

Chronic illness as biographical disruption or biographical disruption as chronic illness? Reflections on a core concept

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Abstract Taking as its point of departure Bury's (1982) concept of chronic illness as biographical disruption, this paper provides a critical assessment of its fortunes since that time. Having 'rescued' the concept from recent postmodern and disability critiques, the paper provides a series of further reflections on its strengths and weaknesses, including the notion of 'normal illness'; the importance of timing and context; the significance of continuity as well as loss; and the role of biographical disruption itself in the aetiology of illness. This, in turn, provides the basis for a broader set of reflections on the vicissitudes of the biographically embodied self in conditions of late modernity: a situation of chronic reflexivity in which our bodies/selves are continually problematised if not pathologised. The paper concludes, given this 'balance sheet', with a discussion of some potentially fruitful lines of future research, including links with the life-events and inequalities literature.

Keywords: biographical disruption, chronic illness, narrative, body, emotions, life-course, life-events

Introduction

It is not long in to any conversation or debate on the sociology of chronic illness and disability before Michael Bury's name is mentioned. Alongside Anselm Strauss and Irving Zola in the US, Bury has been at the forefront of British developments in this area since his classic sociological formulation, in 1982, of the notion of chronic illness as 'biographical disruption'. This, coupled with a proliferation of subsequent work around issues such as narrative reconstruction (Williams 1984) and styles of adjustment (Radley and Green 1987), marked a decisive step, not simply in the sociology of chronic illness, but in the evolution of the discipline as a whole: one involving the

transition to a fully-fledged 'sociology of health and illness' in which the lay voice is accorded an equal legitimacy both inside and outside the medical citadel.

It is useful, however, from time to time, to take stock of such tried and trusted concepts, lest they fall, through unreflexive usage or the ritual doffing of caps, into immutable terms or fixed points of reference with little prospect of theoretical elaboration or empirical development. Indeed, Bury (1997) himself acknowledges this need in his more recent writings and reflections on medical sociology and chronic illness. Certainly the recent upsurge of interest in embodiment (Turner 1984, 1992), including emotions, has moved these debates on somewhat, breathing new corporeal life into old sociological issues. Kelly and Field (1996), for example, have recently argued for a more bodily approach to chronic illness, noting in the process how biological and physical facts are sociologically important because they: (i) impinge on the self; (ii) provide signals for identity reconstruction; and (iii) act as 'limiting' factors on social (inter)action—see also Williams (1996a) and Kelly and Field (1997) on the relevance of 'body-image' to these debates. To this we may add recent postmodernist challenges to the sociology of health and illness, as well as the critique, from within the disability movement itself, of 'personal tragedy' views of illness—in which medical sociology is said to be complicit—and the call for a more thoroughgoing model of disability as 'social oppression'. Whilst these debates have started to facilitate a more self-critical and reflexive turn within sociology itself, health-related or otherwise, much still remains to be done, both now and in the future, to ensure that this momentum is carried forward, and that our conceptual armamentarium, and the paradigms within which it is embedded, are indeed 'fit' for the 21st century.

It is within this particular context of ferment and change that the present paper is located. Whilst biographical disruption continues to serve as an important point of reference in the sociology of chronic illness, including these newly evolving attempts to 'bring the body back in', it also, I venture, needs rethinking, not simply at an analytical level, but more substantively in terms of the nature, scope and future direction of sociological research in this and other related domains. Just how useful a concept is biographical disruption to the diversity of experience which characterises chronic illness and disability in late 20th century Western society? Does a focus on 'disruption' mask as much as it reveals? Can equal weight be accorded both to chronic illness' role in the creation of biographical disruption and biographical disruption's role in the creation of chronic illness? Finally, are these processes confined to chronic illness, as traditionally understood, or are they more or less pervasive features of late modernity, conceived as a chronically reflexive order? These are some of the questions which this paper seeks to address.

Before proceeding, however, some caveats and disclaimers are in order, lest the purpose and intent of this paper be misconstrued. First, a distinction clearly needs to be drawn, in raising these questions, between the role of

biographical disruption as an explanatory concept on the one hand, and its status as an empirical datum at the other. The usefulness of the concept, from this viewpoint, lies in what it can illuminate, theoretically speaking, about chronic illness; something which is not necessarily undermined by evidence as to the limiting conditions of its application. Theoretical speculation without adequate empirical checks, however, as Bury (1986) himself comments, is ultimately redundant, particularly within a substantive field of inquiry such as medical sociology. Conceptual stock-taking, in other words, is essential to good sociological enterprise and the real world issues to which it lays claim. Secondly, far from simply *augmenting* a (modernist) concern with biographical disruption, recent interest in embodiment—alongside broader postmodern and post-structuralist critiques—also entails a critical questioning of *what* the concept itself explains—*i.e.* the very *conditions* for such a re-assessment, radical or otherwise¹. The paper, in this sense, forms part of this broader critique, albeit one, from the latter postmodern viewpoint, which does not go ‘far enough’.

The paper falls into three main parts. The first section discusses the concept of biographical disruption, charting some of its main features and reviewing certain key developments since that time, including a critical appraisal of postmodernist and disability critiques themselves. In doing so, I provide what may loosely be termed a ‘modernist’ defence of the concept against its critics: one which holds on to the (biological) reality of pain and suffering, disability and death, including the legitimacy of medical diagnosis and therapeutic intervention. The next section, in a similarly constructive vein, provides a series of further critical reflections on the concept, as currently deployed in the sociology of chronic illness. Discussion of these issues, in turn leads, in the third section of the paper, to a broader set of reflections on the nature of health and risk in late modernity: one in which biography itself becomes its own chronically reflexive theme, for better or worse. It is to the first of these issues—*i.e.* a ‘revisiting’ of biographical disruption and a charting of its sociological fortunes to date—that I now turn as a backdrop to the discussion which follows.

Mapping a ‘biographically uncertain’ terrain

In contrast to early sociological approaches to chronic illness which drew upon Parsonian (1951) sick role theory and labelling perspectives on deviance—see, for example, Gerhardt (1989)—more recent approaches, stemming from the pioneering work of Strauss and Glaser (1975), have sought to understand, through the use of grounded theory, the meaning and experience of chronic disabling illness from both sufferers and their families’ own perspectives. Central to these developments, particularly in the British context, has been the notion of chronic illness as a ‘disruptive event’ or ‘critical situation’ (Bury 1982).

