Abstracts

Sociology and Social Policy

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De Vries, R. G., Birth and death: social construction at the poles of existence, *Social Forces*, 59, 1981, 1074—93.

An individual's life career can be described by a number of linked status passages. There are two kinds of status passage which are of universal significance to all kinds of societies and to the people who live through them: birth and death. This paper focuses on birth and death and distinguishes them from other status passages because of their relationship to the unknown – they exist at the boundaries of our existence. De Vries calls these significant biological status passages *existence transitions*. His article emphasizes the importance of birth and death whose ties 'with the unknown requires cultural constructions which in some way serve to explain human existence as part of a larger metaphysical realm' (p. 1090).

Both birth and death, although biological phenomena, are socially constructed. Sudnow[1] shows how we socially construct death: the young victim of a car accident will be resuscitated long beyond the time when she is biologically dead while the elderly victim will be allowed to die peacefully. The likelihood of dying systematically varies with hospital organization and perceived social value of the stricken individual. Similarly birth is socially constructed. Foetuses with identical physical characteristics are subject to a range of definitions extending from 'baby' to 'abortus' depending on such things as length of pregnancy and the beliefs and motivations of doctors and parents.

De Vries explores the similarities of birth and death in six general categories: the role of the dying and 'birthing' individual, the place of the family in these transitions, the control of information surrounding the event, medical components of the experience, collective action pertaining to birth and death, and the uses of ritual.

Increased medicalization of birth and death has a number of important implications. First medicalization has helped to redefine the limits of birth and death. Our social constructions are more variable. Second, the quality of health care is linked to the perceived social worth of individuals. Third, medicalization through its institutional settings reduces the individual's capacity to define and control her own situation. Fourth, the institutional-

ization of birth and death becomes part of the general information control of these events although the family still controls the wider dissemination of information. Finally, medicalization has provided the impetus for increased pressure from lay people to redefine *existence transitions* as 'natural'.

Birth and death, however socially constructed, are often followed by culturally constructed ritual confirmations. Funerals and christenings are such ritual events. Yet increasing socialization has decreased the religious significance of *existence transitions*. However the rituals surrounding birth and death are characterized by an increasing professional encroachment which seeks to influence individuals' social constructions. Professionalization has both redefined *existence transitions* and controlled their celebration.

COMMENT

The author is not the first writer to seek similarities between birth and death but is probably the first to create a new concept in order to link the two. From this article I am not convinced of the need for such a concept. What more does the phrase *existence transitions* tell us than biological status passage?

But the article does have some value – it reinforces the important idea that both birth and death are social constructions and constructions in which the health professions have too much influence. But if you want to further your understanding of status passages read or re-read Van Gennep[2] instead.

NOTES

1 Sudnow, D., *Passing On, The Social Organisation of Dying.* Englewood Cliffs, Prentice Hall, 1971.
2 Van Gennep, A., *Les Rites de Passage*, Paris, Emile Nourry, 1909.

Minkler, M., Research on the health effects of retirement: an uncertain legacy, *Journal of Health and Social Behaviour*, 22, 1981, 117–30.

We now turn our attention from the universally experienced status passages of birth and death and consider one which is also experienced by

most old people – namely retirement. This article discusses the old chestnut of the relationship of retirement to health.

Functionalist theory suggested that where a socially acceptable retirement role was not available retirees, particularly those from manual occupations, may opt for a sick role. Ellison[1] argued that retirement may precipitate illness in men who move from an acceptable occupational role to a retired role in which they do not fit. From the functionalist perspective illness, unlike retirement, is an acceptable reason for withdrawing from social roles and responsibilities.

Drawing on this theoretical perspective more recent writers have included retirement under a list of potentially stressful life events. This article shows that few studies have attempted to explain the relationship between retirement, and health and those which have, provide conflicting results. Minkler also shows that the studies reviewed have serious sampling and methodological problems which makes it difficult to generalize from the findings obtained.

