The Fit and the Unfit: The Presentation of "Fitness" in Everyday Life

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This paper examines the ways in which individuals attempt to present themselves as healthy and fit human beings, according to the principles of dramaturgic self-presentation. Accordingly, Goffman's notions of face work, teamwork, and stigma are used to develop a framework for understanding how self-presentation impacts human interaction. This framework is then applied to a brief examination of the stigma of AIDS. Next, the framework is applied to the presentation of a healthy and fit self. Three issues are considered: what is common to the definition of fitness, what are some of the dimensions that become salient in light of that common definition, and, what strategies for presentation are possible based on the definition and dimensions. Finally, four variables that might affect which presentation strategy is adopted are considered: attractiveness, gender, age, and class. It is suggested that none of these variables operates in isolation and some of the implications for presentation are considered.

Keywords: self-presentation, stigma, fitness communication, moral fitness

INTRODUCTION: HEALTH AND FITNESS COMMUNICATION

In *Asylums*, Erving Goffman (1961) describes the physician-patient relationship as a kind of service relationship, whereby the physician performs a "service" for the client by "fixing" the client's faulty object. Insofar as the faulty object in this case is the client's own body, the client entrusts the physician with something that is fundamentally irreplaceable. The nature of this trust is unique among service relationships and, thus, necessarily forces the physician into the role of an expert. "This trustworthiness available upon request would of itself provide a unique basis of relationship in our society, but there is still another factor: the server's work has to do with a rational competence, and behind this a belief in rationalism, empiricism, and mechanism, in contrast to the more self-referential processes that plague people" (Goffman, 1961, p. 328). It is these self-referential processes that are the focus of this paper.

Insofar as they are cast into the role of objective, impartial expert, physicians and other health practitioners are often confronted by two problems:

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> First, the server's increasingly proficient attention to the interests of the client can lead him to form ideal conceptions of client interest and this ideal, together with professional standards of taste, efficiency, and foresightedness, can sometimes conflict with what a particular client on a particular occasion considers to be his own best interests (Goffman, 1961, p. 339).

> Second, the more a server is concerned with giving good service, and the more his own profession is given a public mandate to control him, the more he is likely to be accorded the public task of maintaining community standards, which at times will not be in the immediate interests of a particular client. (Goffman, 1961, p. 333).

In other words, when individuals seek the services of a health practitioner, it is usually with the avowed purpose of restoring their "faulty object" to a functioning capacity. Given that the physician is cast into the role of an expert, "accorded the public task of maintaining community standards," the physician's diagnoses, as communicative messages, convey meanings above and beyond their medical content. Illness, whether considered as disease, absence of health, or loss of optimal functioning capacity, carries moral implications. McCombie (1987) describes how individuals use the term "flu" to avoid the onus of a range of mildly stigmatizing conditions, including "diarrhea, menses, hangovers, or more serious illness" (p. 990). Thus, one of the problems health practitioners face is that individuals may violate the trust of the physician-patient relationship by being less than honest about their condition. This suggests that individuals are aware of the moral implications of the state of their health.

If it is the case that individuals are aware of the moral implications of the state of their health, it seems reasonable to conclude that, in order to present themselves as moral human beings, individuals would actively engage in forms of behavior promotive of the state of their health. In other words, except in the case of chronic illness or certain debilitating conditions, most individuals, most of the time, are in some state of positive health. This state of positive health is a moral state, which carries certain overtones regarding the moral character of the individual in question. An individual's moral character touches upon that person's "fitness": the degree of fitness refers to the degree to which an individual is capable of being considered a valued member of society. Thus, it is posited that, sooner or later, during the course of their everyday social interactions, individuals will find it necessary to offer accounts regarding their healthiness, or fitness. While, on one level, these accounts may offer claims about the physical condition of one's body, on another level, these accounts may offer claims about one's fitness for inclusion as a member of society.

THE CONTENT AND RELATIONAL ASPECTS OF MESSAGES

The idea that there may be communication beyond the verbal message is a central tenet of communication theory. Watzlawick et al. (1967) distinguished between the content and the relational aspects of a message. The content level of a message is the literal, denotative meaning of the words spoken. "The content level of meaning involves a literal message and implies what response is appropriate" (Wood, 1994, p. 30). The relational level "defines the relationship between communicators by defining each person's identity and indicating who they are in relation to one another" (Wood, 1994, p. 30). The relational level is ambiguous, and requires interpretation in the construction of meaning. According to Watzlawick, et al. (1967), in healthy relationships, the majority of interaction occurs at the content level. "Conversely, 'sick' relationships are characterized by a constant struggle about the nature of the relationship, with the content aspect of communication becoming less and less important" (Watzlawick et al., 1967, p. 52).

The implication of this distinction is that, in healthy relationships, people share some common definition of the relationship itself. In order for this common definition to remain intact, it must satisfy the following assumption for both interactants: "I think X about this relationship, and so does my partner." A corollary to this assumption is the following: "I believe that I am someone who my partner can rely upon to support X, and I believe that my partner is someone upon whom I can depend to support X." Implicit within these assumptions are notions about "healthy-ness" or "fitness." In other words, a "fit" partner is a person who does not have to question his or her ability to support the common definition of the relationship, and upon whom one can depend to interpret relational messages at the content level.

It is unlikely, however, that any relationship can survive these ideal conditions indefinitely. Fortunes change, and one of those fortunes is personal health. In other words, illness, whether as disease, "addiction", or sense of vulnerability, threatens the common definition of even the "healthiest" relationship. It is likely that during such periods, partners will begin to focus their interpretations at the relational level. For example, the relational issues may involve how a partner expresses his or her concerns about the other's ability to support the relationship, or concern about the impact of the illness itself, without violating relational taboos, cultural taboos, or without directly violating the face concerns of the partner, family, friends, or peers. The ill person him or her self may have similar concerns about his or her ability to maintain the

relationship. During such periods, each partner faces a kind of "existential" Prisoner's Dilemma, imprisoned by the stance he or she has taken regarding the nature of the relationship, or the stance others assume he or she has taken. One must find a way of getting past the jailer of face concerns, and getting a message "to the outside." The mediator in this case becomes the inventive language of hint, "the language of innuendo, ambiguities, well-placed pauses, carefully worded jokes and so on" (Goffman, 1967, p. 30). However, both the beauty and the bane of this language is that, as Goffman (1967) claimed, hintable communication is deniable communication.