Illness, particularly chronic illness, is an experience in which, as Bury suggests, the structures of everyday life, its taken-for-granted features, and the tacit stocks of knowledge upon which they rest are profoundly disrupted. Chronic illness, that is to say, 'involves a recognition of pain and suffering, possibly even death, which are normally only seen as distant possibilities or the plight of others' (1982: 169). It is in this sense that Bury conceptualises chronic illness as a 'major kind of disruptive experience', or, using Giddens's (1979) term, a 'critical situation'. Three aspects of this disruption, in particular, are singled out for discussion here. First, there is disruption of *taken-for-granted assumptions and behaviours*, and the breaching of commonsense boundaries. This, 'what is going on here?' stage, as Bury suggests, involves attention to bodily states not usually brought into consciousness, and decisions about seeking help. Chronic pain and suffering, as Leder (1990) notes, effects a transition from our normal phenomenological modes of bodily 'dis-appearance'—*i.e.* a body which 'passes us by in silence' in Sartre's terms—to a state of corporeal 'dys-appearance' (*i.e.* a dysfunctional appearance). Pain, in this sense, becomes a form of 'bodily alienation' or 'betrayal' (Williams 1996b, Bendelow and Williams 1995) which, whilst physical and emotional through and through, may nonetheless be depicted as the experience of 'psychophysical dualism' (Vrancken 1989).

Second, are those disruptions in the *explanatory frameworks* normally used by people, necessitating a fundamental rethinking of the person's biography. Key questions here include those of a 'why me?', 'why now?' nature: questions which, given the 'clinical reductions' of modern medicine and the absence of any overarching explanatory or metaphysical frames of reference, prove hard to answer. It is here, as we shall see below, that work concerning the narrative reconstruction of illness, and the symbolic attempt to repair ruptures between body, self and society, has provided new insights into the meaning and experience of chronic illness (Williams 1984, Hyden 1997). The shape and weight of lived experience, in this respect, is created out of the 'dialectic between cultural category and personal signification on the one side, and the brute materiality of disordered processes on the other' (Kleinman 1988: 55)².

Third, there is the practical response to this disruption which involves the *mobilisation of resources* in the face of an altered situation. The notion of biographical disruption, in this respect, brings into sharp focus the meaning as well as the setting within which it occurs, including the resources—physical as well as social, temporal as well as financial, medical as well as cultural—available to individuals and their families in the face of their adversity. A truly sociological focus on biography, in short; 'suggests that meaning and context cannot be easily separated' (Bury 1991: 543).

Two types of meaning, building on these insights, may be seen to coalesce around chronic illness. First, the meaning of chronic illness can be viewed in terms of its practical *consequences* for individuals and their families. Here,

as Bury (1988) suggests, the effects of the onset of disruptive symptoms on everyday life, both at home and at work, including the giving of time to the management of symptoms or medical regimens and the socio-economic costs associated with long-term illness, may be uppermost—see, for example, Blaxter (1975) and Locker (1983). Secondly, the meaning of chronic illness may be seen to reside in its symbolic *significance*. By this, Bury means that different conditions carry with them different symbolic connotations and imagery, which vary markedly within different segments of the cultural order and have a profound effect upon how individuals regard themselves, and how they think others see them. Work on the stigmatising consequences of conditions such as epilepsy (Scambler 1989), for example, and the identity consequences of radical surgery (Kelly 1992a) fit well within this latter framework of symbolic meanings.

Work over the past 15 years or so has drawn heavily on this conceptual framework, including the associated problems of uncertainty—*i.e.* diagnostic uncertainty, symptomatic uncertainty and trajectory uncertainty—which chronic illness brings in its wake and the ‘medical merry-go-round’ it entails (Robinson 1989): one involving many elaborate rituals but little change (Jobling 1988). The sociology of chronic illness, however, has done more than simply document the problems which people face. It has also, as Bury (1991) notes, paid careful attention, through its interpretive lens, to the variety of responses, successful or otherwise, it calls forth, and to the importance of changes over time. Some useful distinctions again have been drawn here. ‘Coping’ for example, as Bury suggests, is perhaps best seen as a cognitive process whereby the individual learns *how* to tolerate or *put up with* the effects of chronic illness. The term, in this sense, refers to feelings of personal worth and a ‘sense of coherence’ or ‘potency’ given the biographically disruptive experience of illness. ‘Normalisation’, for instance, as a form of coping, involves a process of ‘bracketing off’ the impact of illness, so that its effects on the person’s self-identity remain relatively slight, or of treating the illness or treatment regimen as ‘normal’ in order to incorporate it more fully into the person’s identity and public self (Kelleher 1988). Kelly (1991, 1992b), for example, reports on a variety of differing ways of coping with ulcerative colitis (*e.g.* technical, intra and inter-personal) and the effects of an ileostomy. Similarly, Schneider and Conrad (1983) in the US, and Scambler (1989) in Britain, have discussed a range of coping methods which people with epilepsy use to manage their condition. Coping, in short, involves ‘maintaining a sense of value and meaning in life, in spite of symptoms and their effects’ (Bury 1991: 461).

‘Strategy’, in contrast, Bury argues, directs attention to the actions people take, or *what people do* in the face of illness, rather than the meanings and attitudes they develop. Here, the concern is with the strategic mobilisation of resources—the third key feature of biographical disruption mentioned above—in order to maximise favourable outcomes and to maintain a sense of hope for the future. Studies such as Weiner’s (1975) on the skilful

management of symptoms and the minimisation of their impact on everyday life, and Locker's (1983) on the mobilisation of resources to advantage, are indicative of this type of research (see also Blaxter 1975). Williams (1993) too, building on the earlier work of Fagerhaugh (1975), highlights the strategic dilemmas, both at home and at work, involved in 'getting about' and 'keeping up' with chronic respiratory illness. This, together with the wider class distribution of these conditions and the considerable social disadvantage they may bring in their wake, amounts to an implicit, if not explicit, endorsement of the World Health Organisation's (WHO 1980) view of disability as an 'emergent' phenomenon: one constituted at the intersection of physiological 'impairment' and the wider 'handicapping' structures of society (see, for example, Williams and Bury 1989).

Finally, 'style', for Bury, refers to the way in which people respond to and present important features of their illness and treatment regimens. This, as he states, involves a consideration of the:

... 'cultural repertoires' that people draw upon and fashion in presenting their altered physical appearances and social circumstances. Whilst this relates closely to processes of coping and strategic action, it brings into focus variations in the symbolic meanings, and social practices within different segments of the cultural order (1991: 462).

Radley (1989), for example, has paid particular attention to these features of illness in his work on chronic heart disease. Drawing on the earlier work of Herzlich (1973) together with his previous research into illness adjustment (Radley and Green 1987), he suggests that the 'bodily constraints which are resolved in the course of chronic illness need to be located in the practices and in the discourse of the people concerned' (Radley 1989: 233). This he illustrates, echoing Bourdieu's (1984) insights into the class-related habitus and the struggle for distinction, through two contrasting adjustment modalities; namely, 'accommodation' and 'active-denial'. Accommodation, from this viewpoint, tends to occur when roles are more 'flexible' and where choices about how symptoms are to be presented can be developed through more 'elaborate' forms of communication and discourse with others (Bury 1991: 463). 'Active-denial', in contrast, involves the adoption of a style whereby the illness is opposed through increasing engagement in everyday activities and where communication is more 'restricted' in nature (1991: 463).

