; Stearns 1997). Yet, while thinness was regarded as ungainly in these contexts, especially in women, it did not reflect on one's *moral* character (Stearns 1997), nor have individual women been personally blamed for being too thin (Popenoe 2005).

As the agricultural and industrial revolutions reduced food shortages, fatness was no longer a reliable sign of wealth and, as the poor got fatter, the symbolic meaning of body size flipped. As corpulence increasingly became a marker for *lower* prestige and status, those with greater resources had more ability and motivation to avoid the stigma of fatness (Aronowitz 2008). Moreover, as moral condemnation of consumerism lessened, maintaining a slender body became the new way for Americans to demonstrate their moral virtue. As Historian Peter Stearns (1997) argues, beginning in the late nineteenth and early twentieth century:

> People could indulge their taste for fashion and other products with a realization that, if they disciplined their bodies through an attack on fat, they could preserve or even enhance their health and also establish their moral credentials . . . An appropriately slender figure could denote the kind of firm character, capable of self-control, that one would seek in a good worker in an age of growing indulgence; ready employability and weight management could be conflated (p. 59–60).

This moral association of slenderness with "firm character" and heaviness as the embodiment of gluttony, sloth, and stupidity is still with us today (Bordo 1993; Crandall and Eshleman 2003; Latner and Stunkard 2003). In the United States, where there is a deep-seated cultural belief in self-reliance, body size is especially likely to be regarded as under personal control and reflecting moral fiber (Stearns 1997), despite research suggesting that much of the variation in body size is biologically determined (Kolata 2007). Thinness is a *cultural value* in the contemporary United States—it is a quality that is widely prized by members of this society.

In the contemporary United States, body size intersects with other dimensions of inequality. Stereotypes of fat people as gluttonous and undisciplined echo similar stereotypes of the working classes as "the archetypal 'uncontrolled' body in public health discourse, as lazy, dirty, immoral, incapable of resisting their urges" (Lupton 1995:75). Compared to men, women are held to higher standards of thinness and suffer greater penalties if they fall short, in terms of marriage prospects as well as employment (Conley and Glauber 2007; Puhl, Andreyeva, and Brownell 2008). On average, wealthier white people—especially women—tend to be thinner than poorer people of color (Flegal et al. 1998; Flegal et al. 2002; Sobal and Stunkard 1989). This is, in part, because having a thin and toned body is expensive in contemporary Western contexts, where fresh fruits and vegetables are more expensive than higher calorie processed foods and where physical activity requires leisure time (Drewnowski and Barratt-Fornell 2004). Heavier women are also poorer, however, because of weight-based stigma. For women, higher body mass *predicts* lower personal and spousal earnings (Puhl et al. 2008).

Negative stereotypes of fatness and ethnic minority status often reinforce each other, such that a fat black woman is stigmatized for both her body size and race. However, these stigmas can also be disassociated with various consequences. Thus, a white middle class woman will lose some of her class and racial privilege if she is heavy, while a woman of color can gain status by being thin. Realizing this, some black and Latino families pressure their daughters to be thin as part of a strategy of upward mobility (Thompson 1994).

Yet, white middle class women and girls are more likely than poorer women and girls, women and girls of color, and boys or men to be diagnosed with anorexia or bulimia, also referred to as "thinness-oriented eating disorders" (Bruch 1978; Striegel-Moore et al. 2003).[2] In contrast, rates of binge eating disorder, which are often associated with higher body weight, are similar among black women, white women, and white men (Smith et al. 1998). Indeed, some scholars have found recurrent binge eating to be *more* common among black women than among white women (Striegel-Moore et al. 2000). This makes news media discussions of binge eating disorder important for understanding how discussions of eating and body weight are racialized and gendered.

Anorexia is listed in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) as an eating disorder, along with bulimia, which is defined as recurrent episodes of binge eating (eating extremely large amounts of food in one sitting) followed by "inappropriate compensatory" purging (i.e., by vomiting and / or talking laxatives) and an undue influence of body shape in self-evaluation. Binge eating disorder is categorized in the DSM-IV as an "Eating Disorder—Not Otherwise Specified," an umbrella category for various eating disorders that do not meet the precise criteria for either anorexia or bulimia. The APA provides a "provisional diagnosis" of binge eating disorder as bingeing without compensatory purging and/or extreme dietary constraint (APA1994). This provisional diagnosis signals that binge eating disorder is being seriously considered for its own diagnostic category in the DSM-V (expected in 2012), while also providing clinical researchers with shared criteria for studying the disorder. Binge eating is likely to be the object of more public discussions as it gains more attention from clinicians.

The mass media offer important primary sources for cultural and social research. Television, radio, magazines, newspapers, and Internet content provide a sensitive barometer of social process and change. Once created, these texts remain unchanged and available for analysis, making them ideal for the study of attitudes, concerns, ideologies, and power relations, and how they shift over time (Lupton 1994). Aware of these strengths, early feminist work examined the fashion media, demonstrating how fashion magazines and advertisements convey to readers the importance of slenderness and the shame of fatness for women (Bordo 1993). Anthropologist Mimi Nichter (2000) has argued that such images contribute to negative body image and eating problems among young girls; however, she finds that African American girls are buffered from fashion pressures to be thin by a vibrant ethnic culture that values personal style as well as "thicker" body types.

News accounts of health and illness differ from other media texts in that they have the weight of "expert" opinion, making them especially important to study (Lupton 1994; Nelkin 1987). In recent years, a few scholars have begun examining media reporting on the so-called "obesity epidemic" (Boero 2007; Lawrence 2004; Saguy and Almeling 2008). Natalie Boero (2007) finds that news reporting has largely framed obesity as a moral problem of gluttony and sloth. Abigail C. Saguy and Rene Almeling (2008) find that body size is predominantly blamed on individual choices rather than social or biological factors, while Regina Lawrence (2004) shows that there is increasing discussion of social-structural factors over time. Saguy and Almeling (2008) find that news reports on scientific findings are more likely than the original research on which they report to focus on individual blame and to describe obesity as a public health crisis and/or epidemic. They further find that articles discussing the poor, blacks, or Latinos are more likely than articles not discussing these groups to blame body size on individual choices (Saguy and Almeling 2008). Similarly, previous research has shown that news reports are more likely to portray welfare recipients as dependent (and thus unworthy) when they are unmarried or black, compared to when they are widowed or white (Misra, Moller, and Karides 2003). These studies suggest that news reports will blame individuals for overweight and obesity, especially when such individuals are poor and/or from minority ethnic groups, thus reflecting and reinforcing negative stereotypes of fat people, the poor, and ethnic minorities.

While important, extant studies have methodological and conceptual limitations. For instance, Lawrence (2004) does not examine how views about gender, race, or class inform news media reports of obesity, while Boero (2007) draws heavily on qualitative analysis of seven article published in the fall of 2000 as part of a series on the "Fat Epidemic," thereby limiting the generalizability of her findings. Saguy and Almeling's (2008) analysis of news reporting on two special issues on obesity published in the *Journal of the American Medical Association (JAMA)* in 1999 and 2003 allows for a systematic examination of how scientific research is popularized by the news media, but does not constitute a representative sample of reporting on the topic of overweight/obesity. Moreover, because all of these studies lack a comparative case, it is impossible to know the extent to which these patterns are simply a product of generic news media routines that favor sensationalism and morality tales (Schudson 2003), combined perhaps with health policy tendencies to emphasize individual blame and responsibility (Fitzpatrick 2000; Lupton 1995; Tesh 1988).

Motivated by research on social problem construction (Best 2008; Gusfield 1981; Kitsuse and Spector 1973) and news media framing research (e.g., Benson and Saguy 2005; Entman 1993; Gamson 1992), this article examines how news reports *frame* overweight/obesity and eating disorders in particular ways by drawing attention to some aspects of these issues while obscuring others. It draws on quantitative and qualitative analyses of a random sample of news reports on overweight/obesity or eating disorders published between 1995 and 2005 in *The New York Times* and *Newsweek*. The comparative case study allows us to disentangle general aspects of news reporting from the specific cases at hand. In that anorexics and bulimics are seen as pursuing a culturally valued ideal (slenderness), we expect that the news media will be less likely to blame them—compared to the overweight or obese—for their malady. Rather, we expect anorexics and bulimics to be portrayed as victims of a host of complex factors beyond their control. To the extent that the news media focuses on cases of young, white middle class anorexics and bulimics, they risk reproducing cultural stereotypes of young, white female victims. In contrast, in that the news media frame overweight/obesity as a public health crisis produced by irresponsible individuals, while focusing on cases of overweight among the poor and minorities, they are likely to reinforce negative stereotypes based on body size, ethnicity, and class.

DATA AND METHODS

Our news sample is drawn from *The New York Times* and *Newsweek*. Widely regarded as the newspaper of record, *The New York Times* enjoys among the highest national circulation of any newspaper and is considered authoritative, giving it influence over opinion leaders and policy makers. Reporting in *The New York Times* has also been shown to shape reporting in other news media (Gans 1979). *The New York Times* is known for a relatively high quality of reporting on health issues, biasing our sample towards more sophisticated reporting on these issues. The newsmagazine *Newsweek* has the advantage of publishing longer articles than those a newspaper can usually accommodate. These two publications have the methodological advantage of being available in the Lexis-Nexis database for the entire 1995–2005 time period. This sample does not capture some of the range of the news media, including women's magazines, the ethnic press, or political presses (Rohlinger 2007). Given that the majority of readers of these papers are white and from the middle class, it is possible that these publications are more likely—compared to ethnic presses or presses catering to a more working class audience—to uncritically reproduce negative stereotypes regarding heavier people, the poor, and ethnic minorities. Nonetheless, given their cultural influence, they are critical to study.