THEORETICAL FRAMEWORK DERIVED FROM GOFFMAN

It was suggested above that healthy relationships are characterized by a shared definition of the relationship. This definition is likely to be sustained only insofar as partners are able to present themselves to one another as healthy human beings. A focus on how people present themselves suggests a dramaturgic interpretation. The work of Erving Goffman (1959, 1961, 1963, 1967) has been of singular importance in framing this perspective. Thus, in the following section an attempt is made to derive a theoretical framework using Goffman's notions of face work, teamwork, and stigma.

Face work. Face concerns underlie all social interaction. That is, one of the preconditions of an interaction is that interactants are aware of each other as evaluative beings. Being aware that one is being evaluated predisposes one to attempt to project an impression of one's self that will favorably influence the evaluation that is being formed. "The individual's initial projection commits him to what he is proposing to be and requires him to drop all pretenses of being other things" (Goffman, 1959, p. 10). Thus, face is the positive social value others assume a person has claimed for him or her self during a particular interaction (Goffman, 1967).

Face work refers to the process by which two people negotiate a shared definition of the situation based on their respective perception of the other's line, or initial projection. The degree to which face work is successful, or satisfying to each interactant, depends on the interplay of two factors: self-respect and consideration. Self-respect refers to the consistency between the line a person is attempting to project and his or her own perception of who he or she thinks he or she is. The more consistency between the two, the less the chance that the person will be perceived as displaying a "false front." Consideration refers to how far a person goes in accepting, protecting, and allowing for the other person's line. Although these two factors are conceptually distinct, they have

obvious impact upon and implications for one another. For example, a person with a high degree of self-respect ought to be very comfortable with the self being projected during an interaction, which ought to make him or her more likely to be considerate of the other's face. However, this same self-respecting person might become inconsiderate of the other if he or she suspected the other was projecting a false line, or if he or she felt the other was questioning the integrity of his or her own face.

One of the implications of this framework is that people get what they want, not by engaging in the anarchy of Hobbes' war of all against all, but by conforming to social norms. That is, one is enjoined to pursue one's own goals while promoting the notion that this pursuit ought to be conducted in a particular manner, and this particularity ought to hold true for all people, even though their individual goals may vary. As Goffman (1959) claims, "To be a given kind of person, then, is not merely to possess the required attributes, but also to sustain the standards of conduct and appearance that one's social grouping attaches thereto" (p. 75). This is accomplished by working within the constraints established by societal norms for what is appropriate and expected, while maintaining self-respect regarding one's own face, and by extending consideration to the face of others. Furthermore, this accomplishment has a moral dimension: "Society is organized on the principle that any individual who possesses certain characteristics has a moral right to expect that others will value and treat him in an appropriate way" (Goffman, 1959, p. 13). Obviously, the social order is not as harmonious and smooth-running as this view portends. For example, it is possible that a person's goal may be rejection of the norms for what is appropriate. At other times, a person may be incapable of living up to what they believe to be normative, or they may be ignorant of what is normative. That is why the language of hint is so important. Rather than openly and directly making the relational meaning of a message explicit, a person can use hints so that the actual message is embedded at the content level.

Teamwork. According to Goffman (1959), "we commonly find that the definition of the situation projected by a particular participant is an integral part of a projection that is fostered and sustained by the intimate co-operation of more than one participant" (pp. 77-78). Thus, a team refers to "any set of individuals who co-operate in staging a single routine" (Goffman, 1959, p. 79). Teamwork can be defined as the manner in which teammates negotiate the problems of reciprocal dependence and reciprocal familiarity in order to maintain a given projected definition of the situation. Thus, by virtue of the intimate cooperation required of them, teammates must depend on one another not to "give away the show." Yet, at the same time, their intimate

familiarity gives each of them the power to do so, to discredit the projected definition, threatening the face of all the others.

Although any given form of social organization might be represented by more than one team, every team represents some particular form of social organization. To be members of a team, individuals must participate, must be capable of participating, in the activity of the team:

> In crossing the threshold of the establishment, the individual takes on the obligation to involve himself at the moment in the activity. Through this orientation and engagement of attention and effort, he visibly establishes his attitude to the establishment and to its implied conception of himself. To engage in a particular activity in the prescribed spirit is to accept being a particular kind of person who dwells in a particular kind of world. (Goffman, 1961, p. 186).

This definition puts constraints upon the individual's sphere of action. To engage in a particular form of activity is to not be engaged in some other form of activity. Further, the more teams an individual is a part of, the more constrained the individual's sphere of self-derived activity. In order to protect and maintain that sphere it will sometimes be necessary for the individual to resist the constraints imposed by a particular role. Resistance can come in the form of demands of the body, a slackening of the discipline required for dramaturgic success, the incompatible demands of competing roles, or misuse of a situation while maintaining the definition of the situation.

Goffman (1961) thus defines the individual as "a stance-taking entity, a something that takes up a position somewhere between identification with an organization and opposition to it, and is ready at the slightest pressure to regain its balance by shifting its involvement in either direction. It is thus against something that the self can emerge" (p. 320). However, it is also necessary that this "something" remain intact as a source of opposition. Individuals seldom reject outright a team which has deemed him or her fit for inclusion. Rather, resistance is usually intended to reassert the claims of the self that was originally offered for consideration. Or, resistance is offered to the definition of one team, in favor of sustaining the definition of another team. Any individual who goes too far in offering resistance, in relation to the rest of the team, increases the likelihood of giving the game away and discrediting the projected definition, either intentionally or unintentionally. Such individuals may find themselves excluded for their actions. The art of resistance, therefore, involves reasserting a sphere of activity without thereby presenting oneself as someone no longer fit for inclusion.