Bury's concept of biographical disruption has therefore proved an abiding theme within the sociology of chronic illness since the early '80s: from the *meaning* to the *consequences* of chronic illness, and from specific styles of adjustment to the practical strategies and forms of coping it calls forth. It has also, through the championing of lay perspectives and experiences, served to articulate the voices and concerns of those who might not otherwise have been heard. Much of chronic illness, as Anderson and Bury's (1988) edited collection amply shows, is suffered in 'silence' behind 'closed

doors' so to speak. To the extent that the sociology of chronic illness and disability has been instrumental in bringing this reality and the challenges it creates for sufferers and families alike to light, it has indeed contributed much to the 'mapping' of these conditions—issues which extend far beyond the traditional biomedical remit. These 'biographically-informed' perspectives, however, have come under increasing attack in recent years from a variety of quarters.

On the one hand, from a postmodernist perspective, writers such as Fox (1993) have challenged the modernist readings embedded in this biographically-based model of the 'suffering self'. Pain for instance, although allegedly a 'private' or 'inner' sensation, has, according to Fox, been problematically transformed through a modernist model of the 'fabricated' human subject within the sociology of health and illness. The anatomical body is not in fact, he suggests, the 'carapace of the self'. If the self does inhabit such an 'interior' location, then this is best seen, so we are told, as a *consequence* of discourse. The 'organism', following Deleuze and Guattari (1984, 1988), is also a mere *effect*—*i.e.* a 'pattern of intensities on the Body without Organs (BwO)'—which in the modern period is exemplified, par excellence, by medical discourse (Fox 1993: 14). From this 'decentred' perspective on the 'postmodern self', lived experience, including the experience of pain itself as a biographically disruptive event, is simply the:

fabrication of a BwO, a political locus, stratified by discourse, desire and physical sensation (including pain). Pain—as sensation—has no implicit meaning. But a territorialization of the BwO as organism (creature of biomedical and more recently human sciences discourse) provides the possibility for pain to signify. Once it signifies in relation to the organism, it contributes to the self, to subjectivity. In this reading, it is not the self which experiences pain or attributes meaning to it, the self *is* the pain, *the self is an effect of meaning* (1993: 145, my emphasis).

Discourses on health and illness within the medical and human sciences, to put the matter another way, contribute to a particular territorialisation of the 'pained' BwO, organised in terms of the 'organism': a biomedical or biopsychosocial body with organs. The modernist focus on issues of biographical disruption, similarly serves to 'fabricate' a subject who is effectively 'trapped' within her/his 'pained' body and is required to 'adjust' or 'adapt' to the limitation this engenders. As a consequence, the effects of the disciplines of the body (including sociology) in constituting this kind of subject remain obscured (1993: 146). The solution to these modernist dilemmas, for Fox, lies in a process he cryptically refers to as 'arche-health', something which, of necessity defies definition, but nonetheless involves a 'deterritorialisation' of the BwO as a prerequisite for new forms of 'nomadic' subjectivity and the endless process of becoming 'Other'. Arche-health, we are told; 'refuses to be reduced to language or discourse', and is best

understood as the *'play of pure difference'*, which, as soon as it becomes text, ceases to be "arche-health" (1993: 45). As such, it is said to possess emancipatory possibilities.

It is not my intention here to rehearse again the trenchant criticisms which have already been laid at the door of postmodernism and the 'linguistic turn' it embraces within the sociology of health and illness—see, for example, Scambler and Higgs (1998). Suffice it to say that the commitment to desire and discourse, including the de-constructed, de-essentialised self and the endless championing of difference, has something of a hollow ring to it in the context of pain and sickness, disability and death: existential events *par excellence*, which expose the 'matter' of bodies, the 'limits' of discourse, and the 'organic moorings' of identity. Seen in this light, the 'playful de-constructions' of postmodernism are, in truth, really only an option for the healthy rather than the sick (Charlton 1993). When the 'chips are down', when illness throws our taken-for-granted assumptions about our bodies and selves into critical relief, modernist medicine may indeed seem eminently preferable to the 'deconstructive spirit' of postmodernism: providing as it does a 'fixed point of reference' on a terrain of uncertainty (Bury 1982).

If postmodernism represents one, albeit problematic, 'challenge' to a biographically embodied approach to chronic illness, then disability theory represents another: one which similarly ends up 'writing the body out of existence', albeit in a different way. Whilst the World Health Organisation's (WHO 1980) model of *impairment* (abnormality in the structure or functioning of the body), *disability* (activity restriction) and *handicap* (social disadvantage), as suggested earlier, has implicitly, if not explicitly, underpinned much sociological work to date, writers such as Oliver (1990) reject this model in favour of an approach in which disability itself, far from being a result of limitations caused by impairment or physical trauma, is instead seen as a form of 'social oppression'. Disablement, from this more radical viewpoint, has 'nothing to do with the body', its ills or ailments, and everything to do with society, including the prejudices and barriers which mitigate against full participation on equal terms (Swain *et al.* 1993). In endorsing this view of the impaired body, medical sociology, it is claimed, is complicit, wittingly or otherwise, in a 'medicalised' approach to disability—one which is closer to a model of 'personal tragedy' than it is to an endorsement of 'social oppression'. Disability, in short, contra the WHO, is an outcome not of bodily pathology, but of social disadvantage and oppression.

This, to be sure, is a deft move on the part of disability theorists, turning the tables, so to speak, on sociologists themselves through a critique of their supposedly limited 'socio-medical' model. A number of problems nonetheless remain here, only some of which will be touched upon—see, for example, Barnes and Mercer (1996) for a fuller debate. The main one, as with postmodernism, concerns the 'writing out' of the body from any discussion, deliberation or debate on the nature of disability itself. In this respect, a number of paradoxes emerge, not least of which is that the body

itself, through this tactic, is conceded to medicine, rather than remaining open for sociological discussion and debate (Hughes and Paterson 1997). A form of essentialism, in other words, not to mention dualism, remains within the social model of disability, despite its eschewal of impairment or functional limitation (Hughes and Paterson 1997). The sociology of the body and the social model of disability, from this vantage point, are indeed moving in opposite directions: the former *towards* and the latter *away* from the problem of embodiment. As Hughes and Paterson state:

In harbouring an essentialist, natural standpoint relative to the body the social model of disability creates a conceptual barrier to the development of a sociology of impairment and creates a disembodied notion of disability. . . The distinction between disability and impairment de-medicalises disability, but simultaneously leaves the impaired body in the exclusive jurisdiction of medical hermeneutics. While the sociology of the body seeks to challenge biomedical monopoly over knowledge about the body, the social model of disability concedes it (1997: 330).

Disability theorists, in short, like their sociological counterparts of yesterday, seem to be suffering from a peculiar form of what Spelman (1988), in the context of Western feminist thought, has appositely termed ‘somatophobia’: one involving an ‘overly drawn’ view of society itself. That post-modernists, paradoxically, suffer from the same ailment is equally apparent, given the ethereal notion of the ‘discursive’ body with which they operate: one whose matter, to put it bluntly, doesn’t really matter at all (Radley 1995)!