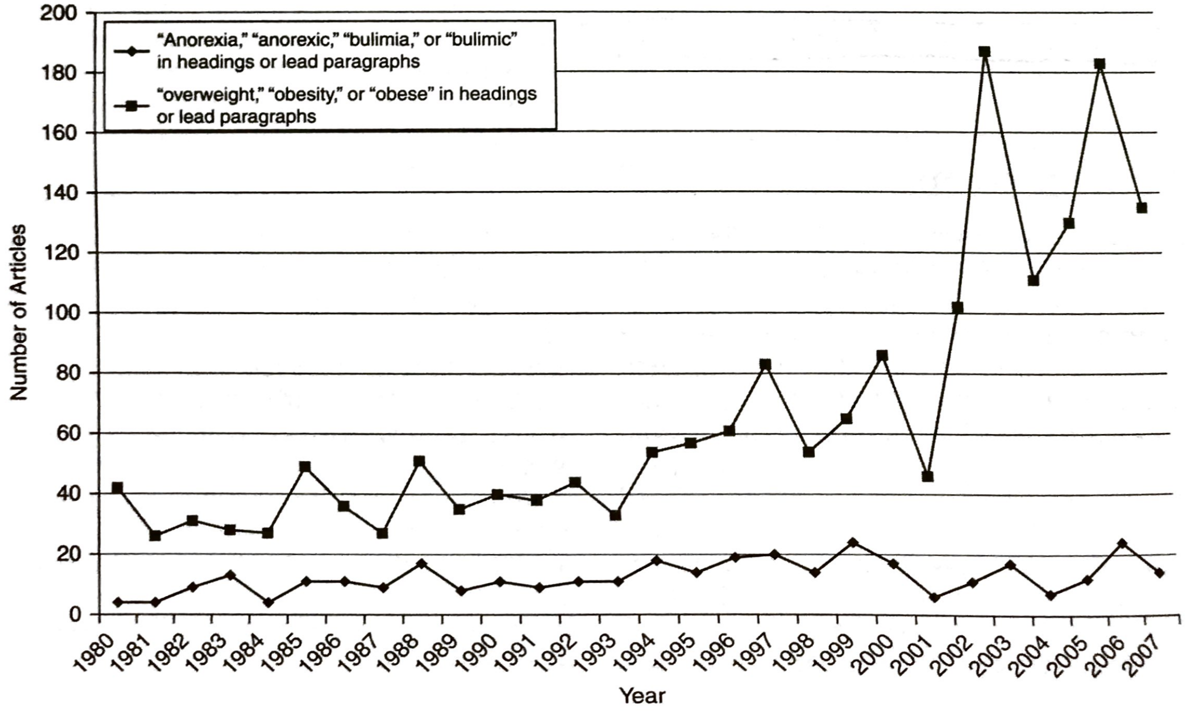
We sampled from news articles and opinion pieces published that had the words "anorexia/ anorexic/bulimia/bulimic" or "obese/ obesity/overweight" in the heading or leading paragraphs. Using these search criteria for the specified time period generated a chronological list of articles by publication and by issue, totaling 1,496 articles. We winnowed down this list using three criteria. First, because there were so many articles published on obesity or overweight in *The New York Times,* we eliminated the first two of every three articles in the chronological *New York Times* list of articles on obesity/overweight, reducing this sample by two thirds. (Cross-publication analyses reveal that the differences between publications on the variables we discuss are minor. Thus, the fact that proportionally more eating disorder articles are from *The New York Times* is unlikely to account for the cross-issue differences we report.) Second, we eliminated articles that were less than 300 words, since it is difficult to develop the themes of interest in such a short article, which reduced the sample further by over one half. Finally, from this list, we eliminated the few articles from the full sample that were completely off topic. This strategy yielded a final sample of 174 articles on obesity and 64 on eating disorders from the *New York Times* and 88 articles on obesity and 6 on eating disorders from *Newsweek*, or a total of 262 articles on overweight/obesity and 70 articles on eating disorders.

This sampling strategy produced seven articles that discussed binge eating disorder—six of which met the sampling criteria for anorexia/bulimia and a seventh that met the criteria for overweight/obesity. An additional search of articles that had "binge eating disorder" anywhere in the full text yielded no new articles. In an effort to expand the number of articles on binge eating disorder, a "newer" eating disorder of growing importance, we further searched for all articles published between January 2006 and November 13, 2007 (the day the search was conducted) that had "binge eating disorder" in the full text. This identified an additional five relevant articles (three from *The New York Times* and two from *Newsweek*). While these five articles are not included in the core 332 articles that were analyzed quantitatively, they were separately analyzed qualitatively (along with the seven articles from our original sampling technique) to inform the discussion of binge eating disorder below.

We focus on 1995 through 2005, a time frame that includes a long period characterized by a moderate level of press attention to eating disorders and a surge of attention to obesity in the late 1990s and early twenty-first century. It does not include the 1980s, a period when concern over anorexia was arguably at its height among the medical community (Hof and Nicolson 1996) but when news media attention to anorexia/bulimia in *The New York Times* and *Newsweek* was actually lower (see Figure 11-1).

Given that there is considerably more news reporting on overweight/obesity beginning in 2002 (see Figure 11-1), following several high-profile pronouncements from the CDC, the World Health Organization (WHO), and the Surgeon General about the "obesity epidemic" at the end of 2001 (Schlesinger 2005), our overweight sample is weighted towards the latter time period, while our eating disorder sample is spread more evenly across the decade. Comparisons of reporting by time period (1995–2001, 2002–2005) reveal one important change in framing over time: there is more discussion of social-structural causes and policy solutions for overweight in later years

Figure 11-1. *News Reporting on Anorexia/Bulimia and Overweight/Obesity,* New York Times *or* Newsweek.



(see also Lawrence 2004). Thus, our sample—by virtue of including disproportionately more articles published in later years—may overstate the extent to which, during the entire 1995–2005 time period, the news media emphasized social-structural causes for the "obesity epidemic" and policy solutions.

Coding

A subsample of articles was initially read to develop variables for the content analysis. Knowledge of the obesity and eating disorders literature was also used to develop the variables. Some variables were added or refined during the analyses, requiring additional coding. Coding was done at the article level for over 200 variables for all of the articles in our sample. In initial "practice" coding, three researchers coded the same articles and discussed differences as a way of arriving at shared agreement. Two coders coded 10 percent of the articles to test for inter-coder reliability, which was very high. The coefficient of reliability (the ratio of coding agreements to the total number of coding decisions) was over .95 (Holsti 1969), and discrepancies were generally due to one person having missed a relevant phrase, rather than to conceptual disagreements about how the variables should be coded. Unless explicitly stated below, variables were dichotomous, coded for whether or not the aspect in question was mentioned at all. Thus all codes are independent of each other. Coders did not determine which themes dominated the article, only if they were present at all. In our discussion, we discuss differences between the overweight/obesity and anorexia/bulimia samples *as differences* only when the chi-square (in cases where cell sizes were 10 or more) or Fisher exact test (in cases where cell sizes were less than 10) were statistically significant at a level of $p < .05$. We cannot statistically test whether a specific theme is more common than another *within* a given sample, since these observations are not independent of each other, a condition of a chi-square or exact test. Discussions of relative frequency of different themes within each sample should be read with this caveat in mind.

Articles were coded for whether they were standard articles or opinion pieces (i.e., editorials, op-ed, or letters to the editor). Opinion pieces offer a revealing window on issue framing since the editorial page's purpose is to air competing frames (see also Lawrence 2004:60). While journalists themselves do not produce most op-ed pieces and letters to the editor, editors do select who among many contenders will be published. Moreover, their publication in mainstream media gives them cultural authority. We did, nonetheless, replicate our analyses with a sample that excluded the opinion pieces and found consistent results.

To evaluate how news reports assign responsibility for eating disorders and overweight, we coded articles for whether they blamed these things on individual choices or structural factors, such as restaurant portions or messages from the fashion industry. For instance, the following article blames an *individual* for his weight gain, writing "he could look back on decades of binge eating and failed diets" and quoting him as saying "I was killing myself" (Feder 2005). The following would be taken as evidence of blaming *structural* factors: "In many low-income minority neighborhoods, fried carryout is a cinch to find, but affordable fresh produce and nutritious food are not" (*New York Times* 2002). Considered a subset of structural factors, we coded specifically for cultural factors, such as mainstream cultural emphasis on thinness, ethnic culinary practices, or cultural attitudes towards body size, as in the following excerpt: "Being curvy or large was a source of pride within the African American community"(Brodey 2005). We coded for whether articles blamed biological factors, including genetics or prenatal environment, as in the following: "Doctors now compare anorexia to alcoholism and depression, potentially fatal diseases that . . . have their roots in a complex combination of genes and brain chemistry" (Tyre 2005). We coded for whether the article specifically described overweight or eating disorders as a *psychological* problem or labeled either as a (physical or mental) *disease*. Labeling a condition a disease did not necessarily mean that it was ascribed to biological factors. Rather, disease could be attributed to bad lifestyle choices or environmental factors.

By focusing on certain kinds of *solutions*, the news media also convey messages about what sort of problem is being discussed and what should be done about it. If they focus on individual-level solutions, they reinforce the sense that these are problems caused by individuals that individuals need to fix. By discussing policy solutions, they convey that these are collective problems. However, by discussing policy interventions that aim to educate or change bad behaviors of certain groups, they reinforce the sense that the targeted groups are ignorant. We coded for different types of solutions to weight problems, including behavioral modification (e.g., dieting, increasing exercise), policy changes, inpatient or "intensive outpatient" medical supervision, or prescription drugs and weight-related surgeries. During analyses, we computed a composite variable for any medical intervention, including weight-loss drugs, psychiatric or appetite regulating medications, weight-loss surgery, medical devices such as feeding tubes, or either inpatient or "intensive outpatient" medical supervision.

Finally, to account for how, and to what extent, these issues are associated with different groups, we coded articles for whether they explicitly mentioned specific demographic groups, including men or women; the poor, middle class, or rich; and whites, blacks, Latinos, Asians, and other race. During analyses, we computed composite variables, including "middle class or rich," "nonwhite" and "blacks, Latinos, or the poor."

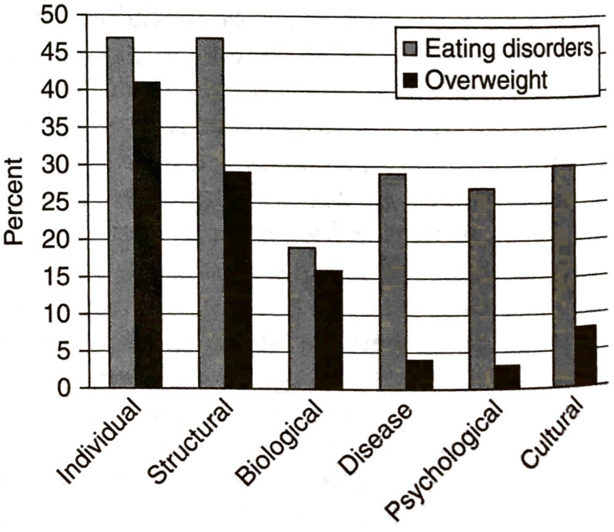
In addition to the quantitative analysis, we used discourse analysis to get at the subtleties of news reports, including the choice of words and ideologies evident in news reports (Lupton 1994). We created theme sheets that included lengthy quotes that illustrated key themes, such as blame, responsibility, and moral judgment. The quantitative data allows for us to test for statistical significance of differences in reporting across these issues, while the qualitative data permits us to dig deeper into the nuances of reporting.