Stigma. To be considered fit for inclusion requires that one is able to sustain a particular definition of a situation. Any characteristic or attribute that might interfere with that ability raises questions about the status of its possessor. The perception is this: "If this person cannot sustain the given definition of the situation, he or she might, if included as a member of the team, inadvertently be put in a position where he or she cannot help but to give the show away." This perception is a moral issue insofar as moral identity is derived from a particular definition, with its implied notions of what the appropriate amount of consideration is necessary to show someone. In other words, the moral dilemma is framed by the thought that the person with the interfering trait may intentionally or unintentionally ask for a degree of consideration that is incompatible with self-respect. "The term stigma, then, will be used to refer to an attribute that is deeply discrediting, but it should be seen that a language of relationships, not attributes, is really needed" (Goffman, 1963, p. 3). This is so because the stigmatized attribute is a sign, a symptom, to the "normal" that any interaction with the stigmatized person may place the normal in the face-threatening position of having to show over-consideration, a position which is likely to discredit the definition of what "normal interaction" consists of.

Goffman (1963) described three main types of stigma: abominations of the body, blemishes of individual character, and tribal stigmas which can be transmitted through lineage. An individual can stand in one of two relationships to any given stigma category: the discredited and the discreditable. A discredited individual is one whose membership in a stigma category is immediately recognizable from physical appearance, or whose membership is widely enough known that it affects potential interactions that have not yet occurred. The discreditable individual is one who is a member of a stigma category, or closely associated with a member of a stigma category, but whose membership is not immediately discernable. Given the amount of dependence and familiarity necessitated by team membership, such individuals often devise unique strategies of interaction, such as direct acknowledgment, limited team memberships, and information control to pass as normal (Goffman, 1963).

Further, given the wealth of attributes which are stigmatizing, every individual is potentially discreditable. At any time, an individual can find him or her self acquiring an attribute that is likely to arouse suspicion concerning his or her fitness for inclusion: having an accident that leaves one with a debilitating condition, putting on weight, losing one's hair, or being diagnosed with a fatal disease. Or, a person can find him or her self intimately associated with someone who finds him or her

self in such a condition. Thus, it is to the advantage of potentially discreditable individuals to maintain two lines: one, to allow some fluidity to the stigma concept, that is, not to demand an overly strict set of criteria and their application; two, to impose negative sanctions upon those who are already clearly discredited. The clearly discredited serve as a reference group, providing a clear definition of otherness, against which the discreditable can maintain the fluidity of stigmatization in regards to themselves.

The underlying principle is that stigma labels are negotiable. Braithwaite (1990) suggests that the "process of becoming disabled is one of cultural assimilation" (p. 469). Through a process of isolation, recognition, and integration, the disabled person comes to be a member of a particular culture. Willingly or not, the disabled person becomes a member of a team, with its own definition of the situation and its own obligations imposed upon team members. At the integration stage, resistance on the part of the individual can take many forms. One form of resistance is a communication strategy designed to present the self of the disabled individual as a "person first." That is, the disabled person attempts to establish communication at a supra ordinate level, the fact that we are all part of a team composed of human persons.

Other strategies involve more active forms of resistance. Herman and Miall (1990) report some of the positive consequences of being labeled with a stigma: therapeutic opportunities, personal growth experiences, and interpersonal opportunities. Therapeutic opportunities refer to the benefits that accrue from an officially recognized label. Benefits can come in the form of economic aid, reserved job opportunities, and support groups. Personal growth experiences refer to the ability of a stigmatized individual to claim a deeper insight into the human condition, to have been a participant in two worlds, to assume leadership roles in support organizations, and to become a socializing influence upon others similarly stigmatized. Interpersonal opportunities refer to such things as the ability to use a stigma label to take chances, to attempt things that normals typically refrain from, and also, opportunities to strengthen family bonds.

The principle enumerated above is subject to further modification. First, the more culturally ambivalent the concept or characteristic, that is, the more categories the label covers, the greater the potential for the characteristic to become stigmatized. Fluidity implies that stigmatization is not applied uniformly, to the same degree in every situation. Rather, a stigma hierarchy seems to be in operation. "The term stigma hierarchy refers to the order of preference for some disability groups over others as revealed by the application of such scales" (Westbrook, Legge, &

Pennay, 1993, p. 617). Westbrook et al. (1993) found differences in the degree to which persons with various disabilities were accepted in different communities. Asthma, diabetes, heart disease, and arthritis were the least stigmatized, while AIDS, mental retardation, psychiatric illness, and cerebral palsy were the most stigmatized.

Second, the more stigma attached to something, the greater the potential for the label to be negotiable. In other words, the more extreme the stigma case, the more likely it is to evoke sympathy on the part of normals, and the more willing they will be to employ a "softer" term, which term can then also be adopted by less extreme stigma cases. For example, being in a wheelchair is more stigmatizing than being on crutches in this culture, partly because it implies a greater limitation on personal freedom of movement. However, there are subsequently more ways of referring to such confinement. For example, "the difference between 'being confined to a wheelchair' and 'using' one is a difference not only of terminology but of control" (Zola, 1993, p. 170). One would rarely say that someone is confined to crutches. Similarly, there is more stigma attached to the term "cripple" than either the term "handicapped" or "disabled." Different degrees of latitude are given to different people regarding appropriate usage of the different terms. Yet, these more recent terms have come into usage in opposition to the earlier term, and may suggest something about our changing notions of what it means to have personal freedom.

AGENCY AND AFFILIATION

The simultaneous need for both a sense of agency and a sense of affiliation seems to be a fundamental propensity of human behavior. That is, human interaction tends toward team formation, but team participation imposes constraints upon the individual's self-derived sphere of activity. Attempts to reassert or redefine that sphere thus qualify as necessary forms of resistance which are promotive of agency. McAdams (1988) proposed the following functions of the tendency toward agency: social control, attaining status, displaying shyness, exhibiting excitement, exerting power, helping others, publicly disgracing another, engaging in conflict, and displaying masculinity; as well as the following functions of the tendency toward affiliation: establishing intimacy, being accepted, communicating loneliness, exhibiting joy or excitement, self-disclosure, privately betraying another, separating oneself from others, and displaying femininity. It is possible, and very likely, that some of these factors can be operative at the same time, in regards to the same relationship; as for instance, publicly disgracing another as a means of being accepted, or to self-disclose in a

masculine manner. At the very least, given the intimate cooperation required of team members, all of these functions will, at one time or another, be of concern in maintaining the projected definition of the situation.