There is also the thorny issue of diversity and difference. In by-passing the body, disability theorists have tended to assume, implicitly if not explicitly, a homogeneity of interest between themselves and those whose interests they claim to represent. This, of course, is far from the case (Bury 1996). Much of disability, as numerous studies attest, is the product of chronic illness conditions with a diverse array of symptoms and their own disease-specific trajectories. Moreover, the bulk of this is contained within the middle to latter part of the lifecourse, making age and gender, class and ethnicity, important factors in the ‘social patterning’ of chronic illness and disability. The needs and wishes, desires and interests of a middle-aged woman with chronic rheumatoid arthritis, for example, are likely to be very different from those of an elderly dribbling man with senile dementia, or a young person confined to a wheelchair through traumatic spinal cord injury following a life-threatening, motor vehicle accident.

To the extent that heterogeneity is acknowledged, it tends to be confined, by and large, to the ‘linguistic register’ and the subtle play of signs and symbols through a politics of identity reconstruction and the telling of ‘stories’—see for example, Shakespeare (1996). Certainly a concern with narrative is not, as we shall see in the following section, synonymous with

postmodernism—despite Morris' (1998: 250) claims to the contrary. All too frequently, however, the ontological foundations of these stories are lost through the 'relativist' claims they are pressed, if not 'forced', to make. Again we return here to the problem that whilst bodies/selves may indeed be 'lodged' in these stories, they are rarely if ever anything other than this in these accounts: the latest version of social 'imperialism' (Strong 1979, Craib 1997) to be sure. Diversity and difference, in short, far from being simply social or linguistic are rooted in real impaired bodies: bodies problematically 'written' both in and out of the picture by postmodernists and disability theorists alike.

Fortunately, however, signs of rapprochement are beginning to appear, including an opening up of questions surrounding impairment itself. For example Crow (1996)—herself a disabled feminist who has been active in the disability movement for over a decade—has cogently argued that impairment must be brought 'back in' to the disability debate. Bury (1996) too, argues for what he terms a 'relational' view of disability which focuses on the *interactions* between the individual and their social location: something which, he stresses, moves policy makers away from a narrowly defined medical viewpoint—see also G.H. Williams (1996), Kelly (1996) and Pinder (1996) for further variants on this theme.

What then remains to be said about the 'limits' of biographical disruption, both conceptually and empirically?; how best might the sociology of chronic illness develop in this light?; and what broader debate does it flag up at the turn of the century? It is to these particular questions that we now turn in the remainder of the paper.

Aetiological puzzles and 'normal' illnesses

Biographical disruption, as the foregoing discussion suggests, is indeed, contra postmodernist and disability theorists alike, a useful concept, shedding important sociological light on the nature of chronic disabling illness and the coping processes, practical strategies and symbolic styles of adjustment it calls forth. A further set of observations can, nonetheless, be made which advance the critique of biographical disruption in other more fruitful directions, mapping new terrain and new alliances along the way.

The first of these issues concerns the fact that as a concept, biographical disruption is predicated, in large part, on an adult-centred model of illness. The bulk of chronic illness, to be sure, tends to strike in the middle to later years of life; most sociological studies tending faithfully to reproduce this picture. Biographical disruption, in this context, does indeed become an apposite term, denoting the shift, however gradual or imperceptible, from a 'normal' state of health to one of illness. In doing so, however, the whole question of conditions which one has from birth or early childhood, including congenital abnormalities and deformities, is neglected: conditions, from

the very start of life, which are integral to an individual's biographically embodied sense of self. Doubtless struggles still occur, whenever the condition emerges. Compared to socially-set standards and cultural prescriptions of 'normality', moreover, the lives of these individuals may appear (profoundly) disrupted. Yet, phenomenologically and existentially speaking, it remains the case that these biographies have not, in any real or significant sense, *shifted*. Continuity rather than change remains the guiding principle here, including important elements of *biographical confirmation or reinforcement*. The (adult-centric) transition from health to illness, therefore, remains a problematic assumption upon which much biographically-oriented research to date has unquestioningly rested.

To this first existential-phenomenological point, we may add a second, more contextual issue concerning a variety of so-called 'normal' crises, adult-centred or otherwise, in conditions of general adversity and material deprivation. Cornwell's *Hard-Earned Lives*, for example, highlights the cheerful stoicism and pragmatism with which much illness is greeted by many East-Enders, including notions of 'normal illnesses' and 'health problems which are not illnesses' (1984: 130–31). Health, as she clearly shows, may indeed be a 'matter of luck', but illness, like hard work itself, is only to be *expected* and not therefore to be moaned about. These East-Enders, in direct parallel to their attitudes towards work and life more generally:

...take seriously the idea that having the 'right attitude' is the passport, if not to good health, at least to a life that is tolerable. The moral prescription for a healthy life is in fact a kind of cheerful stoicism, evident in the *refusal to worry, or to complain, or to be morbid* (1984: 129, emphasis added).

Health, from this viewpoint, may indeed be an important moral category which few if any of us wish to relinquish, but the biographically disruptive nature of illness is perhaps most keenly felt amongst the privileged rather disadvantaged segments of society. Biographical disruption, in other words, carries particular class- and age-related connotations, as well as gender and ethnic dimensions, which remain, at present, under-played and under-researched.

More recent studies suggest a similarly complex picture. Pound and colleagues (1998), for example, building on Cornwell's earlier work, provide some valuable insights into the nature and experience of stroke amongst predominantly elderly working-class people in the East End of London. The theme of stroke as something which was 'not that bad', as they show, contrasted markedly with the commonsensical view, popular in both lay and medical circles alike, that the condition 'shatters lives'. Stroke, in this sense, became a 'normal crisis', one which made sense in the context of age, patterns of co-morbidity and the 'Hard-Earned Lives' which many of these elderly East-Enders had experienced. Cases such as that of Mrs Jacobs, for

instance, provide a perfect illustration of just such a life spent amidst these 'normal crises':

...in her late 20s she gave birth to two boys. At the age of seven, one of them became sick and was admitted to the children's hospital. He lay in a coma for several weeks and Mrs Jacobs sat with him day and night, as did her husband until his employers threatened to dismiss him. After seven weeks their son died. When Mrs Jacobs was only 51, her husband died of a heart attack at work, and not long after that her mother died, also of a heart attack (1998: 499).

Age, as this study suggests, is again a key factor here, *mediating* between the experience and response to chronic illness. By the time people have survived into their 70s, 80s and 90s, their experiences, 'may have equipped them with considerable skills which enable them to deal with crises and successfully adapt to new situations such as chronic illness' (Pound *et al.* 1998: 502). Alternatively, these authors suggest, it may simply be that older people, particularly those from working class backgrounds, have 'lower expectations of health and may anticipate illness as *inevitable* in old age, or meet it with a greater sense of acceptance' (1998: 502). Seen in this light, chronic illness, particularly in the context of a lifetime's general hardship and adversity, may be a biographically *anticipated* rather than a disruptive (*i.e.* unanticipated) event: not the 'slings and arrows of outrageous fortune', but the 'normal chaos' (Beck and Beck-Gernsheim 1995) of everyday life and existence.