FINDINGS

Our news sample typically attributes anorexia and bulimia to a host of complex and interrelated factors, thus mitigating individual blame while representing anorexics and bulimics as victims. In contrast, it predominantly blames overweight exclusively on bad individual choices and emphasizes individual-level weight loss solutions. News reports emphasize medical intervention when it comes to anorexia and bulimia *but not* when discussing binge eating disorder, which they tend to deny the status of a real eating disorder and frame instead as *ordinary* overeating caused by lack of self-control and requiring greater personal discipline. After reviewing the quantitative patterns, we examine each case qualitatively.

As shown in Figure 11-2, news reports on both eating disorders and overweight invoke personal choices, with over 40 percent of articles in both categories mentioning personal choices as contributors. However, several factors are described as equally contributing to eating disorders, while individual choice is the *predominant* explanation offered for overweight. Articles about eating disorders discuss structural causes at the same rate as individual choices (47 percent for both), while 19 percent of eating disorder article cite biological causes. In contrast, 41 percent of articles about overweight mention individual choices, with socio-structural and biological causes mentioned in 29 and 16 percent of articles, respectively. Press reports are more likely to describe eating disorders, compared to overweight, as a disease (29 percent versus 4 percent) and/or as a

Figure 11-2. *Percentage of articles discussing specific causes.*



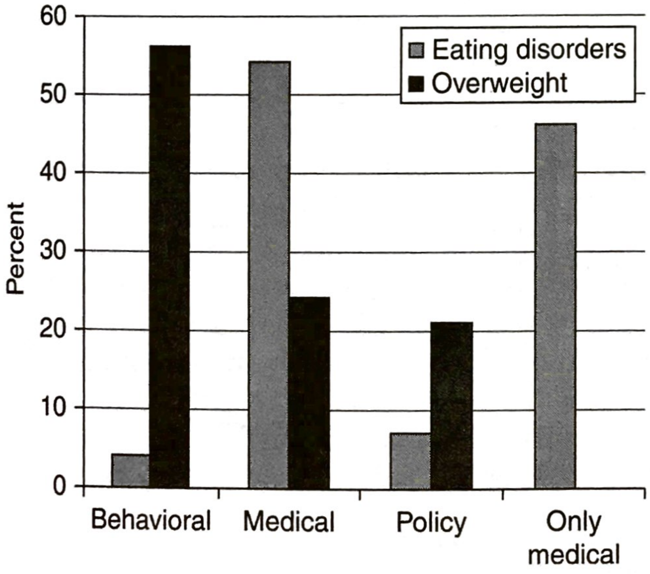
Note: With the exception of individual and biological causes, all cross-issue differences are statistically significant ($p < .05$, one-tailed tests).

psychological problem (27 percent versus 3 percent) triggered by cultural messages (30 percent versus 8 percent).

Even more strikingly, as shown in Figure 11-3, the articles were much less likely to hold individuals responsible for curing eating disorders (4 percent of eating disorder sample) than for fixing overweight (56 percent of overweight sample). Articles in the eating disorders sample discuss medical interventions at least *seven times* more frequently than they mention either policy or behavioral solutions (54 percent versus 7 percent and 4 percent, respectively). In contrast, articles on overweight/obesity are over twice as likely to discuss behavioral modification than either medical interventions (24 percent) or policy solutions (21 percent). Forty-six percent of articles on eating disorders, but no articles on overweight, discuss *only* medical solutions.

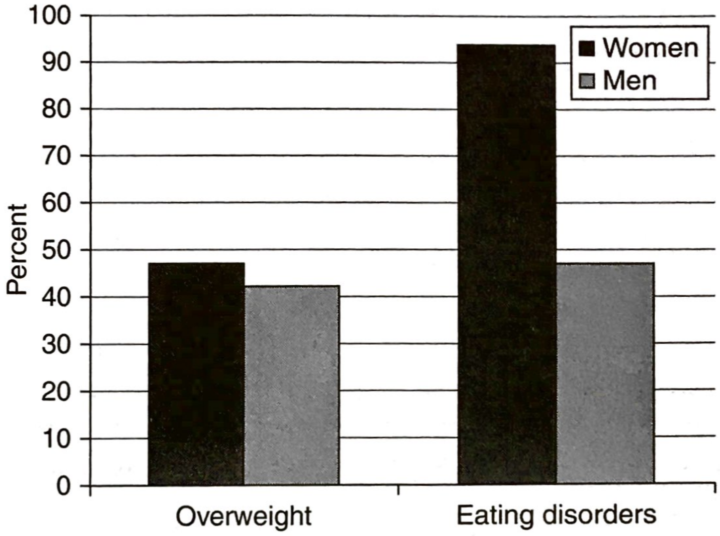
As is shown in Figure 11-4, 94 percent of eating disorder articles discuss women or girls, compared to 47 percent that mention men or boys. By contrast, articles on overweight mention women/girls and men/boys at similar rates, (47 percent compared to 42 percent). As shown in Figure 11-5, 13 percent of articles on eating disorders discuss people from the upper or middle class, compared to the four percent that discuss poor people, and 17 percent mention whites, compared to 13 percent that discuss minority races, despite the tendency for "white" to function as an unmarked category.[3] In contrast, articles on overweight discuss nonwhites (including blacks, Latino, Asian, and other race) more often than whites (13 percent versus 8 percent) and discuss the poor as frequently as the middle class or rich (7 percent versus 5 percent).

Figure 11-3. *Percentage of articles discussing specific solutions.*



Note: All cross-issue differences are statistically significant ($p < .05$, one-tailed tests).

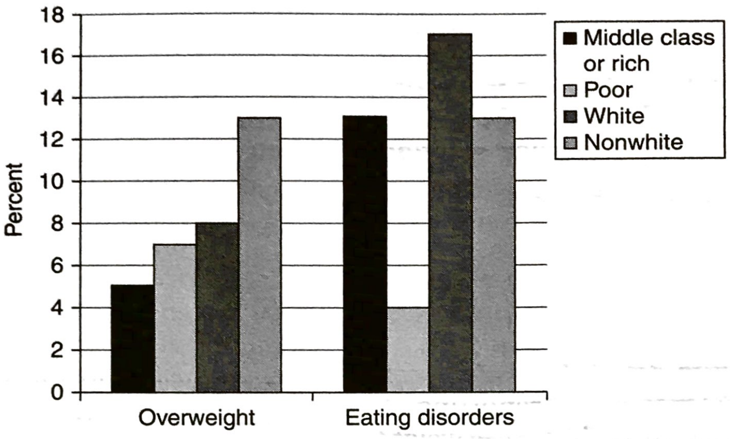
Figure 11-4. *Proportion of articles discussing women or men.*



Note: Frequencies of specific themes *within the same sample* are *not* independent of each other and are therefore unsuitable for a chi-square text of statistical significance.

Moreover, as shown in Figure 11-6, we find that news reports mentioning blacks, Latinos, or the poor are more likely to blame social structural factors, but not biological factors, for overweight/obesity. Forty-three percent of articles mentioning these groups, compared to 26 percent of articles that do not mention these groups, cite social structural contributors to obesity, a difference that is statistically significant. Coded as a subset of social-structural factors, cultural causes for overweight/ obesity are also significantly more likely to be mentioned when blacks, Latinos, or the poor are cited (17 percent versus 4 percent), often because—as we discuss below—*minority culture* is being blamed. Articles that mention blacks, Latinos, or the poor are also more likely than those that do not mention these groups to discuss obesity policy solutions (37 percent versus 18 percent). As we discuss below, many of

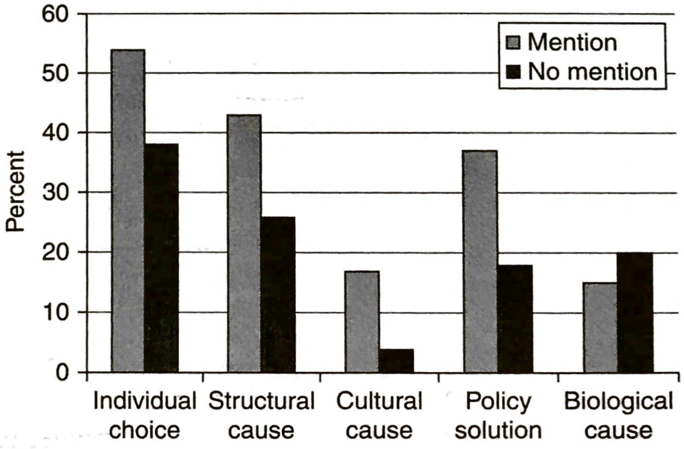
Figure 11-5. *Proportion of articles discussing specific demographic groups.*



Note: Frequencies of specific themes *within the same sample* are *not* independent of each other and are therefore unsuitable for a chi-square text of statistical significance.

these not only address social-structural problems, such as access to affordable fresh fruits and vegetables, but also seek to educate people considered unable to make good food and exercise choices, and to change minority ethnic *cultural attitudes* about food and eating.[4] Fifty-four percent of articles that mention blacks, Latinos, or the poor, compared to 38 percent that do not, discuss how individual choices lead to overweight, but this difference is just shy of statistical significance at $p < .05$ ($p = .055$). Fifteen percent of articles mentioning blacks, Latinos, or the poor discuss

Figure 11-6. *Percentage of overweight articles evoking specific frames, by whether or not they discuss Blacks, Latinos, or the poor.*



Note: With the exception of biological cause and individual choice, all differences are statistically significant ($p < .05$, one-tailed tests). Thirty-five articles mention blacks, Latinos, or the poor whereas 227 articles do not explicitly mention these groups biological causes of overweight, compared to 20 percent of articles not mentioning these groups, a difference that is not statistically significant.

Note that the number of articles that *explicitly* mentions blacks, Latinos, or the poor are relatively small, so that most articles that frame obesity as an individual, social-structural, cultural, or biological issue or mention policy solutions do *not* explicitly mention these groups. However, the fact that certain kinds of frames are more or less prevalent depending on the groups being discussed suggests that these news publications may be reproducing common social assumptions about these groups. Below, we flesh out these quantitative patterns with details from the qualitative analyses. We discuss news reporting on (thinness-oriented) eating disorders, overweight, and binge eating disorder, respectively, in three separate sections.

Anorexia and Bulimia: No-One to Blame

A typical article on anorexia evokes "complex webs of cultural factors and psychological processes" (Isherwood 2005), serving to diffuse responsibility amongst several factors. Similarly, a *Newsweek* editorial proclaims: "Good news: scientists are developing a better sense of how genetic and social triggers interact" (Whitaker 2005). In such articles, genetic factors and social constraints are said to work in tandem, jointly diffusing focus away from individual blame. In contrast to how parents are frequently blamed for their children's (over) weight problems, the article cited in the introduction to this article concludes: "Parents do play a role, but most often it's a genetic one. In the last 10 years, studies of anorexics have shown that the disease often runs in families" (Tyre 2005). In other words, when it comes to anorexia there is, as the title of this article proclaims, "no-one to blame" (Tyre 2005). Contemporary reports on anorexia tend to portray parents as part of the solution, rather than as part of the problem. For instance, an article on anorexia describes how parents of anorexics "are encouraged to think of the disorder as an outside force that has taken over their daughter's life. And they are exhorted to be unwavering in finding ways to feed their child" (Goode 2002).