The simultaneity of these needs produces a sort of dialectical tension between them. That is, there is a strong central tendency operating here, a tendency toward the mean. Movement away from the mean dissolves the tension and produces a position untenable from the perspective of human phenomenology. It is contradictory to human phenomenology to find individuals who are purely affiliative or purely agentic. What must be borne in mind is that a team is composed of individuals, such that when any two individuals are interacting, they are doing so through the processes of face work. Managing the tension between maintaining one's status as a teammate while asserting one's self as an agent will be chiefly carried out through forms of talk, in particular the language of hint.

One of the ways in which the language of hint works to manage this tension is through the use of "specific ambiguity" (Nichter, 1989). "Reference to an ambiguous state may be used indexically to increase or decrease social distance. Named (specified) ambiguity also serves to reduce anxiety through a process of naming a state one has little control over as a means of gaining control over the unknown..." (Nichter, 1989, p. 91). There ought to be a correlation between the amount of agency desired by a particular individual and that individual's reliance on "specific ambiguity." That is, specific ambiguity makes agency possible, because it gives an individual a means of creating a sphere around him or her self within which to act. When everything is taxonomically ordered and categorically divided, as when an overly strict definition of the situation is applied, agency is dissolved and the individual is determined by powers without. Thus, it is the felt wanting of internal, creative power that may seek to impose order and dissolve ambiguity. Conversely, the felt abundance of creative power ought to seek to advance agency. The question of affiliativeness can be dealt with in one of two ways: by appeal to a more inclusive term common among equals, or by creating higher spheres (professional spheres) to which equals are subordinated. Language, as the human expression of creative power, is the medium through which these issues must be negotiated. In terms of stigma, terms with specific ambiguity, such as "freedom of movement" or "disability," ought to provide ideal candidates for defining normalcy in terms of "not Other." Further, discourse about such terms ought to promote both agency and affiliativeness, to define who is normal and

who is the other, and to depend to some extent on whose power to name such things is recognized as legitimate.

THE STIGMA OF AIDS

The possessor of a discreditable attribute is keenly aware of the potential for disruption in any interaction with normals. Therefore, any attempt to examine a stigmatizing condition through a language of "relationships, not attributes," must begin with the fact that the more stigmatizing the condition, the more likely it is to be the center of awareness for the discreditable individual. Green (1995) has found this to be the case with those who are HIV positive. Normal individuals' responses to an attitude questionnaire were compared to the responses of individuals who had tested positive for HIV. Although both samples reported generally liberal attitudes toward people with HIV, individuals who were HIV positive perceived that the general public held far more illiberal attitudes than were actually reported. Part of this "felt stigma" stems from the perception among HIV positive individuals that, if their condition were discovered, they would be assumed to be members of one of the risk groups, such as homosexuals or IV drug users.

One way of interpreting Green's (1995) results is in terms of the two lines suggested above which it is in the interests of individuals to adopt regarding stigmas. First, the finding that people generally held fairly liberal views supports the notion that it is in our interests to maintain some flexibility regarding the stigma concept. HIV is still a predominantly acquired condition, and one that even "innocents" can acquire through accidental means. To demand an overly restrictive criteria in response to HIV would be incompatible with expressions of sympathy for those "innocents," not the mention the possibility that one might find oneself in that condition at some time. Second, Weitz (1990) reports on the impact which ARC and AIDS have had upon the interpersonal relationships of a sample of homosexual and bisexual men. Predominantly, the condition has had a negative impact upon these mens' personal lives. This finding supports the second line, namely, that it is in the interests of normals to impose negative sanctions against those who are already discredited. For, it is only in direct interaction with a discredited individual that the moral implications of the definition of the situation that were taken for granted are brought home to the normal. At such times, times when what it means to be "normal" is made clear in reference to the "otherness" of the stigmatized individual, the normal person will feel an urge to affirm the threatened definition of the situation provided by membership on the team of normals. The person with HIV, ARC, or AIDS, whether homosexual, an IV drug user, or not,

is likely to be aware of this difference between a general attitude and an attitude directed specifically toward him or herself. This awareness of the impact which being discredited can have at the interpersonal level is the first factor which must be taken into account when examining the behavior and attitudes of the stigmatized.

AIDS remains one of the most stigmatized conditions in US society (Goldin, 1994; Weitz, 1990). This is partly the result of the principles enumerated above. First, AIDS covers all three of Goffman's stigma categories: it affects the body, it is often seen as a punishment for engaging in immoral or sinful behavior, and it is associated with particular stigmatized groups, such as homosexuals and IV drug users. Second, those diagnosed as HIV positive often engage in various strategies to manage the stigma, so as to avoid being discredited. Weitz (1990) reports that patients sometimes work with physicians, finding ways to label the condition ARC rather than AIDS.

The virus which is associated with AIDS, HIV, is suspected of being transmitted principally through the direct exchange of body fluids. Thus, one means of slowing the spread of the disease is to encourage individuals to limit their exposure to situations where the direct exchange of body fluids is involved. In terms of the exchange of fluids which characterizes sexual encounters, the message is clear: use a condom every time. Public health campaigns designed to stop the spread of AIDS by promoting condom use typically approach the issue as one of health communication, assuming that if the public knows the risk of unprotected sex, and knows the safety afforded by condom use, and knows the proper manner of using condoms, then the campaign is successful and the spread of AIDS ought to be slowed.