Bury himself, as Pound *et al.* acknowledge, takes up these issues of *timing* and *context* across the lifecourse in his later work on the 'oldest old' in England today (Bury and Holme 1991)—see also Bury (1997: 133–40). Most of us it seems, as they suggest, operate with a definite 'social clock' which 'guides our expectations of events within the biographical context' (1991: 94). This, in turn, explains the finding, pertinent to any consideration of biographical 'disruption', of a divergence between:

...subjective evaluations and objective circumstances. . .the former usually presenting a more favourable picture than the latter would seem to warrant. People regularly suffer from pain, for example, yet look forward to the day; they are severely restricted physically, yet are never bored; their housing is deficient in amenities such as plumbing, yet it does not, it seems, worry them as they 'have been used to it all [their lives]'; even those few who, by any standards, might be considered poor are reluctant to admit to having to 'go without' (1991: 159).

Prejudging the issue of illness as biographical disruption cannot, from this viewpoint, be justified. Instead, *timing* and *context*, *norms* and *expectations*, alongside our *commitment* to events, anticipated or otherwise, are crucial to

the experience of our lives, healthy or sick, and the meanings with which we endow it.

If Pound *et al.*'s study forces us to confront issues of biographical *continuity* in the lives of these East-Enders, and Bury and Holme's own study drives home the point about 'social clocks' and the discrepancy between subjective evaluations and objective circumstances, then Carricaburu and Pierret's (1995) research brings into sharp focus important elements of *biographical reinforcement* as well as disruption, both *individually* and *collectively*, in the lives of HIV-positive haemophilic and homosexual men. The meanings given to infection, as they show, arose as these men reinterpreted their individual and collective pasts: a reinterpretation which reinforced components of identity that, before HIV-infection, had been built around haemophilia and homosexuality respectively. For haemophilics, for example, the transition to HIV-positive status simply *confirmed* a lifetime's illness experience. For homosexuals, in contrast, it served to reaffirm their struggle, both individually and collectively, personally and politically, as gay men. Biographical reinforcement rather than disruption, therefore, appeared the more apposite concept in the lives of these men. Although not identical, Carricaburu and Pierret's research, in this respect, builds upon the earlier work of writers such as Corbin and Strauss (1987) on the 'three steps' in identity work—*i.e.* defining and redefining the self, refocusing of direction, and integration—as well as Charmaz's (1987) notion of the 'restored self'. In addition, it also resonates with Yoshida's (1993) notion of the 'pendular self' in chronic illness, particularly its 'supranormal' modality.

Discussion of these issues, in turn, leads to a third key point. Whilst sociological accounts of illness creating biographical disruption in the lives of the chronically sick and their families abound, biographical disruption as a *cause* of chronic illness has been less well documented, despite its implicit presence within the illness narratives literature. A significant part of Bill's working life for example, the first of Williams' (1984) three case-studies, had been 'disrupted'. Indeed, it was shortly after assuming his 'expanded responsibilities' as a 'working gaffer' that things began to 'go wrong' (1984: 180). In particular, Bill's attachment to *workplace toxicity* as a causal factor in the genesis of his illness, as Williams shows, related to his image of society as a place of '*exploitative relations* and power inequality' (1984: 198).

For Gill, in contrast, her illness was located in a '*web of stressful events and processes*: a genesis arising out of particular features of a woman's relationships in the modern world' (1984: 189). Accounting for her illness, in other words, involved a 'socio-psychological' interpretation of the relationship between 'personal identity and social roles in modern society' including the contradictory demands of social being and womanhood itself (1984: 198). If for Bill and Gill it was *biographical disruption* which *triggered* their illness, then for Betty, the last of Williams' respondents, these secular notions of causality were altogether irrelevant. Illness, instead, was 'necessitated and justified by reference to her intrinsic relationship to a suffering

God' (1984: 198). The biographically troubling issue, 'why me?', in other words, became a more religiously founded theodicy of pain centred on the question 'why not me?'. For Betty, as Williams explains:

...most people live their lives in the immediacy of personal and material interests. Their lives follow a narrative thread defined by everyday events and happenings and routines, and when major problems occur in their social world their identity is bound to be threatened and it is not surprising that they should become lost and depressed. But for her 'there is an end in it' [*i.e.* a *telos*] and all analytic puzzlement and personal doubt evaporate in the glare of God's purpose (Williams 1984: 195–6, my addition).

Again, we confront here the different cultural and existential meanings with which people endow their illness, some of which confer a *less than disruptive gloss* on what, for others, may indeed appear a fairly miserable if not abject existence. We also glimpse, as suggested earlier, the manner in which the very genesis of chronic illness may itself be narratively 'read back', legitimately or otherwise, into a set of former life crises and biographically disruptive circumstances: factors which, not infrequently, provide a radical critique of existing social arrangements and biographical circumstances. Once, as Williams claims: '...you begin to look at causal models as narrative reconstructions of the genesis of illness experience in the historical agent, moral or religious, and indeed political and sociological factors become central to elucidating illness experience' (1984: 197).

These issues find further support in Skultans (1997a,b, 1999) recent analysis of illness narratives in Soviet occupied Latvia: another powerful illustration of how life in such adverse circumstances, including the dispossession of private land, enforced (military) labour, and severe material and financial hardship, all too frequently results in illness—from neurasthenia to alcoholism. Latvian illness narratives, in this sense, as Skultans notes, do not simply reverse Bury's preoccupation with the biographically disruptive consequences of chronic illness, they also provide a story in which the values elucidated therein stand in stark contrast, as an act of political resistance, to the dominant ideologies foisted upon Latvian people throughout the period of Soviet occupation.

This focus on the *narration of biographical disruption* in the *genesis* of chronic illness, in turn, feeds into a fourth point concerning the role of life-events in the aetiology of disease, both physical and mental. George Brown, for example, through a series of illuminating studies over the years, has perhaps done most to trace these aetiological links. From early work on expressed emotion (EE) in schizophrenia, to more recent research on the role of severe life-events and long-term difficulties in the onset of a range of illness conditions—from clinical depression to menstrual disorders (Brown and Harris 1978, 1989)—these causal links, mediated through

context-specific processes of meaning endowment and emotional investment, have been demonstrated with ever-increasing precision. Two main types of emotion, as Brown and Harris note, can be distinguished here. First, those arising from *everyday activities* of a largely routinised or taken-for-granted nature (e.g. feelings of self-worth and self-esteem emerging from social performances and interaction rituals of various kinds). Secondly, those arising from *motives and commitments* (i.e. those linked to human intentionality). Central as they are to the aetiology of illness, these latter feelings typically occur at the *junction of plans and purposes*, when an estimate of likely outcome is (radically) changed. It is here it seems, that biographical disruption has its most profound pathogenic effects, hastening or facilitating the passage of an illness which may otherwise not have occurred, at least for some time to come. In reality, of course, these two types of emotion, linked as they are to our embodied biographies, are inextricably interrelated. Commitments and intentions, for example, invariably rest on tacit, taken-for-granted assumptions that certain core features of everyday life, including the ritualised conventions it contains, will continue (1989: 442). What is important here, as Brown's more recent research demonstrates, is our *commitment* to or anticipation of certain events, and the moderating effects which social support and self-esteem play in this process: factors which return us to the point that biographical disruption cannot simply be assumed or 'read-off', as a standard response, with similar effects, to a similar event, illness-related or otherwise. This, indeed, explains Brown's methodological emphasis on 'contextual-ratings' *vis-a-vis* more standardised approaches such as the Social Readjustment Rating Scale (SRRS) (Holmes and Rahe 1967).