Even when an eating disorder is described as beginning with a choice (i.e., to start a diet), the choice is depicted as a "normal" response to cultural pressures, rather than as an irresponsible or self-indulgent behavior. For instance, an article entitled "When Weight Loss Goes Awry" describes a teenager's anorexia as beginning with an innocent diet: "last summer, as friends started dieting, she decided to lose five to 10 pounds. Within a few months Amelia, now 15, was on the death-march called anorexia nervosa" (Kalb 2000). Of course, in a society where watching one's weight is a moral obligation, it makes sense that Amelia would not be faulted for beginning a diet. Rather, anorexia is viewed as a case in which good intentions go too far. Amelia is described as "a straight-A student and cheerleader" who says "in a weak but determined voice from her bed at the Children's Hospital in Denver" that she "would never want this to happen to anybody else" (Kalb 2000). The article thus describes anorexia as something that "happens to" people, even model teenagers, rather than something people bring upon themselves. The article states, "there's no simple explanation for why intelligent, often highly accomplished kids spiral into such destructive behavior." It considers a host of factors from "obsessive-compulsive disorder, depression, low self-esteem and anxiety" to the "'reduce fat in your diet' drumbeat, which can haunt children who already feel pressure—from gaunt models or each other—to be thin" (Kalb 2000). Similarly, absolving anorexics from blame, the article cited at the start of this article explains that "For some kids, *innocent*-seeming behavior carries enormous risks" (Tyre 2005, emphasis added).

Despite wide acceptance of dieting as normal and desirable, many news articles point the finger at the narrow beauty standards of popular culture. For instance, discussing anorexia and bulimia, one articles declares that "the apparent precipitant of these [eating] disorders seems to be an overwhelming desire to be thin, thin enough to walk down a Paris fashion runway, to act in a Hollywood movie, or to dance with a leading ballet company" (Brody 2000). In these discussions, African American subculture, and specifically an alleged preference for larger female bodies among black Americans, is cast in a positive light, as protecting minority girls from internalizing mainstream pressures to be thin. Quoting a medical doctor, one article reads:

> Dr. Brooks said experts traditionally had thought that "anorexia and bulimia didn't happen to black, Asian or Hispanic women, that they were somehow immune." . . . "Curvy African-American women were celebrated," Dr. Brooks said. "These girls didn't experience anxiety and shame about their bodies. Being curvy or large was a source of pride within the African-American community" (Brodey 2005).

Those black (and sometimes Latina) girls' who do develop eating disorders are often seen as being especially vulnerable to "white" pressures. The article quoted above, for instance, describes how one black teenage girl developed bulimia because, as one of nine black students in a high school of 3,000, she was "struggling simply to be accepted. [In her words:] 'When it came to body image, my perception of beauty was based on my white peers and images of white celebrities in the media'" (Brodey 2005). Thus a mainstream diet culture is implicated in (thinness-oriented) eating disorders, while African American culture is praised as offering some cultural buffering.

Yet, even such blaming of mainstream cultural pressures is tempered by arguing that they only result in eating disorders among people with a biological or psychological predisposition. For example, after noting that doctors have observed a "disturbing trend: a growing group of women in their 30s, 40s and 50s who have eating disorders," one article reassures readers that many of these newly diagnosed older women have actually had lifelong psychological problems and that "lots of people in our culture diet, [but] relatively few end up with an eating disorder" (Rothman Morris 2004). Here, not only are individual dieters not blamed for their behavior but the *culture of dieting* is normalized. Another similar article writes that:

> While everyone is exposed to similar societal pressures to be thin, only a small percentage develop eating disorders. Those who succumb typically are prompted by extreme career pressures, as often happens to ballerinas, models, actresses, and jockeys, or they have some underlying emotional and/ or physical vulnerability" (Brody 2000).

Similarly, the article cited in the introduction to this article compares anorexia to alcoholism and depression, "potentially fatal diseases that may be set off by environmental factors such as stress or trauma, but have their roots in a complex combination of genes and brain chemistry" (Tyre 2005). It continues:

> Many kids are affected by pressure-cooker school environments and a culture of thinness promoted by magazines and music videos, but most of them don't secretly scrape their dinner into the garbage. The environment "pulls the trigger," . . . but it's a child's latent vulnerabilities that "load the gun."

By stressing the complex interplay between individual factors, biological predisposition, and macro-level environmental factors, this type of reporting mitigates blame of individual anorexics and their parents.

As victims of a complex illness, sufferers of eating disorders are not expected to "pull themselves up by their bootstraps." Rather, they are depicted as needing medical intervention. For example, one article describes an anorexic 14-year-old who, despite wanting "to improve," had failed to recover when going it alone: "It took a second hospitalization at Schneider, the following spring, before Molly could maintain a healthy weight" (Hochman 1996). The article cited at the start of this article similarly describes how young Katherine was only able to recover after *repeated* hospitalizations, because she frequently relapsed when not under direct medical supervision (Tyre 2005). Such failures are not seen as evidence of weak-will, as failed diet attempts are, nor are they blamed on their parents. Rather, they are used to underscore the seriousness of anorexia as a medical illness that requires medical intervention.

Even when eating disorder articles explicitly state that individuals can cure themselves, it is almost always under the guidance of a doctor. Thus, we read about new therapies for bulimia in which specially trained nurses coach bulimics to help themselves: "Many bulimics do not need traditional psychiatric therapy. Instead, he said, patients will learn to help themselves. 'What we've done is change the treatment into a self-help format,' said Dr. Fairburn" (Liotta 1999). Yet, when "self-help" for eating disorders is enacted under medical supervision, curing disordered individuals is still presented as the responsibility of an expert physician.

Obesity: No-One to Blame but Yourself (and Your Parents)

In contrast to reporting on eating disorders, even when articles mention more than one cause for overweight, individual blame usually predominates. For instance, a *Newsweek* article explains that "you can't pick your parents, but you can pick what you eat and how often you exercise" (Barrett Ozols 2005). Thus, genetics does not provide an excuse for body weight. Rather, the article emphasizes people's ability (and, seemingly, their obligation) to make *choices* regarding diet and exercise. Similarly, another article cites new research on "race and weight," explaining that "on average, black women burn nearly 100 fewer calories a day than white women do when their bodies are at rest" but cautions that "the new findings do not mean that controlling and losing weight is a hopeless task for people with lower metabolic rates, just that it may require *more attention to diet and exercise*" (Brody 1997, emphasis added). Again, the reader is reminded that managing her weight is her responsibility. In that pursuing health has become a moral obligation (Edgley and Brissett 1990), this responsibility carries moral connotations.

Moreover, while heaping the blame on individuals, news reports also draw upon and reproduce stereotypes of fat people as gluttonous, slothful, and ignorant, and of parents of fat children as neglectful and irresponsible. Thus, such reports reproduce the negative moral valence of fatness. For instance, one *Newsweek* article writes:

> Bruce and Lisa Smith never skimped much on food. Chips, fried chicken, canned fruit, sodas—they ate as much as they wanted, whenever they wanted. Exercise? Pretty much nonexistent, unless you count working the TV remote or the computer mouse. "We were out of control," says Bruce, 42. And so was their son, Jarvae, who is 5 feet 4 and weighs 176 pounds (Springen 2007).

The Smiths' obesity is portrayed as the direct consequence of a lifestyle of sloth and gluttony. Few readers would consider working a TV remote or a computer mouse physical exercise. Rather, sarcasm is employed to convey disdain and contempt for the Smiths, who are portrayed as lazy and irresponsible individuals and parents. This same article is unrepentant in its blaming of parents for an alleged impending crisis of global proportions. It continues: "The problem [of childhood obesity] is so grave that some researchers predict that the life expectancy of today's children could shrink by as much as five years. The key to reversing the trend? Parents" (Kalb and Springen 2005). Thus, individuals and parents are not only blamed for the onset of obesity, they are held responsible for "reversing the trend."

The fix is presented as a matter of common sense: "One simple way to get the entire family fit is to turn off the television and shut down the computer" (Kalb and Springen 2005). By describing solutions as "simple," the authors imply a logic under which those who have fat children must be stupid, ignorant, or willfully disobedient. Indeed, in the context of childhood obesity, parents (and especially mothers, who are mentioned over twice as often as fathers)[5] are sometimes described as legally unfit to care for their offspring. This was the context in which Heavy T, discussed in the introduction, was removed from his mother's custody. This type of reporting reproduces negative stereotypes. Likewise, from another *New York Times* article:

> [It] is the confounding truth that parents—whether distracted, oblivious or both—are ultimately to blame for what their children eat. "Parents were created for that function," said Dan Jaffe, executive vice president for government relations at the Association of National Advertisers, an organization based in Washington whose members include food companies. "I don't know of any little child who jumps in the car and drives to a supermarket and buys their own food" (Buss 2004).

Again, this article portrays obesity as the product of parental neglect, heaping moral blame on the parents of heavy children. Another article portrays a lawsuit against McDonald's as absurd, arguing that it was the plaintiffs own fault for "gorging themselves so wantonly" on fast food, whether ignorant of, or indifferent to, the likely consequences:

> The [two black-girl plaintiffs from the Bronx] in the McDonald's lawsuit use their ignorance as an argument, claiming that if they'd only known about the nutritional shortcomings of fast food, they certainly would not have gorged themselves so wantonly. (If that's really true, they should consider a lawsuit against their parents for endangering the welfare of their children rather than a suit against McDonald's) (Kuntzman 2002).

The word *wanton* is often used to indicate lewd or bawdy behavior and is clearly moralizing. Similarly, to *gorge* is to consume greedily, thus conjuring up gluttony. Thus, these girls are represented as immorally stuffing themselves with food. That they did not know any better is mentioned as grounds for a lawsuit for neglect against their parents. Also evoking parental responsibility, a letter to the editor in *Newsweek* (2000) asks "Are adults who permit their children to eat as they please (meaning anything and everything) supremely ignorant or genuinely abusive?"