However, knowing the proper technique regarding condom use is often not the issue. Given the close association between AIDS and certain already stigmatized groups, public health campaigns have tended, until recently, to be targeted towards these "risk groups" rather than "risk behaviors." "The notion of 'risk group' (for example Haitians, homosexuals or IV drug users), rather than 'risk behavior', focuses negative attention on already stigmatized categories of persons" (Goldin, 1994, p. 1360). This focus has several implications. First, it provides those who are not members of a risk group a false sense of security. An increase in the reporting of the disease among heterosexuals has been the primary reason for a shift in public health campaigns toward 'risk behaviors.' Second, the increased negative attention on already stigmatized groups further disrupts their interpersonal relationships. Third, a focus on 'risk groups' fails to distinguish between those who are, and those who are not, 'at risk' within a 'risk group.'

Not all homosexual men are 'at risk' to the same degree. "This is most apparent for those men who are in monogamous relationships and who are aware of their own and their partner's HIV negative antibody status. In the absence of other infections or ill health, there is no reason why these men should not have 'unsafe sex'" (Hart et al.:1992). Or, as Berkeley psychologist Walt Odets puts it:

> "We don't say to heterosexuals: 'A condom every time' for the rest of their lives. We expect them to enter relationships and dispense with condoms when their HIV-negative status is confirmed. It's a very old story, telling gay men how to have sex; publicly they're complying, privately they're doing something else" (Green, 1996).

This failure to discriminate between those who are at risk and those who are not provides an example of the defining power of language. Scientific and health experts, using their mandate to maintain community standards, have assumed the legitimate authority to name the 'other' with the term 'risk group.' As the disease spreads among the 'normal' population, some of that legitimacy has been undermined. The scientific community and the community of AIDS sufferers and homosexuals are currently engaged in a process of renegotiating the definition of the situation (Green, 1996, Hart et al., 1992). This example shows the tendency of stigma labels to resist being subjected to overly strict application.

Earlier, it was asserted that health concerns are embedded within a context - a total presentation of self - and therefore likely to be impacted by other relational concerns. The rational man model adopted by the public health campaigns assumes that, given the proper information, individuals will do what is in their best interest to do, on their own, and there will be nothing for them to talk about in regards to eliminating risk. In regards to preventing the spread of AIDS, the assumption is that, if people know the risk of unprotected sex, and know the proper way to use a condom, they will not need to talk about it; they will simply use a condom because anything else would be irrational. But there is always something to talk about, especially regarding something as intimate as sex. People know how to use condoms; they often don't know how to use the language of hint to get their partner to put the condom on. This problem is particularly relevant for those members of the gay community who are not in long-term monogamous relationships, but who are looking for such relationships. The real problem, then, is a problem of relational communication.

Goffman's (1967) concepts of *deference,* the manner in which one shows appreciation of another, and *demeanor,* the manner in which one shows oneself to be an individual of "certain desirable or undesirable

qualities" (p. 77), are applicable here. The relationship between the two has to do with trust. As one homosexual man reports:

> "And people like us don't pay attention to the posters and ads. Don't they get it? It's *hard* to be safe. Think of the situation if you're looking to meet someone" (Green, 1996, p. 40)

> "If you can't trust, you can't love, so why even bother having a relationship?" (Green, 1996, p. 44).

It must be kept in mind that the relational concerns of the stigmatized will be different from the normals. Given that the stigmatized may often perceive that normals hold more negative attitudes than normals themselves report, it may be of especial importance for a homosexual man to find a partner who will accept him for what he is. Thus, to ask a partner who might potentially become a long-term partner to use a condom implies a lack of trust, a show of improper deference, which betrays a show of improper demeanor. In other words, to ask one's partner to use a condom is to imply a mistrust of their HIV status, and thereby to betray oneself as a mistrustful individual who is consequently unfit to be a long-term relational partner. Thus, public health campaigns targeted at homosexual males which are based on fear appeals and information regarding condom use are doomed to failure. An effective campaign must take into consideration the relational issues. Otherwise, the same loneliness and sense of isolation that drives some gay men to singles bars, may provide them with a sense of relief should they find out they are HIV positive, insofar as such a discovery opens up doors to a whole new world of supportive and open relationships, in the sense of Herman and Miall's (1990) therapeutic opportunities.

APPLICATION OF THE FRAMEWORK TO FITNESS COMMUNICATION

At this point, a brief summary of the framework developed above is in order: Illness is a condition disruptive of everyday life. As such, this condition draws attention to itself, increasing the focus of talk on the relational level of meaning. For the stigmatized, this condition is a constant, making it difficult for them to sustain relationships at the content level, giving rise to their sensitivity to their condition, their perceptions of how they are being perceived, and their attempts to integrate their condition to their daily life. For normals, the stigma of illness is less severe, is assumed to be transitory, and is usually satisfied with the legitimization provided by health practitioners.

If illness is disruptive of everyday life, certain things are implied about everyday life which are taken for granted in the absence of illness. Health, or fitness, as the default condition for normals, tends not to be the central focus of their lives. Health concerns are embedded within a total presentation of self. This presentation of self has a moral dimension, such that people presenting a particular self lay claim to particular moral qualities. This moral claim qualifies people as fit for inclusion into various social organizations, each of which constitutes a type of team. Although every team makes particular claims upon its members, there are also general claims common to all teams regarding fitness for inclusion.

Team participation satisfies needs for affiliation, which can be maintained by a general presentation of moral fitness. However, the strong central tendency suggests that affiliation is counterbalanced by needs for agency. That is, people resist the definition provided for them by their participation. At times, people take a stance against their own moral presentation. In so doing, they re-establish their own sphere of activity. However, there are prescribed and proscribed ways of offering resistance. Although both types are potentially threatening to the presentation of a fit and healthy self, prescribed means of resistance are less likely to become grounds for exclusion, whereas proscribed means almost always involve exclusion.