This, in turn, places the 'mindful' (Scheper-Hughes and Lock 1987), emotionally 'expressive body' (Freund 1990, 1998) centre stage, linking as it does the realm of personal troubles to broader public issues of social structure; itself the defining hallmark of the sociological imagination (Mills 1959). Differing existential modes of emotional being, in effect, as Freund suggests, are different ways of feeling *empowered* or *disempowered*: feelings which are very much linked to people's material as well as their psychosocial conditions of existence throughout their embodied biographies. It is here, he claims, at this biographically embodied nexus, that:

'External' social structural factors such as one's position in different systems of hierarchy or various forms of social control can influence the conditions of our existence, how we respond and apprehend these conditions and our sense of embodied self. *These conditions can also affect our physical functioning* (Freund 1990: 461, emphasis added).

From here it is only a short step to a series of broader questions concerning the relationship between emotions, health and 'distributive justice' within contemporary Western society, including problems of income distribution,

social cohesion and 'emotional capital' (Wilkinson 1996, Williams 1998): issues which need to be at the 'heart' as well as the 'head' of future research and policy initiatives in this area. The relevance of biographical disruption, in short, both conceptually and empirically, may extend far beyond the traditional remit and concern with the personal *consequences* or *significance* of chronic illness, providing as it does a crucial *aetiological* link, via the emotionally expressive body, to on-going research within the life-events and inequalities literature concerning the psychosocial causes of disease. Biographical disruption, in this sense, does indeed have a 'healthy future' ahead of it. It also, moreover, resonates with certain key features of life in reflexive modernity; something, as we shall see below, which both consolidates and complicates the picture still further.

Health, reflexivity and risk: biographical disruption as an 'ailment' of modernity?

Let me take this opportunity to recap here on the central arguments of the paper so far. Set within the context of a broader series of corporeal reflections at the turn of the century, including postmodernist critiques and the disability debate, four major revisions to the notion of biographical disruption, drawn from recent literature on this and related topics, have been proposed. First, that the concept, by and large, is predicated on an *adult-centred model* of chronic disabling illness. Second, following directly on from this first point, that biographical disruption, as a generic term, fails adequately to account for a series of '*normal crises*', particularly in conditions of general adversity and material hardship (Pound *et al.* 1998). Third, that much of the literature on illness narratives can itself be read as an elucidation of the role of *biographical disruption in the genesis of chronic illness* (Skultans 1999). Finally, moving from a lay to a more scientific register, that these narrative insights, in turn, find further *aetiological support in the life-events and illness literature*; research in which the emotionally expressive body provides a crucial mediatory role between the realm of personal troubles and broader public issues of social structure. Prejudging the issue of biographical disruption, from this viewpoint, becomes untenable. Instead, *timing and context, norms and expectations*, alongside our *commitment* to events themselves, anticipated or otherwise, is crucial to the experience of our lives, healthy or sick. The original remit of biographical disruption as a sensitising concept or explanatory tool is therefore, at one and the same time, both qualified and extended. As an embodied 'fact' rather than a mere 'construction', biographical disruption exists in the real lives and real worlds of sentient subjects and socio-political agents, however 'mediated' this might be.

This, however, still leaves open the question of how, precisely, these biographically disruptive themes mesh with the broader contours and existential parameters of life in late modernity. The social changes currently

sweeping through contemporary Western society, as Kelly and Field note, have had a 'potentially profound effect' on the nature of the experience of chronic illness: a situation involving both *continuities* and *discontinuities* with the past (1998: 9). This in turn, they suggest, may require some 'reconsideration' of the standard sociological concepts used to describe and analyse chronic illness (1998: 19).

The central thrust of their argument, pertinent in the present context, is that in a world of 'less determinative social structures'—including more 'flexible' patterns of work and a wide range of 'explanatory discourses'—there is the potential for the experience of chronic illness to be 'less disruptive' and 'non-normal' than in the past. The 'narrow' definition of what is and what is not 'normal', in other words, has been replaced by a recognition (if not always acceptance) of:

... a range of appearances and lifestyles. That is, 'normality' itself is seen as more differentiated and relativistic, encompassing an increasingly wider range of 'differences in normality'. Thus, the assumption that chronic illness will inevitably disrupt normal patterns in a pathological manner is no longer valid, or at least its validity is a theoretical problem (1998: 18–19).

Alongside this are other key advances in (medical) treatment and management concerning the commonplace nature of chronic conditions themselves in everyday life, and the potentialities, given these and other developments, of an increasing 'tolerance' (if not celebration) of diversity and difference. All this suggests a number of different options for 'doing' chronic illness at the turn of the century (1998: 18).

In these and other ways, Kelly and Field reinforce the points raised earlier, setting the notion of biographical disruption in this broader context of rapidly changing social relations, both at home and at work. Whilst the body/self, from this perspective, is a continuing presence in this and other eras, the very nature of this 'presence' has profoundly altered in the current era. The body limitations and activity restrictions of chronic illness cannot however, as Kelly and Field rightly maintain, be ignored. For many people, chronic illness is indeed still 'greatly life limiting'. Any new paradigms must therefore be able to embrace both the 'change and diversity' of contemporary society and the 'continuing physical and material bases of chronic illness' (1998: 19).

A 'balanced' picture, to be sure: one, returning to the critique of post-modernism identified above, which acknowledges this somewhat more 'fluid' world without writing the body out of existence in the process. In doing so, however, Kelly and Field may also be guilty of an overly 'positive' or 'optimistic' reading of these very trends themselves. The crucial issue to tackle here, it seems, is whether or not these supposedly more 'open', 'plural' or 'reflexive' environments of action, and the biographical trends they

embody, spawn their own particular pathologies, including the potential for ever more subtle forms of control—*i.e.* a new ‘inflexible flexibility’ and the ‘disempowering’ modes of ‘empowerment’ this entails.