In that heavier body weight is negatively associated with socioeconomic status and given that blacks and Latinos tend to have higher body mass than whites, any discourse that blames people for weighing too much risks reinforcing class and racial stigma. This is even more true when news reports focus on cases of overweight among blacks, Latinos, or the poor. Moreover, many news articles *explicitly* blame ethnic communities for contributing to higher rates of obesity amongst their own. For instance, an article reporting on a women's health study states that "more subtle societal influences, like differences in acceptable body images among different ethnic groups, all contributed to greater obesity among women with lower incomes and those in certain ethnic groups" (Santora 2005). Ethnic culinary practices are also blamed for the alleged obesity epidemic. For instance, a 2003 *New York Times* article discusses how Latino culinary preferences contribute to overweight among Latino children: "[Mr. Batista] says some cultural habits are simply getting the best of his people. Latinos eating vegetables? Come on, he says, raising his hands in frustration. 'We don't eat vegetables. It's rice and beans and meat. It's very natural'" (Richardson 2003).

Another article, discussing the higher rate of overweight among minorities in inner cities, quotes a news source who acknowledges that "it is easier and less expensive to eat fast food and very difficult to find, in some of these neighborhoods, appropriate foods, fruits, and vegetables at a reasonable price" (Braiker 2003). But the article then shifts to a focus on ethnic culture:

> In the end, she says, "it will take a culture change" to reverse the trend . . . "Eating healthy is synonymous with whiteness for some of these kids," [an activist] says. They'll be like, "Salmon? That's white people food." There are ways to make it more accessible; the first part is about education. (Braiker 2003).

Thus, ethnic minorities are depicted as backward or ignorant and needing to be educated in proper food choices and preparation, thus reproducing stereotypes based on race as well as body size.

Consistent with such stereotypes, many of the policy interventions discussed seek to educate people—and especially ethnic minorities—to make better choices. For instance, an article chronicling a public health intervention in a southern black community describes a recipe for "low-fat catfish" developed by nutritionists as "one of a series [of new recipes] showcasing revered family recipes purged of their sins by two Auburn University nutritionists" and notes how a leader of a public health intervention "recited a litany of virtuous eating for her largely female audience" (Markus 1998). The moral associations with food and eating in this article are striking. As with articles on eating disorders, this article identifies mothers as a crucial part of the solution, recounting how these interventions recruit minority mothers as "cheerleaders for good health" (Markus 1998) and target them as the preparers of food for their families: "We're building on community talent with women who are cooking for their children and passing on behavior patterns to their children and their children's children" (Markus 1998).

Binge Eating Disorder: A Need for Self-Control

Articles that discuss binge eating disorder in detail draw upon frames typical of *both* thinness-oriented eating disorders articles and of articles on overweight, underscoring the extent to which this condition straddles the symbolic space between usually polarized conceptions of body size. Ultimately, however, binge eating disorder is more firmly situated within an "overeating" frame, depicting sufferers as needing "self-control" more than medical assistance. For instance, in an account of her personal struggle with binge eating disorder, reporter Jane Brody (2007) writes: "My despair was profound, and one night in the midst of a binge I became suicidal. I had lost control of my eating; it was controlling me, and I couldn't go on living that way." A psychologist helped Brody resist suicide but "was not able to help me stop binging. That was something I would have to do on my own." As with eating disorder victims in other accounts, this binge eater is presented as needing help from a doctor or therapist, but ultimately, as with overweight, it is suggested that she needs to control overeating on her own.

Two articles that discuss binge eating disorder argue that the most important reason binge eating disorder needs to be taken seriously is because it makes it more difficult to *succeed at weight-loss*. In other words, the concern with achieving a "normal" weight, which also dominates discussions of overweight, seems to trump more general concerns about eating disorders as psychological problems. One article explains: "The importance of binge eating disorder is that people who fit these criteria do worse than others in weight management programs" (Alter Hubel 1997). By focusing on the importance of weight loss, these articles obscure or downplay the psychiatric symptoms experienced by binge eaters, which have been shown to have negative health effects independent of body size (Telch and Agras 1994). Another article draws upon binge eating disorder's relationship to overweight in order to depict it as a *public* health risk: "Because of the disorder's close link with obesity . . . it's a major public-health burden" (Springen 2007), a theme that we *never* encountered in discussions of anorexia or bulimia.

Further, while feminist authors have identified binge eating and compulsive overeating as serious "eating problems," which—like anorexia and bulimia—often "begin as ways women numb pain and cope with violations of their bodies" and are "a logical response to injustices" (Thompson 1994:26), our news sample describes individuals with binge eating disorder as "overeaters" who have an "ordinary, if unfortunate, human behavior" (Bakalar 2007), and a few articles express concern that binge eating disorder has been "invented" by greedy drug companies. For instance, another article quotes an eating disorders researcher who says, "Outside North America, it's basically a laugh . . . No one thinks it's a serious condition . . . These are overeaters" (Goode 2000). In other words, there is resistance to giving binge eating disorder the status of a full-fledged eating disorder like anorexia or bulimia, for which outside forces of biology or culture—rather than individual choices—are to blame.

DISCUSSION AND CONCLUSION

Previous research has shown that the news media frame obesity as a moral problem of gluttony and sloth (Boero 2007) and overwhelmingly blame bad individual choices (Saguy and Almeling 2008), despite increasing discussion of social-structural factors over time (Lawrence 2004). Extant work, however, has been limited either analytically—by, for instance, not examining the role of gender, class, or race (Lawrence 2004)—or methodologically, by relying heavily on a small (Boero 2007) or nonrepresentative sample (Saguy and Almeling 2008). In contrast, the current study draws on a relatively large and representative sample of news reports in the *New York Times* and *Newsweek*, while harnessing the analytical power of both quantitative and qualitative analysis. Moreover, the systematic comparison of reporting of overweight/obesity with reporting on eating disorders—a first on its kind—allows us to tease out the effects of negative attitudes about fatness from generic media routines that favor morality tales and the tendency in the United States to individualize responsibility for health (Fitzpatrick 2000; Lupton 1995; Tesh 1988). We find that, in the contemporary U.S. society where thinness is highly prized, news articles are less likely to blame individuals for being (or trying to be) too thin than they are to blame them for being too fat. This suggests that, more generally, cultural values shape how the news media assign blame and responsibility. In turn, such reporting is likely to reinforce and naturalize such values. This article further suggests that, depending on how they report on the demographics of a given condition, the news media may reinforce group-based stereotypes.

Specifically, the association of heavier bodies with gluttony and sloth and thinner bodies with discipline and responsibility, leads our news sample to frame anorexics as victims of cultural and biological forces beyond their control, while blaming the obese for their weight, which, in turn, reinforces these original associations. Our sample of news articles tends to deny binge eating disorder, in which sufferers eat large quantities of food and tend to be heavier, the status of a "real" eating disorder, reframing it instead as ordinary and blameworthy overeating. Moreover, because anorexia and bulimia are described as more often affecting middle class white girls and women, the analyzed news reports on these disorders reinforce the image of white middle class girls and women as victims. Since overweight/obesity is described as a problem most common among the poor and minorities, such news reporting on obesity reinforces stereotypes of poor minorities as ignorant or willfully defiant of health guidelines. While articles discussing blacks, Latinos, or the poor are more likely to blame weight on social-structural factors, they are also more likely to blame ethnic preferences for larger women or ethnic cuisine.

These findings have important substantive implications. To the extent that reporting on bigger bodies as a health problem reinforces the negative stigma associated with being heavier, women—who suffer more from weight-based discrimination (Puhl et al. 2008)—will bear the brunt of this stigma. Women, the greater consumers of medical weight-loss interventions, including weight-loss diets, drugs, and surgery (Bish et al. 2005; Santry, Gillen, and Lauderdale 2005), are also likely to increase their use of these costly and often risky interventions. As higher body weight is increasingly discussed as a medical and public health crisis, men may increase their consumption of these products as well. Moreover, characterization of obesity as an "epidemic"—warranted or not—creates a sense of urgency and potentially justifies forms of regulatory intervention that would otherwise appear excessive (Lupton 1995). Given the greater vulnerability of the poor and ethnic minorities to surveillance, we can expect regulatory intervention to target these groups.

Demand for increasingly punitive measures may come in response to images of fat populations as "wantonly gorging" themselves and allowing their children to do the same, thereby bringing diabetes and heart disease upon themselves, their families, and their communities. Removing children from their homes, like Heavy T, discussed in the introduction, is the most chilling example of such punitive measures. Anamarie Regino is another such child who was wrested from her parents by state officials, in her case at the age of four years (Belkin 2001). The state of New Mexico justified putting her in foster care on the grounds that her weight was both life threatening and her parents' fault (Belkin 2001). In Anamarie's case, her family's Latino ethnicity was taken as further evidence of her parents' ignorance and inability to care for her. Despite the fact that Anamarie's mother was born in the United States and spoke fluent English, the social worker's affidavit stated that, "the family does not fully understand the threat to their daughter's safety and welfare due to language or cultural barriers" (Belkin 2001).

As these examples show, the way in which body size and eating are framed in public discourse has far-reaching consequences for individual behavior, public policy, and social control. Because of their visibility and cultural authority, the news media are important sites of meaning making and merit serious attention from sociologists. We hope that others will join us in investigating, not only the content of news reporting on eating and body size, but also its ramifications for individual behavior, interpersonal relations, public policy, and personal freedoms.

NOTES

1. The definition of "overweight" and "obesity," and even these terms themselves, are contested. Fat-acceptance activists, who advocate for civil rights on the basis of body size, argue that these terms pathologize normal biological variation and reclaim the word "fat" as a neutral descriptor like "tall" or "short" (Cooper 1998; Wann 1999). Similarly, many feminist scholars have avoided the term "eating disorder" because it situates "disorder" within individuals rather than in complex social structures. We do not use "overweight," "obesity," or "eating disorders" because we endorse a medical or public health framing, but because we seek to

establish how *these particular terms* have been constructed in the news media. We note that a search for articles using the term "fat" produced very few relevant articles, which is not surprising given that this word is still taboo in most social circles in the contemporary United States. An article search using the term "eating problems" was similarly unproductive. For stylistic reasons we do not place the terms "overweight," "obesity," or "eating disorder" in quotations throughout the article, but we wish to be clear that this is the spirit in which we use them.

2. However, new evidence suggests that bulimia—but not anorexia—may be more prevalent among poor minority, compared to middle class white women and girls (Goeree, Ham, and Iorio 2009).
3. Note, however, that following research trends, there is increased discussion of nonwhites with eating disorders in our sample over time, with 29 percent of the 2002–2005 sample metioning nonwhites, compared to 8 percent of the 1995–2001 sample.
4. Race and class are often conflated in news media discussions of obesity, by, for instance, discussing "the poor and minorities" as a group or by using examples of poor members of ethnic minorities to illustrate larger discussions of, say, "black" or "Latino" culture.
5. On mother blame, see the work of McGuffy (2005).