Minkler provides an alternative perspective, which sees retirement as a process that takes into account such elements as degree of control over the event and its timing. However she is concerned that many of these studies exclude from their analysis broader socio-political contexts which play an important role in the shaping of retirement policies. She argues that further research which focuses specifically on the influence of major social and economic changes on retirement is required. Further refinements of life events scales is also advocated.

The article concludes with a shopping list of further research:

(a) Prospective studies of the health of workers approaching retirement age.
(b) Analyses of mortality and morbidity data to document stressful phases in the retirement process.
(c) Studies of social contacts in relation to health of elderly people.
(d) Prospective studies of matched pairs of individuals to see the effect of their control over the timing of retirement.
(e) Studies to examine more carefully the relationship between retirement and health.
(f) Studies to examine the health status of female retirees.

COMMENT

I found this a most useful article which reviewed both the theoretical and empirical literature concerning the postulated relationship between retirement and health. The only disappointment was the author's inability to answer this question once and for all! Like unemployment and health

I think that the relationship between retirement and health will require further research before general conclusions can be drawn. This author's shopping list is only a start and underplays socio-political influences, the importance of which, she highlighted in this article.

NOTE

1 Ellison, D. L., 'Work, retirement and the sick role', *Gerontologist*, 8, 1968, 189–92.

Fenwick, R. and Barresi, C. M., Health Consequences of Marital Status Change among the Elderly: A Comparison of Cross-sectional and Longitudinal Analyses, *Journal of Health and Social Behaviour*, 22, 1981, 106–16.

Another status passage which has a postulated relationship with health status is bereavement. This paper describes a study which examined the effects of changes of marital status on changes in health status of elderly respondents over a fourteen month interval.

A growing body of literature has focused on the effects that life events have on an individual's physical and mental health. In particular, changes in marital status are thought to be related to the development of physical and mental ill health. Fenwick and Barresi present two explanations of how severe life events lead to ill health. One view suggests that it is the change in status that creates stress which leads to physical or psychiatric disorders. The alternative view suggests that since not all life events are stress invoking it is only those not desired by the individual, such as bereavement, which lead to a deterioration in health.

The authors also report a number of methodological problems with existing studies. Some have only employed a cross sectional strategy, an approach not suited to measuring change. Longitudinal studies also have problems. Many really analyse the effects of life events on changes in health status. Where this has been done some studies have not attempted to identify the specific effects of life events from the effects of other factors on health status.

With these problems in mind the authors of this article addressed three sets of questions:

1. What are the effects of changes in marital status on changes in the level of health of low income elderly people?

2. What are the relative effects of changes in marital status on level of health for low income elderly compared with the effects of more permanent statuses such as race or gender?
3. What is the component of marital-status change that is linked to level of health and to changes in level of health for low-income elderly?

To answer these questions the authors re-analysed data collected as part of a survey of low income aged and disabled undertaken in 1973 and 1974. The analysis is based on 7,696 individuals aged sixty-five or over who were interviewed at two points in time – T1 (1973) and T2 (1974). Health status is measured by subjective health status, number of days ill in bed at home and number of days in hospital. Marital status at T1 and T2, age in years, race, gender and education in years were entered into a regression analysis along with the three measures of health status.

Significant differences were found in health statuses, measured cross sectionally and longitudinally, among different age, gender, race and educational groups, with better health found among younger respondents, women, whites and the longer educated. Marital statuses added significant explained variance (R^2) to the longitudinal equations of respondents' subjective health status and days ill in bed. Respondents who lost their spouse between T1 and T2 had significantly lower subjective health at T2 than those who remained married, yet they spent fewer days ill in bed than married respondents. A higher proportion of respondents widowed at T1 spent time in hospital than married respondents. Respondents who had never married had better subjective health and spent fewer days ill in bed than married respondents. The authors argue that it is the change from married to unmarried status, rather than unmarried status per se, which leads to a decline in subjective health status. They argue that these data support the view that only life events which are undesired by the respondent affect health status.