Reflexivity, as Giddens (1990, 1991) suggests, becomes a *chronic*, defining feature of late modernity. It is something which—alongside the ‘manufactured risks’ and ‘uncertainties’ of contemporary life and living (Giddens 1994, Beck 1992)—involves a never-ending cycle of biographical appraisals and re-appraisals, assessments and re-assessments across all aspects of modern social life. Bodies and selves, in this sense, are continually ‘problematised’ throughout society. This occurs through modern systems of knowledge and expertise, through the idealised images of consumer culture, and the auto-telic projects of ‘body-maintenance’, ‘self-improvement’ and ‘risk-avoidance’ that they engender. Confronted with a pluralisation of lifestyle options and choices about everything from the food we eat to the clothes we wear, the occupations we pursue to the sexual identities we adopt, the management of our bodies and emotional selves becomes a continual process of biographical revisions and reversals, successes and failures. Two particular manifestations of these reflexive biographical trends warrant further consideration here: first, our ‘obligation to be free’ (Rose 1990) and the continual emotion-work this entails (Hochschild 1983): second, the constant ‘monitoring’ and ‘surveillance’ of our bodies and their boundaries which life in ‘risk-society’ increasingly demands and necessitates. Both, as we shall see, are predicated on notions of reflexivity as a chronic theme: one in which our biographically embodied selves can rarely, if ever, be taken for granted.

As notions of reflexivity and lay re-skilling suggest, late modernity is characterised not simply by the significance we invest in emotions (*i.e.* *what* we feel, *how* we feel, *why* we feel the way we do), but also by the way in which we seek advice for our emotional problems. In contemporary Western society, as McCarthy (1989) notes, we’ve given up the idea of ‘cures’ and replaced it by a growing number of therapies in which the emphasis is placed upon voluntary relationships and lengthy conversations about the self in order to get us back ‘in touch’ with our feelings through the emotional component of the therapeutic encounter. This, in turn, resonates with a broader set of concerns, in which emotions are seen as ‘things’ to be ‘worked at’ or ‘worked on’: ‘one has an “emotional life”...in which its protagonist, the self, discloses and creates its authenticity at the same time’ (1989: 66).

Therapy, from this viewpoint, is emotion work *par excellence* (1989: 64). From self-help books to psychiatrists, celebrity status doctors to counsellors, psychotherapist to agony aunts, we are increasingly advised and instructed, encouraged and cajoled, on how best to manage ourselves and ride the emotional waves of everyday life, from the stresses and strains of the workplace to the ups and downs of relationships, and from assertiveness training to ‘handy tips’ on how to ‘improve’ or ‘spice-up’ our (faltering) love lives. As Hochschild comments:

While the counsel of parents, grandparents, aunts and uncles, ministers, priests and rabbis holds relatively less weight than it would have a century ago, that of professional therapists, television talk show hosts, radio commentators, video producers, magazine and advice book authors assumes relatively more weight (1994: 2).

Not only have the number of so-called experts in the field mushroomed in recent years, but lay people themselves are increasingly coming to 'frame' their problems in professional terms: what de Swaan (1990) refers to as a process of 'proto-professionalisation'. Authors of advice books, for example, like other commercially-based advice-givers, act as 'emotional investment counsellors', recommending to readers of various types 'how much, and in whom, to "invest" emotional attention' (Hochschild 1994: 2).

In these and countless other ways, as Rose (1990) observes, the individual is not some 'isolated automaton' who is dominated and controlled by others. Rather s/he is a 'free citizen', endowed with 'personal desires' and enmeshed, for better or worse, in a network of 'relations with others'. Post-modern selves, that is to say, have become 'attached to the project of freedom, have come to live it in terms of identity, and to search for the means to enhance that autonomy through the application of expertise' (Rose 1990: 258): trends which seem to have gone into 'over-drive' in the US context. Within this complex emotional web, psychotherapy, as Craib (1994) observes, has itself become caught up in the very ideology of late modernity which, from client to client, it is called upon to disentangle. It is one based on powerful illusions of 'personal growth' and fulfilment' which, like all good ideologies, is never quite attainable. The upshot of this is clear, if somewhat paradoxical: on the one hand, a chronic cycle of biographical revisions and reflexively-styled 'self-improvements' and, on the other, a variety of discontents, given these 'unattainable ideals'. Therapy, in this sense, together with the broader processes of social reflexivity of which it is a part, generates its own particular ailments and pathologies at one and the same time as it responds to them.

If emotion management and the 'psy complex' constitute one particular strand of biographical revision, if not disruption, in late modernity, then our current obsessive preoccupation with health promotion, screening and surveillance, constitutes another. Again the upshot of these processes suggests that our bodies, like our emotional selves, can rarely if ever be taken for granted. Instead they are continually problematised through a proliferation of health-related, risk-based discourses, the net result being a chronic form of bodily surveillance if not *dys*-appearance. Lupton and colleagues (1995) for instance, to take just one example, note how discourses of risk, including the current obsession with screening and the early detection of disease, rely upon the inspiring of 'anxiety, vulnerability and concern about hidden illness or disease lying in wait' (1995: 105). The HIV test, for example, like many other tests and warnings in the age of

health promotion and 'predictive medicine', becomes a; '...fetishised way of regulating bodies, by invoking fears about bodily integrity leading to unconscious self-surveillance and surveillance of others'—mandates which fit well the 'new sobriety' discourse of late capitalism' (1995: 105). This, in turn, taps into what other writers see, in a more radical vein, as a new age of 'panic bodies': one predicated on a corporeal politics of 'body McCarthyism' which seeks to distinguish between the 'clean' and 'unclean' according to the 'purity' of body fluids (Kroker and Kroker 1988, Crawford 1994).

It is within this particular constellation of late modern concerns, particularly the shadow of AIDS, that issues of 'immunity' come to the fore. From the immunology labs to the corporate training rooms of multinational companies, people, it seems, are actively using the immune system to organise and comprehend their lives (Martin 1994, Haraway 1991). The immune system, together with the fears associated with its breakdown, becomes a term, or more correctly a field of terms, in which all manner of questions and definitions are given meaning and measured (Martin 1994). Within all this, Martin observes a new conception of 'fitness' is being forged, one in which, just as surely as 19th century social Darwinism, some will 'succeed' and others will fail due to their 'inflexible bodies' and 'unresponsive selves' (1984). To this we may add the more general rituals of health promotion (Crawford 1984, 2000) throughout the lifecourse, including the battle against ageing (Featherstone and Hepworth 1991) and death (Bauman 1992) itself. 'Flexible bodies', in short, predicated as they are on 'robust immune systems' and a 'healthy balance of "control" and "release"' become the 'passport to success' in all walks of life, from the boardroom to the bedroom.

Biographical revision, if not disruption, from this viewpoint, becomes a perennial theme in conditions of late modernity: one in which few, if any of us, are wholly 'immune'. This, at first glance, may appear to contradict the earlier line of argument concerning the limitations of biographical disruption, particularly in the latter stages of the lifecycle where expectations surrounding health and illness may be somewhat lower and 'normal crises' loom large. At another level, however, this seeming paradox is simply explained. Reflexivity is indeed a more or less pervasive feature of life in late modernity, something as we have seen which profoundly affects the body as well as the self. The key words here, however, are 'more or less pervasive'. Whilst these processes may well extend into the far reaches of the lifecourse, they are perhaps most apparent amongst certain segments of the (new) middle class in which the 'cult' of health has reached almost obsessive proportions. For the East Enders in Cornwell's (1984) study, and for the 'oldest old' in Bury and Holme's (1991) research, for example, things indeed may appear very different.