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23 FROM LYDIA PINKHAM TO QUEEN LEVITRA: DIRECT-TO-CONSUMER ADVERTISING AND MEDICALISATION

Peter Conrad and Valerie Leiter

INTRODUCTION

The medicalisation of life problems has been occurring for well over a century (Conrad and Schneider 1992, Shorter 1992, Wertz and Wertz 1989) and may have increased in the past 30 years (Conrad 2005, 2007). Medicalisation occurs when previously non-medical problems are defined and treated as medical problems, usually in terms of illnesses or disorders, or when a medical intervention is used to treat the problem. In a recent article we argued that the push towards medicalisation comes more from the creation of medical markets than from professionals' desire to expand their jurisdiction (Conrad and Leiter 2004). Conrad (2005) has recently suggested that the shifting engines of medicalisation include biotechnology, managed care, and consumers.

In this paper we examine one strand of medicalisation over the last century and a half: the role of direct-to-consumer advertising (DTCA) in the medicalisation of life problems. To do this we compare patent medicine advertising with contemporary DTCA, highlighting the role of federal regulation of pharmaceuticals and advertising as a constraint on medicalisation during the 20th century. We rely primarily upon secondary data sources plus some primary Congressional documents on DTCA in our analyses. This historical comparison allows us to analyse current DTCA practices not as a new development, but as hearkening back to the patent medicine era, and to analyse the role that the medical profession played in creating and maintaining constraints on the advertisement of pharmaceuticals. Lydia E. Pinkham's Vegetable Compound was an exemplar of advertising in its time, and erectile dysfunction drugs, including Levitra, are exemplars of the contemporary DTCA era. History is often a great relativiser. By contrasting drugs that were promoted 130 years apart we seek to reflect more clearly on the potentials and pitfalls of DTCA in the 21st century.

PATENT MEDICINES IN THE 19TH CENTURY

It is important to recall the context of medicine in the 19th century. For example, in the US medicine was not a particularly prestigious profession, with often poorly trained practitioners and extremely limited medical knowledge. When the American Medical Association (AMA) was organised in 1847, among its goals were the improvement of the image of medicine and gaining control over the licensing of physicians (Freidson 1970). The public was ambivalent about the invasive and heroic medicine that most physicians offered, and hospitals were seen as places to go to die. In many communities in America there were no trained physicians, so self-help was an important alternative to medical care. One sector of medical care was so-called 'patent medicines'.

Medicines could be divided between 'ethical' drugs of known composition and patent drugs of undeclared composition. After the Civil War, there was a growing division between ethical drug firms and patent medicine firms (Spillane 2004). The ethical drug firms attempted to distance themselves from patent medicine firms and to align themselves with the fledgling medical profession by adopting the AMA code of not advertising directly to the public (Starr 1982). 'Indeed, the ethical firms took great pains to publicise the fact that they did not make direct advertising appeals to the general public, but confined their sales pitches to persuading doctors and druggists

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of the superiority and reliability of their brands' (Spillane 2004: 2).

Patent medicines in the US originated in Britain and were imported until entrepreneurs discovered the potential domestic market (Young 1961). They were not actually patented but were proprietary drugs with secret or unlisted formulations, with a copyrighted trademark. Patent medicines were advertised directly to the public, encouraging consumers to medicalise everyday symptoms, such as being tired or nervous, through self-diagnosis and self-medication. By the 1850s 'the medicine taking habit was instilled by large usage in the American people. People wanted to take something and many doctors prescribed to demand' (Young 1961: 158). Patent medicines were advertised widely in Britain as well. For example, Thomas Holloway, a patent medicine merchant and later philanthropist, in 1880 spent 50,000 pounds, a great sum at the time, on advertising nostrums that made him wealthy but were later deemed to have little medicinal value (Harrison-Barbet 1994).

There were no limits on what manufacturers or sellers could claim; it was caveat emptor for consumers. At first, cure-alls of the snake oil variety were promoted but manufacturers soon discovered that marketing drugs for specific ailments was more profitable (Applegate 1998). Most of these nostrums were promoted with wildly excessive claims as cures for cancer or arthritis, remedies for baldness or small busts, or restorers of manhood. Almost any possible problem could yield to patent medicine cures.

Advertising for patent medicines went directly from the manufacturer to the consumer. The invention of cheap pulp paper for newsprint helped create an important route for patent medicine advertising. Nostrum advertising accounted for nearly one-third of profits in the newspaper business. 'In 1847, 2000 newspapers ran 11 million medicine ads' (Anderson 2000: 38). By the 1870s, a quarter of all advertising was for proprietary drugs. Dr. James C. Ayer pioneered saturation advertising for his best-selling Cherry Pectoral, by running ads in every newspaper in the US (Anderson 2000: 41).

Ads often emphasised symptoms most people experienced (*e.g.* fatigue, pains, indigestion, sleeplessness, headaches), contributing to a cultural medicalisation of life problems. These drug companies borrowed from the rising prestige of medicine while at the same time distancing themselves from doctors, advertising their treatments as cheaper, safer, less brutal and quicker. Nostrum advertisers 'recognised that nearly every man (sic) is vulnerable to the power of suggestion and sought to make him sick so they could make him well'. (Young 1961: 184). As one analyst suggests, 'Medicine manufacturers didn't collect orders and then fill them, as was the practice with other goods. Rather, they created a steady supply of the product, and then generated the demand' (Anderson 2000: 11). By the early 20th century Americans shelled out $75 million a year, which translates into $1.6 billion in current buying power for patent medicines (Crossen 2004: B1). Patent medicines were at their zenith at the turn of the century, with over 28,000 nostrums, few as successful or well known as Lydia E. Pinkham's Vegetable Compound (Young 1961).

Lydia E. Pinkham's Vegetable Compound

After the financial 'panic' of 1873, the 54-year-old Lydia Pinkham, an abolitionist and school teacher, saw a business opportunity. She added ingredients to a herbal formula that her husband had received as part of a settlement for a debt and made it into a proprietary medicine, which she brewed and bottled in her cellar in Lynn, Massachusetts. Two years later, upon the advice of her son, she began marketing her product as Lydia E. Pinkham's Vegetable Compound for 'women's weaknesses,' including menstrual cramps. Lydia's motto was 'Only a woman understands women's ills' (Pinkus: 2002). The compound had a pungent odour and a sharp aftertaste, and is thought to have contained black cohosh (roots and stems of a perennial herb), fenugreek seed, and at least 18 per cent alcohol (as a preservative, because Pinkham was a temperance supporter).

Pinkham was a pioneer in DTCA. After placing an elaborate first page newspaper ad in the *Boston Herald* in 1876, sales of the product rose significantly, and Pinkham became convinced of the value of advertising. In 1879, her son suggested that she place a likeness of herself on the label, replete with her grandmotherly features. Sales of her product increased dramatically and her picture became one of the most well known female images in print at the time (Simmons 2002). She encouraged women to write to her in confidence for counsel, and answered their letters, a service which continued even after her death in 1883. These letters offered sterling testimonials of the product's efficacy.

Over the years, more maladies were added to the advertisements. For example, an 1887 ad in the *New York Times* proclaimed:

> LYDIA E. PINKHAM'S VEGETABLE COMPOUND Offers the SUREST REMEDY for the PAINFUL ILLS AND DISORDERS SUFFERED BY WOMEN EVERYWHERE. It relieves pain, promotes regular and healthy reoccurrence of periods and is a great help to young girls and women past maturity. It strengthens the back and the pelvic organs, bringing relief and comfort to tired women who stand all day in home, shop and factory.
>
> Leucorrhea, Inflammation, Ulceration and Displacements of the Uterus have been cured by it, as women everywhere gratefully testify. Regular physicians often prescribe it. Sold by all Druggists $1.00 (cited in Applegate 1998: 80).

Lydia Pinkham's advertising to consumers was innovative and ubiquitous. Her Vegetable Compound was everywhere; her face was on labels, in newspaper ads, on fences in rural America, on trading cards, and in drug store displays. Very few nostrums had such wide recognition. In 1912 sales exceeded $1 million. In 1914, in response to federal regulation, the company changed the formula to remove the alcohol so it would not be taxed as an alcoholic beverage and modified its claims about effectiveness (Applegate 1998). After 1925 or so, sales of the product declined. The patent medicine companies' DTCA had been wildly successful for some companies but, increasingly, it was opposed by the medical profession and other articulate critics.

CAMPAIGNS AGAINST PATENT MEDICINES AND DTCA

In Paul Starr's (1982: 128) words, 'The nostrum makers were the nemesis of physicians'. They competed with physicians for medical business, offered supposedly safer but unproven 'cures', and undercut the authority of medicine. Patent medicines, with secret formulas and advertising to the public, posed a threat to physicians' still fledgling professional aspirations. Both patent medicines and physicians grew in popularity and use in the late 19th century. In fact, despite the competition, physicians also used patent medicines in their practices; by one count, in 1874 one per cent of physicians used patient medicines, increasing to over 20 per cent by 1902 (Starr 1982: 130). By another count, 90 per cent of doctors were prescribing proprietary medicines (Young 1961: 160).

The medical profession's concern about patent medicines manifested itself in a variety of campaigns against the industry. In 1900 the AMA started a campaign 'to make the "legitimate proprietary drugs" respond to the ethics of medicine', which included disclosing formulas and not advertising directly to the public (Starr 1982: 129). The AMA announced it would stop taking patent medicine advertisements around this time, then relaxed their standards for revenues' sake. As Young notes, 'In 1905, JAMA did not have as many bad ads as many medical journals, but that is only faint praise' (1961: 207). Medical journals and newspapers continued to rely on patent medicine advertising as a major source of revenue.

In 1906, the AMA set standards for both advertising and prescribing medications with the publication of *New and Nonofficial Remedies* (Starr 1982: 131). Drugs were not accepted if their manufacturers made false advertising claims, refused to disclose their drugs' composition, advertised directly to the public, or whose 'label, package or circular listed the diseases for which the drug was used' (Starr 1982: 132). Ethical drug companies had a 'gentleman's agreement' with physicians, under which physicians would legitimise the drugs with the 'ethical' label and the drug companies would acknowledge physicians' authority to diagnose illness and determine treatments. This agreement did not guarantee that drugs were safe, as ethical drugs might contain poisons such as arsenic. Rather, the term 'ethical' meant that the drug companies would be honest about the contents of their wares, would not knowingly make fraudulent claims about their efficacy, and would not bypass physicians' authority. The line was drawn. Companies could advertise to physicians only or they could not advertise to physicians at all. Despite losing revenues, newspapers began to cut back on DTCA for drugs that the AMA listed as fraudulent.