Fitness defined. There are several explanations for why fitness has become such an important concept in our society. One explanation might be called the cynical view (Stein, 1982). According to this explanation, a series of national crises has given rise to a national identity crisis and a feeling of moral failure. By displacing anxieties over the national body onto anxieties over the health and well-ness of individual bodies, national leaders have averted discussion of the larger social problems. The second explanation might be called the medical view (Glassner, 1989). This view begins with the finding that, as people live longer, morbidity concerns begin to displace mortality concerns among the aging population. The effects of chronic morbidity take a heavy toll at both the social and economic level. In an era of rising health costs, it is in the economic interests of individuals to take steps early on to prevent or offset the effects of morbidity in later life. The third explanation takes a more individualistic approach. According to this view, the impetus for action is located within the individual. Gillick (1984), for example, suggests that jogging became increasingly popular before the potential benefits of jogging became the subject of scientific enquiry. This view suggests that the "lay population" of individual men

and women, rather than merely reacting to the opinions of experts, has played an active part in making fitness a concern in their lives.

It is likely that all three explanations have some merit. What is common to all three explanations is the suggestion that both the experts and the lay population share some common definition of fitness. This common definition can be laid out as follows: "'Fitness refers to the general state of a person's psychophysical well-being - mind as well as body. (Glassner, 1989, p. 181). This general state of fitness, or healthiness, has moral implications (Backett, 1992). "The moral universe, not merely the medical, is divided into 'the fit' and 'the unfit'" (Stein, 1982, p. 174). Thus, fitness is good, a desired state, while lack of fitness is bad, something to be avoided. This definition betrays a pessimistic view of human nature. The body is seen as weak, susceptible to the many corrupting influences in which society is slowly drowning.

Left to its natural tendencies, the body would slide toward unfitness. Thus, one must take action against one's body, striving to achieve the desired state of fitness. "To be healthy is almost equivalent to pursuing health through adopting the appropriate disciplined activity or controls" (Crawford, 1984, p. 66). In this sense, health becomes a goal in itself. However, a goal is only as credible as there exist realistic means of attaining it. If no one believed the goal was attainable, no one would strive for it. In order to be attainable, the goal must be made concrete. That is, attention must be focused on particular behaviors that are within the power of individuals to act upon and see effects. The particular behaviors which have come to be central to the definition are narcotics, particularly smoking, diet, and exercise. Taking the appropriate stance toward these behaviors is the first step in becoming fit.

The final part of the definition includes what might be called a legitimate "escape clause." Health becomes one goal among many. The pessimistic view of human nature acknowledges that it is an imperfect world. "In short, health-related behavior can be seen as a largely routinized feature of everyday life which is guided by a practical or implicit logic" (Williams, 1995, p. 538). Thus, health concerns must be balanced with other concerns. Insofar as these other concerns require a discipline and a logic of their own, people can insulate themselves from drawing out the full conclusion of the logic of their own definition. Their thinking is thus: "My body would tend toward unfitness unless I discipline myself to prevent it. But discipline is discipline. I may not have the greatest discipline in regards to pursuing health, but I have more than enough discipline in other areas of my life. Therefore, most of the time, I ought to be able to maintain a relatively positive state of health." The best protection this insulation offers people is against the pessimism

of the definition to which they must subscribe if they are to be considered fit for inclusion.

Fitness dimensions. The definition outlined above is posited as the projected definition of the situation regarding fitness. It is likely that this common definition shapes the ways in which people think about health and fitness. This thinking is likely to further impact upon important cultural constructs. In other words, ideas that are central to a culture's conception of itself are likely to influence the definition of health that emerges; this definition, in turn, is going to reflect back upon those central ideas in a reflexive manner. Two dimensions that seem particularly relevant to notions about fitness are ideas about control and ideas about the body.

The interplay between social and personal control seems to be one of the underlying themes of US culture. Ideas about control operate at two levels: the collective and the individual. Peterson and Stunkard (1989) define "collective control as a norm - or shared belief - about the way that the group works, what it is that the group can and cannot accomplish by what actions" (p. 822). Further, "Cultural norms concerning collective control are perhaps the single most important determinant of personal control" (Peterson & Stunkard, 1989, p. 822). Issues of control are likely to be a central concern in the presentation of a fit self. Control is a central part of the definition because it is a central concern of this culture. It is possible that even the least self-controlled among us displays a degree of control greater than the most self-controlled member of a culture which shows less collective concern with control. The bias toward individualism in this culture suggest that, in our thinking, we will tend toward the view that control begins with the person. The individual is a more supra ordinate, more inclusive category than the collective; during times of crisis, it is to such supra ordinate categories that our thinking tends.

Internal and external locus of control are thus the typical endpoints of the control dimension at the individual level. In terms of fitness, this conceptualization has given rise to a distinction between "fatalists" and "lifestylists" (Peterson & Stunkard, 1989; Pill & Stott, 1985). Fatalists see health as something they have little control over, whereas lifestylists see a relationship between their efforts and their health status. This perspective has been criticized as being over simplistic (Davison, Frankel, & Smith, 1992; Pill & Stott, 1985). Although there do seem to be some differences in orientation, research has found that people are generally aware of the constraints which social organization places upon them. Fatalists are not unaware of a relationship between their actions and their health status, while lifestylists do give credit to factors such as

luck that can affect even the most conscientious efforts. It seems that ideas about control interact with lay epidemiology, or "the routine observation of cases of illness and death in personal networks and the public arena" (Davis et al., 1992, p. 678). Such observation is likely to be the most persuasive evidence for or against behaviors taken in regard to health.

Rather than focusing on internal or external locus of control, a more useful approach might be to look at ideas of control and release (Crawford, 1984). According to the definition of fitness given above, the body, by nature, is inclined to unfitness, addiction, and ceaseless indulgence. These tendencies are held in check through the imposition of controls exerted by exercise of the mind. Yet, everyone is familiar with the harmful effects of trying to drive nature out with a pitchfork. In the common conception, an overly-strict discipline can be as harmful as a complete lack of discipline, bolstered by the evidence of lay epidemiology. Thus, forms of release are legitimated, and can often be used as forms of resistance. It is possible that fatalists show less a tendency toward an external locus of control and more of a tendency toward using legitimate forms of release as forms of resistance. In other words, insofar as fatalism carries only a mild stigma, and fatalists are not routinely held up for exclusion, fatalism becomes a justification for abuse of the common definition.