Here we confront the limits of these 'overly reflexive' approaches themselves, ones which paint these transformations in broad brush strokes with

little attention to empirical detail. We also return to the point raised earlier, concerning the importance of meaning, timing and context: issues which any truly satisfactory sociological discussion of biographical disruption, reflexively grounded or not, must necessarily confront. Our bodies/selves, may be more likely to *dys*-appear in conditions of late modernity—their taken-for-granted features thrown into critical relief—but this it seems appears more troublesome and intrusive for some rather than others. Age and class, as we have seen, like gender and ethnicity, are crucial mediating factors here, patterning these reflexive themes in more or less predictable ways.

We have come a long way, from the traditional concern with chronic illness as biographical disruption, through biographical disruption as chronic illness, to a broader series of reflections on the contours and existential parameters of life in late modernity, including the various pathologies of reflexive self-control it spawns. Where then does this leave us as to the nature and status of this ‘core’ concept, and what future directions of study does it signal, within and beyond the sociology of health and illness? It is to these final questions that I now turn in the concluding part of this paper.

Concluding remarks

Taking Bury’s notion of chronic illness as biographical disruption as our point of departure, this paper has sought, through a range of recent literature, to tease out both its strengths and weaknesses as a concept, not simply in the light of existing critiques—of which postmodernists and disability theorists are perhaps the most dismissive and problematic—but also in terms of some relatively new terrain and previously uncharted issues. Whilst a distinction has been drawn between the *analytical* utility of biographical disruption as a concept, and its explanatory potential as an *empirical* datum, theoretical speculation without adequate empirical checks, it has been suggested, is ultimately redundant, particularly in a substantive domain such as ours. It is also important to distinguish here, as noted earlier, between the continuing presence of the body/self in this and other eras, and the *nature* of this presence in contemporary Western society. The position taken in this paper, in these and other respects, is perhaps best described, contra postmodernists and disability theory alike, as a series of ((late)modernist) revisions of this ‘core’ concept, rather than its abandonment altogether.

Biographical disruption, from this or any other viewpoint, rests on problematic foundations concerning the ‘shattering’ of our taken-for-granted assumptions about our bodies, our selves and the world in which we live. In doing so, it fails to account for a range of other possibilities in which illness may already be a central part of one’s biography, either from birth, early childhood or in later life, including the notion of so-called ‘normal crises’

(*cf.* Pound *et al.* 1998). To this we may add other important elements of *biographical continuity*, if not *reinforcement*, both individual and collective in nature, which the advent of illness may bring (*cf.* Carricaburu and Pierret 1995). Reference to chronic illness, in blanket terms, as biographical disruption, cannot therefore be sustained. Rather, attention to *meaning* and *context*—themselves core features of the concept according to Bury—*timing* and *purpose*, *commitment* and *expectation*, suggests that what, for some, may be a disruptive experience may, for others, be part and parcel of normal everyday life, particularly in circumstances of general hardship and adversity, illness related or otherwise.

Bury's emphasis on chronic illness *creating* biographical disruption, can also be complemented, as we have seen, with a focus—highlighted most clearly within illness narratives—on biographical disruption as a *cause* of (chronic) illness. This, moreover, provides a promising new bridge between the sociology of chronic illness, the sociology of emotions, and on-going research concerning the social patterning of disease, within the life-events and inequalities literature.

Finally, in a more speculative vein, biography, I have suggested, has itself become a chronically reflexive theme in conditions of late modernity. Whilst writers such as Kelly and Field (1998) provide a largely 'positive' reading of these trends (in relation to chronic illness), the line taken here suggests that a somewhat more cautious interpretation is needed. Few if any of us, it seems, can (wholly) take our bodies or selves for granted. Instead, whether through advice books or psychotherapy, emotion work or body maintenance, health promotion or predictive medicine, our bodies and selves are continually problematised. Life in late modernity, in other words, becomes a never-ending cycle of biographical appraisals, revisions and improvements, health related or otherwise: developments which spawn their own particular ailments or pathologies—from 'panic' bodies to anorexia/bulimia nervosa. These contentions in turn, however, require further empirical study—see, for example, Nettleton and Watson's (1998) refreshing volume of essays *The Body in Everyday Life*. At present it seems, these 'pathologies of reflexive self-control', of which the cult of health is merely one, appear most prevalent amongst the 'worried well', particularly those segments of the new middle classes anxious for status and distinction (Bourdieu 1984, Featherstone 1991).

As to future agendas: first, is the need to *extend* the biographical focus of studies within the sociology of chronic illness to *both ends of the lifecourse*, thereby moving away from the hitherto predominant concern simply with the middle years of life. The experience of 'becoming old', as Hepworth notes, is not 'unidirectional', nor is it distinctive of people who are old. Rather it is intergenerational and reflexive: 'the individual moves... through a spectrum of emotions in which the past, present and future are in essentially unstable combination' (1998: 183). This, of necessity, brings research on the sociology childhood (*cf.* James *et al.* 1998, Mayall 1996, 1998), ageing

(*cf.* Arber 1995) and chronic illness into a new alignment: links, at present, which remain embryonic. Secondly, greater attention to the *timing, context and circumstances* within which illnesses are ‘normalised’ or ‘problematized’, and the manner in which identities are threatened or affirmed, is equally central to any future developmental work in this area. Thirdly, reversing the argument somewhat, the role of biographical disruption itself as an aetiological factor in the onset of chronic illness may indeed be profitably pursued, not simply through further narrative-based work of the kind identified above, but also through the forging of new alliances with ongoing research in the sociology of emotions, the life-events paradigm, and the inequalities in health literature. Biographical disruption, in this context, alongside notions such as the emotionally expressive body, may provide a crucial ‘missing link’ between the personal troubles of illness and broader public issues of social structure (Williams and Bendelow (1996, 1998), Bendelow and Williams (1998)). Finally, at the broadest possible level, is the need for further empirical work on the health-related implications of social reflexivity itself, positive or negative, and the extent to which, given its alleged all-pervasive effects, it involves the lives and concerns of some or all segments of the socio-cultural order. In short, the future of biographically-related health research, albeit in guises very different from those first envisaged by Bury, looks both promising and assured. A ‘continuous’ theme in a ‘changeable’ world?

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Notes

- 1 I am grateful to the anonymous reviewers of this paper for drawing these points to my attention.
- 2 Whilst Kleinman is cited here in this connection, his work, strictly speaking stems from anthropological rather than sociological concerns regarding ‘suffering, healing and the human condition’. Others too, such as Frank (1995) and Morris (1998), display more ‘postmodern’ leanings concerning the body and illness. Bury’s work, in this respect, is one amongst many influences on the recent upsurge of interest in the ‘illness narratives’.

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