COMMENT

This paper is better written than many which use fairly complex statistical models. However the model uses only a few variables which suggests that the authors have probably only presented a partial explanation of the relationship between stressful status passages and health status. In policy terms the results of this study reinforce health care practice in Britain, which has highlighted the vulnerability of bereaved spouses, but probably provides little additional insight into the process.

Most multivariate analyses, as the present authors indicate, are problematic when dealing with change. In the present paper the authors have overcome some of the problems in categorizing marital status. Yet in a

single year a lot of other changes may have also taken place in the respondent's life. This raises the old question of whether this theoretical approach is the most appropriate. I would be encouraged if further research on this topic adopted an interactionist perspective, this would require more intensive data collection but could give greater insight into the process of bereavement and widowhood among elderly people.

Hughes, M. and Gove, W. R., Living alone, social integration, and mental health, *American Journal of Sociology*, 87, 1981, 48–74.

My final selection of articles deviates from the theme of status passages but focuses on the relationships between isolation and health status. This article describes a study which examines the effects of living alone on mental health, mental well being, and maladaptive behaviours. Hughes and Gove review both classical and modern sociological theory and conclude that there is general agreement that close social bonds involving continuing primary interaction are critically important in developing and maintaining an individual who functions effectively and is psychologically healthy. Their review of empirical studies suggests that there is a strong positive relationship between social isolation and mental illness although there is some ambiguity in regard to whether isolation is causal or produced by factors associated with mental illness. The authors describe studies that indicate that at least some of this relationship is not due to drift, but the relative importance of drift has not been established. It is also argued that many of the studies deal with very extreme cases of illness, and make little attempt to study the mental health of the normal population of people who are isolated. Consequently, Hughes and Gove argue, most of the evidence for social integration theory must be viewed as resting on a tenuous empirical base.

The study reported in this article is based on the responses of a stratified random sample of 2,248 respondents aged eighteen or over in 1974–75. A univariate analysis of the data indicated that there was no evidence that people who live alone are selected into that living arrangement because of pre-existing psychological problems, negative personality characteristics or low economic status. Indeed these data show that unmarried people who live alone are no worse, and on some indicators are in better mental health than are those who live with others. This is contrary to what would be predicted by both structural functionalist and symbolic interactionist theory.

Hughes and Gove also found that divorced and never married people

who live alone have more in common with married people, in terms of mental health, than unmarried people who live with others. These data suggest that unmarried people who live alone are more likely than unmarried people who live with others to engage in drug or alcohol use.

In conclusion, Hughes and Gove argue that living alone is not particularly problematic; a finding which raises serious questions about social integration theory. They argue that many of the effects normally attributed to social integration may not be a consequence of close, intimate, warm social relationships, but simply a consequence of social control. They also argue that such relationships can have negative effects and therefore costs. Thus socially integrated relationships not only provide direct social rewards through reinforcement and increased meaning to life but also incur costs in the form of social constraint, obligation and responsibility.

COMMENT

This article is useful in a number of ways. First, it looked at another old chestnut as to whether social isolation causes mental illness or whether people with mental illness tend to live alone. As I have reported they show that there is no evidence that people who live alone are selected into that living arrangement because of pre-existing psychological problems. Second, the article is useful because it challenges traditional sociological theory on the nature of social integration. As a heuristic device I found the article fairly challenging but felt that the ideas presented in the discussion were somewhat confusing, and I am not convinced that they have fully substantiated their criticisms of the theory. However, this article will certainly encourage me to look more closely at social integration theory in the future.

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Social Services — John E. Tibbitt

Heumann, L. F., 'The function of different sheltered housing categories for the semi-independent elderly', *Social Policy and Administration*, 15.2, Summer 1981, pp. 164–80.

Sheltered housing is now well established as a key element in the range of accommodation available for the elderly. The rage is often thought of as