Another possibility is that the mild stigma associated with fatalism is the result of the perception that fatalism is a kind of extremism signifying a lack of balance. Backett (1992), among a middle-class sample, found that "extremes of behaviour defined as representing extremes of healthiness and unhealthiness were disapproved of" (p. 262). What was sought among these middle-class informants was balance: a balance between family and job, between eating what was good for you and eating what was good tasting, between engaging in activities that were relaxing and those that were invigorating, between those that required control and those that allowed release. This notion of balance is responsive to context in two ways. Within the context of oneself as an individual, it allows one room to "make up for" indulgences by exerting a little extra control somewhere else. Secondly, within the context of oneself as a member of a family, it allows one to "make excuses for" one's forms of release; for example, one might say; "I like to have a couple beers with dinner, but she likes to have a smoke after dinner." Thus, one finds ways of not having to give up everything one enjoys, while at the same time, one can alter the context to make it appear as if one is striving toward the goal of better health; for example, "Now that I've got a family, I've cut back on X." The locus of control approach

assumes that it is better to have an internal locus of control, and that is what we should all be striving for. By acknowledging legitimate forms of release, the control and release approach may yield a more realistic picture of how people manage the presentation of a fit self.

Notions regarding the body constitute the second dimension. Three common themes underlie perceptions of bodily fitness: the absence of illness, functional capacity, and a positive condition (Colantonio, 1988; D'Houtaud & Field, 1984, 1993; Herzlich & Graham, 1973). These themes might be placed along a dimension ranging from an instrumental end, viewing the body as a means to an end, to a hedonistic end, viewing the body as an end in itself (D'Houtaud & Field, 1984). Again, most individuals do not fit neatly at one end of the dimension. Colantonio (1992) found that "...the most recurrent concepts of health refer to being fit, particularly with reference to fulfilling both necessary and desired activities and to a positive emotional and physical state (feeling and looking well)" (p. 5). Saltonstall (1993) found that, among a middle class sample, health was identified as both "the positive aspect of 'being' in the world" (p. 8), but also the idea "that the body is like a machine and must be maintained because it is believed to be subject to aging, deterioration, disease and abuse by oneself and others" (p. 10).

Fitness presentations. Ideas about fitness are posited to affect the presentation of self. Goffman (1961) claimed that there are two basic approaches one can take in constructing a life story, or "apologia:" the success story and the sad tale.

> If the person can manage to present a view of his current situation which shows the operation of favorable personal qualities in the past and a favorable destiny awaiting him, it may be called a success story. If the facts of a person's past and present are extremely dismal, then about the best he can do is to show that he is not responsible for what has become of him, and then the term sad tale is appropriate (Goffman, 1961, p. 150).

Regarding the success story, there are two interpretations: the active definition and the protective definition. The active definition stresses the actions taken which are promotive of the definition of the situation. Individuals can stress their participation in various ways: jogging in highly visible places, wearing a t-shirt with the name of a gym across the front, attending AA meetings, Jenny Craig, or wearing the patch. Additionally, individuals can talk about these activities, with success partly contingent upon the sophistication of their terminology.

It is also possible for individuals to construct a success story without necessarily going that far. Self-handicapping is involved here: one handicaps oneself in terms of one's ability to claim a moral identity, but this stance leaves more room for resistance than is allowed the active

definition. This is where Backett's notion of balance becomes important. Crucial to this strategy is to emphasize constraint. For example, one stresses one's desire to engage in active forms of fitness, but emphasizes the constraints of job and family; or, one shows one's good faith by buying the appropriate equipment, engaging in minimal use, (to be able to say "I did X for awhile"), and then, once again, emphasizing time constraints upon one's ability to maintain a vigorous fitness regimen. Success lies in still being able to present oneself as an active person, thus disciplined and controlled in regards to some activity, thus still fit for participation. One twist of this strategy is that it allows its adherents to question the fitness of the active definition in terms of time spent in "useful activity."

As a strategy, the sad tale is a particular form of self-handicapping. According to Arkin and Shepperd (1990):

> Indeed, the handicaps which are likely to be most persuasive are the same ones that debilitate task performance the most. In short, persons who construct handicaps not only (1) must admit to embracing an action which, if it is to be persuasive as a handicap, is likely to be negatively sanctioned, but also (2) diminish the likelihood that a successful performance on the task will occur (p. 191).

As a handicap, the protective success story usually follows the line: "I engage in harmful activity X, but I balance that with beneficial activity Y." The sad tale usually follows the line: "I engage in harmful activity X, because of A, B, and C." In these terms, fatalism can be seen as a type of sad tale. It is not that fatalists are non-strategically unaware of the effects of lifestyle on health. They are likely to have at least some of the information, as well as knowledge of the moral implications of being unfit. However, by refusing to acknowledge the link between their own behaviors and their health status, they can protect themselves from the moral implications of being unable to sustain the definition involved in the success story.

SUPPORTING THE PRESENTATION OF FITNESS

It has been asserted that ideas of health are embedded within the total presentation of self, and that this presentation has a moral dimension. The moral implications of being fit are well documented. It has further been claimed that there are a few basic approaches to the presentation of a morally fit self: the active success story, the protective success story, and the sad tale. Given these possibilities, what strategy is a particular person likely to adopt? It is hypothesized that the strategy adopted will depend upon the individual's ability to support that

definition of the situation. This ability to support a given projected definition of the situation is likely to depend on such factors as physical attractiveness, gender, age, and class.

Attractiveness. One of the best indicators that one can support one's presentation ought to be physical attractiveness. Attractive people tend to be seen as more socially competent, dominant, assertive, sexually warm, mentally healthy, and socially skilled (Eagly et al. 1991; Feingold 1992; Reis et al. 1982). However, Eagly et al. (1991) found that the direct effects of attractiveness are moderated by individuating information. Regarding their own self-perception, attractive people report less loneliness and lower social anxiety. Anxiety has been associated with a tendency to resort to self-handicapping strategies of self-presentation (Arkin & Shepperd, 1990). It is possible that attractiveness provides a support base such that an attractive person may be able to use a success story, so long as it is not contradicted by other individuating information. Unattractive people, lacking that support base, may have less latitude to adopt an active success story, and may find it more within their power to support a protective success story definition of themselves.