Muck-raking journalists were also on the case of exposing useless potions that were sold in the name of health. In 1903 the *Ladies Home Journal* published an exposé on the dangers of patent medicines. Samuel Hopkins Adams' in-depth investigative series, 'The Great American Fraud', published in *Colliers Weekly* in 1905, really made the public case against patent medicines. The articles named specific names and identified specific false promises and deceptions made in patent medicine advertising. The writers and editors of these magazines advocated for federal regulation on the promotion and sale of patent medicines (Applegate 1998).

Some states had already considered regulating patent medicines, but they were 'easily outmatched by the well funded lobby of the Proprietary Association of America' (Crossen 2004). The AMA distributed 150,000 copies of these articles from 1905 to 1910 (Starr 1982: 130). Adams' investigation, along with Upton Sinclair's *The Jungle*, a muckraking exposé of the meat packing industry, the AMA's campaign against nostrum marketing, and scientist and crusader Harvey W. Wiley's work with Congress, finally resulted in the Pure Food and Drug Act of 1906, the first federal legislation to control drugs and medications.

FEDERAL REGULATION AND DRUG ADVERTISING

The Act put constraints on advertising and marketing, stating that manufacturers had to print accurate ingredients on the label, they could not make false or exaggerated claims on the label, and that drugs had to meet certain standards of purity. As one indicator of the Act's impact, the 1897 Sears Roebuck catalogue had 17 out of 770 pages dedicated to the 'Drug Department'; the 1908 catalogue had fewer than two pages of 1200 on drugs (Isreal 1968 cited in Pinkus 2002). The federal law was amended in 1912 to include claims of effectiveness and in 1920 to cover newspaper advertising (Starr 1982: 132). By 1915, Lydia E. Pinkham's Vegetable Compound had to cease advertising specifically for women's disorders and instead made the innocuous claim, 'Recommended as a Vegetable Tonic in conditions for which the preparation has been adapted' (Starr 1982: 132).

Between 1906 and 1980, the FDA consolidated regulatory authority over prescription drugs and gained jurisdiction over all communication from the pharmaceutical industry. Likewise, in the first half of the 20th century, physicians continued to solidify their medical authority over diagnosis of illness and prescribing drugs as treatments (Starr 1982). Both the profession of medicine and the FDA operated to constrain the advertising of pharmaceuticals during most of the 20th century, thereby also constraining consumers' access to pharmaceuticals to treat their aches and troubles. This concurrent consolidation of medical and regulatory authority began to break down in the 1980s.

THE EMERGENCE OF DTCA OF PRESCRIPTION DRUGS: 1981–1996

Direct-to-consumer advertising for prescription medications has fuelled the medicalisation that analysts noted as increasing in Western societies in the 1980s (Conrad 1992). DTCA has become a major source of expanding medical markets and public engagement with medical solutions for life's conditions and problems (Conrad and Leiter 2004).

In 1981, Boots Pharmaceutical (a British firm) issued the first DTC broadcast ad for an ibuprofen product called Rufen and Merck Sharp & Dohme advertised a pneumonia vaccine called Pneumovax (Pines 1999). According to Pines, who was at the FDA at the time, the FDA's first response was shock, and 'Physicians at the FDA generally felt that such advertising was inappropriate' (1999: 492). Yet the very next year, FDA Commissioner Arthur Hull Hayes, Jr. gave a speech before the Pharmaceutical Advertising Council, in which he stated that, 'In sum, my impression is that we may be on the brink of the exponential growth phase of direct-to-consumer promotion of prescription products' (U.S. House of Representatives 1984: 1).

In that speech, Hayes describes the changing dynamics between patients, physicians, and pharmaceutical companies:

Is this Democratizing giving patients choice

> There was a time when prescription product advertising to consumers was limited to an occasional institutional ad. Physicians were your industry's sole target audience. Patients had an insignificant voice in choosing prescription products they were given. Generic drugs were not yet an issue. The demographics of consumer publications were such that a very high percentage of the exposures paid for by a prescription product advertiser would be to people who could not possibly use the product. And members of the advertising profession did not want to run the risk of offending physicians by appearing to circumvent them or undercut their freedom of judgment.
>
> It is no longer so. One result of the consumer movement has been increasing numbers of patients who demand a role in the selection of all their health care products. The *Physicians Desk Reference*—as Charlie Baker would be pleased to tell you—is a best seller. It's difficult to remember the last time that the weekly book best seller lists didn't include several volumes about prescription drugs and health care. Specialised health magazines have proliferated. And 90 per cent of prescriptions are now for drugs no one heard of only a generation ago (U.S. House of Representatives 1984: 23–24).

webMD

Hayes' speech describes a shift to more consumer-demanded healthcare, with lay persons playing a larger role in determining their own needs and treatments, opening the door to increased medicalisation by health 'consumers'.

In response to this speech, the FDA commissioned a study of physicians and pharmacists regarding patients and prescriptions, and the US House Subcommittee on Oversight and Investigations sent out letters to 37 pharmaceutical companies asking for their position on DTCA (U.S. House of Representatives 1984). Not surprisingly, almost all of the response letters said that the companies would engage in DTCA if their competitors did so. What is striking about the letters is that *they were almost unanimous in their negative responses to the potential of DTCA.* Wayne Davidson, president of the U.S. Pharmaceutical and Nutritional Division of the Bristol-Myers Company, wrote:

> It will be very difficult, if not impossible, for a federal agency (FDA or FTC) to distinguish between when self-diagnosis is possible and when it is not. Where the line is drawn will be the subject of much legal controversy. We are of the opinion it is much better not to attempt to draw the line, but to prohibit this type of advertising to the patient consumer. This type of advertising will also put the prescribing professionals on the defensive in the relationship with their patients, just the reverse of the most productive relationship. . . .(U.S. House of Representatives 1984: 89).

Similarly, Thomas Collins, president of Smith Kline & French Laboratories, replied:

> We do not believe that PDAC [Prescription Drug Advertising to the Consumer] is a good idea. . . .We believe that the chances for damaging doctor-patient relations and for encouraging costly competitive battles are real, while the likelihood that meaningful patient education will occur is small. We certainly welcome, let me stress, the increased consumer participation in health decisions in recent years. It is well for patients to take part, to the extent they wish, in decisions affecting their care. It is however very important to differentiate the capabilities of advertising from those of educational programs. Advertising can inform, but it is not education; and PDAC should not be portrayed as part of the education process (U.S. House of Representatives 1984: 152–3).

Both of these letters voice concerns about consumers' ability to self-diagnose, essentially questioning consumers' medicalisation of their own problems and highlighting the important role that physicians play as gatekeepers in the medicalisation process.In September of 1982, at the beginning of these explorations, the FDA requested a formal, voluntary moratorium on DTCA (Feather 1998 cited in Pines 1999). In 1983, the FDA issued a policy statement calling for a 'period of cautious restraint on the part of would-be prescription drug advertisers' (50 Fed. Reg. 36677 (1985)). Then in 1985, the FDA withdrew its moratorium, concluding that 'for the time being, current regulations governing prescription drug advertising provide sufficient safeguards to protect consumers' (50 Fed. Reg. 36677 (1985)). According to Pines, the FDA's policy change was 'not intended to open the floodgates for DTC advertising. On the contrary, it was a reluctant recognition by the agency of a new trend, and was intended to ensure that FDA had jurisdiction and that the industry had a framework within which to consider DTC advertising' (1999: 493).

Thesis: DTCA leads to medicalization.

After the FDA withdrew the moratorium, companies increased their print advertising considerably, with companies spending $12 billion in DTCA in 1989 (Medical Advertising News 1999 cited in Pines 1999). However, the cumbersome 'fair balance' and 'brief summary' requirements indirectly kept companies from engaging in DTC broadcast advertising, constraining their outreach to consumers.

DTCA COMES TO TV: 1997 ONWARD

On 8th, August 1997, the FDA issued draft guidelines for DTCA of product-specific prescription drug broadcast advertisements (62 Fed. Reg. 43171), which described how television and radio ads might fulfill FDA requirements for 'adequate provision' of product information and a 'major statement' of the drug's major risks. Prior to this, these requirements made TV drug advertising all but impossible.

Under this new interpretation of the regulations, the FDA would allow DTC broadcast advertising if the advertising would provide consumers with the product's approved labelling information through one of four sources: a toll-free telephone number that consumers could call; a concurrent print advertisement containing a brief summary of risk information; a web page (URL) that included the package insert; or additional product information from pharmacists, physicians, or other healthcare providers (Food and Drug Administration 1999). The FDA also announced that it wanted the industry to conduct studies of the effects of DTCA and that it would evaluate the policy in two years (Pines 1999). On 6th, August 1999, the FDA issued its final guidance for DTCA of prescription drugs (64 Fed. Reg. 43197), making very few changes to its original guidelines.

Three types of prescription DTCA would be permitted: product claim advertisements, which included the product name and specific therapeutic claims; reminder advertisements, which gave the name of the drug but did not state its use; and so-called help-seeking advertisements, which told consumers about unspecified treatment possibilities for diseases or conditions (Goldman 2005). From our perspective, all three contribute to medicalisation, with the help-seeking ads the most likely to promote it.

This shift in policy was controversial. Those supporting the change suggested that there would be a public health benefit, depicting broadcast DTCA as 'an excellent way to meet the growing demand for medical information, empowering consumers by educating them about health conditions and possible treatments' (Holmer 1999 quoted in Hollon 2005). Critics voiced reservations, especially regarding how DTCA could lead to overprescribing, how it emphasised newer and more expensive medicines over cheaper existing ones, and regarding 'the medicalising of normal human experience' (Mintzes 2002, Frosch *et al.* 2007).

Broadcast DTCA has grown enormously in the past years, up from $55 million in 1991 to $4.2 billion in 2005 (USGAO 2006), with 330 per cent growth in DTCA from 1996 to 2005 (Donahue *et al.* 2007). The ads focus on chronic problems affecting relatively healthy people, with large potential treatment populations and long-term usage, including drugs for allergy, anxiety, obesity, arthritis, erectile dysfunction, and high cholesterol. About 20 prescription drugs make up 60 per cent of the pharmaceutical company spending on DTCA (Hollon 2005) and advertising for one specific drug can have ripple effects for all drugs that are touted for a particular condition. The US Government Accountability Office has estimated that 'each 10% increase in DTC spending within a drug class increases sales in that class by 1%' (2002: 15). DTC ads for drugs to treat erectile dysfunction have become common, especially on television.

DTCA AND ERECTILE DYSFUNCTION

The Viagra story is by now a familiar one. We need not repeat it in detail here (see Conrad and Leiter 2004, Loe 2004) but will review some points that are relevant to DTCA and medicalisation. In 1992 a consensus conference officially labelled what used to be called impotence as 'erectile dysfunction' and as a biogenic rather than psychogenic problem. In March 1998, the FDA approved Viagra (sildenafil citrate) as a treatment for this condition. In the early days it was marketed primarily to older men with erectile problems and for erectile dysfunction associated with prostate cancer, diabetes, and other medical problems (Loe 2004). Estimates for prevalence ranged from 10 million to half of all American men (Laumann *et al.* 1999). The market potential was not lost on the drug companies, so within a short time Pfizer Pharmaceuticals began advertising Viagra more broadly. With an ageing population, a high prevalence of erectile dysfunction, and an even broader concern with sexual performance, the potential market was huge. DTCA expanded the market to include virtually *any* man who might consider himself as having erectile problems or just wanted a boost in performance (Conrad and Leiter 2004). Within a few years of Viagra's introduction, pharmaceutical competitors came on the scene.

boost in performance
medicalization

Levitra was introduced in 2003 as a faster drug with fewer adverse effects than Viagra. Levitra ads focused more on recreational uses, targeting 'men who may have successful sexual relationships but simply want to improve the quality or duration of their erections' (Harris 2003). The most visible DTCA spokesman for Levitra was Mike Ditka, a former hardnosed football coach and Hall of Fame player. Levitra became an official sponsor of the National Football League (NFL) and in 2004 became the first pharmaceutical ad during the Super Bowl with its 'Levitra Challenge'. In the week after the Super Bowl, Levitra prescriptions grew by 15 per cent (GSK news release 2004). However, there may be limits to what kind of DTC ads are acceptable for television. The FDA asked Bayer Pharmaceuticals, maker of Levitra, to pull its 15-second spot of 'My Man' ads that promoted Levitra. The ads starred an attractive actress, Marie Silvia—hailed as 'Queen Levitra' by the *Wall Street Journal*—who said how the drug's 'strong and lasting effects' provide a 'quality experience' (Snowbeck 2005). Apparently the ad did not include enough safety information and made a misleading comparison with other drugs for the condition. While the short version of the Queen Levitra ad was pulled, the 45-second version continued to be aired (Snowbeck 2005).

DTCA has shaped and developed the erectile dysfunction drug market. In 2004, drug companies spent over $382 million in advertising these drugs in the US, with sales of $1.36 billion (Snowbeck 2005). The demand for these drugs may have stabilised; doctors wrote 10 per cent fewer new prescriptions in October 2005 than the year before (Berenson 2005). While erectile dysfunction has been firmly medicalised, there may be limits to the demand for medical solutions for sexual difficulties.

FROM QUEEN LYDIA TO QUEEN LEVITRA

Lydia Pinkham was the queen of patent medicine. Her product, cooked up in her cellar and composed of herbs and alcohol, epitomises the patent medicine industry in the late 19th and early 20th centuries, which was built largely upon proprietary recipes and grand promises printed on cheap, pulp paper. Patent medicines contributed to a cultural medicalisation of life problems. Advertisements told consumers that they could diagnose their own symptoms and use patent medicines to alleviate those symptoms, without having to resort to consulting physicians. These symptoms ranged from everyday aches and pains, such as being tired or nervous, to serious diseases such as tuberculosis. While over-the-counter medications have continued to fill this self-help niche, during most of the 20th century the profession of medicine and the FDA successfully constrained the advertising of pharmaceuticals to the public, making physicians key gatekeepers to prescription drugs.

More recently, 'Queen Levitra' was on television, touting Levitra's ability to produce 'strong and lasting effects' and a 'quality experience', alluding to the sexual ability that men may gain (to women's benefit) by taking Levitra. We have come a long way since the days of patent medicine 100 years ago. Yet DTCA hearkens back to those days, in that the pharmaceutical industry is once again reaching out to consumers directly when selling their products and creating wider avenues to the medicalisation of life problems. In this way, the advertising of pharmaceuticals is becoming more like the advertising of over-the-counter medications. In fact, the distinction between prescription drugs and these medications may be less clear now than in the mid-20th century, due to

DTCA shaped + developed
erectile dysfunction drug
market

DTCA as well as some pharmaceuticals shifting from prescription to over-the-counter status. For example, Claritin, a well-known antihistamine that was advertised heavily on broadcast media early in the contemporary DTCA era, is now available over the counter.

Pharmaceutical companies' advertising activities have changed considerably, with important implications for medicalisation, as summarised in Table 23-1. Before 1906, drug manufacturers were split into two increasingly distinct camps: ethical drug manufacturers and patent drug manufacturers. Much of the distinction between these two types of manufacturers was based on the type of advertising that they used to sell their wares: ethical drug companies advertised to physicians only, while patent medicine companies advertised directly to consumers. This gentleman's agreement allowed physicians to legitimise ethical drugs and ethical drug companies to defer to physician's authority in diagnosis and prescribing. During this period, physicians, patent medicine manufacturers, and consumers contributed to expansion of medical definitions and treatments for life problems.

After Congress passed the Food and Drug Act of 1906, the AMA stepped up its efforts to police the boundaries between ethical and patent drug firms, working with the federal government to identify firms that violated the Act. Through this legislation, the government could disrupt the direct relationship between patent drug producers and consumers, protecting consumers in the name of public health. As a result of these efforts, advertising for prescription medications became restricted between 1906–1980 to physicians only and drug companies had a limited role in medicalisation. It is important to note that drug companies always had direct access to consumers for over-the-counter medications. They did not require a medical prescription and were advertised widely. These were typically cold remedies and headache medications, although they would occasionally also encourage medicalisation of new ills such as the 'halitosis' (bad breath) mentioned in Listerine mouthwash advertisements. However, physicians' control over access to pharmaceuticals limited medicalisation.

Around 1981 pharmaceutical companies began to test the gentleman's agreement concerning prescription advertising by initiating limited forays of DTCA. There were no laws against advertising drugs but firms were unsure of what was permissible. A 1985 FDA statement permitted the pharmaceutical industry sufficient latitude to allow a broader engagement with print ads for prescription drugs. The drug companies did not yet venture into broadcast ads due to the difficulty of fulfilling the FDA's requirements regarding the 'major statement' of risks and side effects of drugs.

The reinterpretation of FDA advertising guidelines in 1997 had major implications for DTCA, especially on television. Now drug companies could market directly to consumers. Physicians became gatekeepers for drugs advertised direct to consumers rather than initiators of pharmaceutical treatments: 'Ask your doctor if [name of drug] is right for you'. The drug industry and consumers, facilitated by DTCA, have become major

Table 23-1. Summary of drug advertising activities and implications for medicalisation

Time periods	Pharmaceutical advertising activities	Implications for medicalisation
Before 1906	Ethical: to physicians Patent: to consumers	Both consumers and physicians are agents of medicalisation
1906–1980	Advertising of prescription drugs to physicians only	Physicians dominate medicalisation
1981–1996	Advertising to physicians; growth in print ads to consumers	Consumers have more information to participate in medicalisation
1997–present	Advertising to physicians; widespread DTCA print and broadcast ads to consumers	Drug industry and consumers become more significant; physicians' centrality decreased

players in medicalisation with physicians relegated to somewhat less of a role (Conrad 2007). In fact, direct access to consumers has increased the pharmaceutical industry's incentive to medicalise human problems, encouraging consumers to self-diagnose and request drugs that they see on TV. Furthermore, the Internet has become another direct avenue from pharmaceutical companies to consumers, and one that is not limited to national boundaries. This electronic form of DTCA can already be considered as a factor in internationalising medicalisation. Some Internet sites bypass physicians altogether with a veneer of medical oversight.

The impacts of DTCA on medicalisation and health are complicated. DTCA can raise awareness about disease and risk, and provide some useful medical information for consumers, although most physicians believe that DTCA does not provide balanced information (Perri *et al.* 1999, Hollon 2005). DTCA has significant impact on patient demands, physicians prescribing, and by implication, medicalisation. DTC advertising leads to increased requests for advertised medicines and more prescriptions (Mintzes *et al.* 2003). A study by Kravitz *et al.* (2005) sent trained standardised patients to physicians. The 'patients' presented symptoms of either major depression or adjustment disorder and made DTC-related requests of a brand specific drug, a general class of drugs, or no request. 'Patients' who made brand-specific requests or general requests for drugs were much more likely than patients who made no requests for drugs to receive a prescription. Requesting medications increased the amount of prescribing, at least for these two disorders. What is disturbing here is that although there are no data to support the use of antidepressants for adjustment disorder, half of those who requested it, based on DTCA, received prescriptions. The authors conclude that DTCA 'may stimulate prescribing of more questionable than clear indications' (Kravitz *et al.* 2005: 2000).

The scrutiny and criticism of DTCA appears to be increasing from various quarters. U.S. Senate Majority Leader Bill Frist (a physician) expressed concerns that DTCA creates a wedge between physicians and patients (Henderson 2005). An article in *Advertising Age* questioned whether recent drug safety scares may shift the balance of power back to physicians (Thomaselli 2005) as consumers respond to cases such as Vioxx's well-advertised entry and quick removal from the market. In July 2005, the drug industry drafted guidelines that called for a period of notifying doctors about new drugs before advertising to consumers (Saul 2005a). These new voluntary guidelines would 'virtually eliminate 15-second spots' because they do not provide enough time to list risks, and require that all ads will be submitted to the FDA for review before they are used (Saul 2005b). While it is too early to judge the impact of these changes on medicalisation, it seems doubtful that these changes would significantly decrease the roles of DTC advertising and consumers on medicalisation.

CONCLUSION

While DTCA appears to be flourishing, even FDA personnel seem concerned about its effects on medicalisation. In a meeting about DTCA, Janet Woodcock, the director of the FDA's Center for Drug Evaluation and Research, highlighted two concerns: 'First, that many common and relatively minor complaints of daily life represent diseases. This has been called the medicalisation of life. And second, the perception that all life complaints can and perhaps should be treated with a pill' (Food and Drug Administration 2003: 22). Broadcast DTCA is now only permitted in the US and New Zealand and is prohibited in the United Kingdom and most developed countries. Should DTC advertising be introduced in Europe (Watson 2003), most of the same issues would exist (Metzl 2007).

One of the ironies of DTCA is that it expands the relationship of drug companies, physicians and consumers, returning it to a situation similar to Lydia Pinkham's day, when the drug manufacturers had a direct and independent relationship with consumers. It encourages self-diagnosis and requests for treatment. It allows pharmaceutical companies to create specific markets for their products and promote them to waiting customers. Of course, with stronger government regulation and a more powerful medical profession, the situation is also different from what it was a century ago. The extravagant claims of Lydia

Pinkham's day are constrained by laws, but modern advertising is both more subtle and sophisticated than what was available to the patent medicine peddlers. It seems clear that the pharmaceutical industry and consumers are becoming increasingly important players in medicalisation and that DTCA facilitates this shift.

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