Gender. Several researchers have found gender differences regarding fitness concerns. Saltonstall (1993) found that men tend to speak of a healthy body in terms of sports, while women tend to refer to exercise, such as aerobics. Backett (1992) reports that women accorded exercise a low priority in their lives, in deference to domestic and work obligations, while for men, "physical exercise was put forward as a *necessary* antidote to work and stress, and was prioritized in the family time scheduling" (p. 267). Wiles (1993) found that women who use private health care do so in order to minimize the disruptive effects of illness on the home, while men "go private" to minimize the disruption of their work schedules. Walters (1993) found that women who reported more problems managing work and home reported more stress, while women who reported more loneliness also reported more anxiety. These findings suggest that gender will interact with such things as family status in affecting the presentation of self. For example, single mothers may feel more stress and anxiety, which may affect the likelihood that they will adopt the sad tale. Or, men who participate in sporting activities which culminate in "tossing back a few beers with the boys" may rely on the protective success story.

Age. A great deal of ambivalence surrounds the aging process in this culture. Using samples from Britain and Finland, Rahkonen, Arber, and Lahelma (1995) found that differences in health status are apparent by ages 35 to 39. Health status continues to be a concern as people age.

Sankar (1984) found that her elderly sample "could be clear and concise concerning the distinction between their complaints due to old age and those due to illness" (p. 259). However, their abilities were often dismissed by health practitioners. Seeman and Lewis (1995) found an association between feelings of powerlessness and increased reports of activity limits and psycho social symptoms among an aging sample. That is, participants' health status was monitored for more than a decade; self-reports of perceived powerlessness were predictive of increased incidences of mortality, activity limits, and psycho social symptoms. Zola (1993) suggests that "Being seen as the object of medical treatment evokes the image of many ascribed traits, such as weakness, helplessness, dependency, regressiveness, abnormality of appearance and depreciation of every mode of physical and mental functioning" (p. 168). Thus, age might interact with something like the amount of treatment an elderly person is receiving in affecting which strategy he or she adopts in the presentation of self.

Class. Class has been cited as a critical variable affecting health status. D'Houtaud and Field (1984, 1993) have suggested that those in the lower classes tend toward a more instrumental view of the body, while those in the higher classes adopt a more hedonistic stance. Several researchers have found that education, rather than class per se, is the more salient discriminating variable (Davison, et al., 1992; Pill & Stott, 1985; Rahkonen et al., 1995). One possibility is that education provides information, and the more information one is exposed to, the more one is able to construct justifications for one self. Thus, the more education one has, the more likely one might be to adopt a protective success story rather than a sad tale.

CONCLUDING REMARKS

This brief look at some of the variables affecting the presentation of a fit self suggests three things. First, it is plain that none of these variables operates in isolation. Every individual occupies a position with regard to every one of these variables, and that position is going to affect the stance that person takes. Further, all of these variables are fluid to some degree, such that opportunities to exploit one's situation and alter one's stance arise through the interaction of transitory states. Thus, if a person makes a claim for him or her self based on this interaction of transitory states, and can support that claim, that person stands in a moral relation to everyone else. If, through that stance, that person claims some moral superiority over us, and can support it, we become participants in a projected definition that attempts to define us as *a priori* inferior. If we accept that definition, we must, of necessity, engage in

activities that realize the superior person's claim upon us. We must make it so, by actively engaging in actions that perpetuate our perception of ourselves as inferior, relative to the superior person. The other alternative is that we can reject that person's claim to moral superiority over us. It is likely here that environmental factors and situational constraints will exert their effects in frustrating our intentions. That is, we may not recognize someone's claim to superiority over us, but we may find ourselves in a position such that we cannot support our own claim to superiority.

Second, given that there is often a struggle for superiority, and that one's stance changes as the interactive effects of one's position changes, it is often in our interests to encourage unhealthy habits and practices in others, and to provide that support for others, when necessary. Encouraging unhealthy habits in others elevates our own moral status by allowing us to claim a supportable superiority over them. For example, most nonsmokers would be far more intolerant of smoking if the preservation of the state of their lungs was their primary motivation. For those who engage in unhealthy habits, it is also often in their interests to encourage others to continue in unhealthy habits. That is, someone with an unhealthy habit may accept a slightly inferior status, provided he or she has fellow "co-conspirators" who will support that definition of the situation. For example, smokers may sometimes encourage smoking by offering a free cigarette to co-workers, so as to have a companion during a "smoke break." The individual at greatest risk of exclusion is the individual who refuses to adopt one of these lines. That is, the nonsmoker who really does have zero tolerance for smoking, or the smoker whose refusal to share is taken as a form of discouragement. But even here, it can be seen that such an individual cannot escape embarking upon a course of action that involves some element of risk.

Finally, the dramaturgic interpretation has been criticized as emphasizing appearance at the expense of reality. This is where the content/relational distinction becomes important. In initial interactions between strangers, during the acquaintance stage, it is likely that both interactants are concerned with establishing a particular presentation of self. During this stage, it is likely that the relational implications of meaning are paramount, with each person dropping hints and drawing inferences about the nature of the relationship that might develop between them, should they both be inclined to pursue it. Through this process of relational negotiation, a common definition of the relationship is established.

During the course of repeated interaction, as knowledge and familiarity of each other increases, relational partners are likely to fall

into routinized, "normal," patterns of interaction. Face concerns are likely to shift to the content level of talk. This does not mean that the established definition no longer holds, merely that, by this point, it is taken for granted. That is why self-respect is so important: so that inconsistencies with one's initial projection do not surface later which might threaten the established definition. Thus, once the relationship has reached the point where interaction occurs predominantly at the content level, a shift back to the relational level is an indication that one of the partners feels that the definition is threatened. Every person is potentially discreditable, either by something that has happened to them or something that might happen to them. Thus, every relationship is threatened at every step of the way. The manner in which people present themselves is going to affect their ability to successfully deal with the threats they encounter in their relationships. That 'appearance' is as much a part of the reality of relationships as the 'reality' of which the critics are so fond.

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