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Guest Editors **KAREN CICLITIRA** *and* **JANE WEAVER** *introduce the Psychology of Women Section's special issue on the body.*

THE way the body is talked about, manipulated and represented, by scientists and in popular culture, is of increasing interest to social psychologists. The body has also been of particular concern for many years to feminist academics, and continues to generate numerous articles, books and lively debate. Feminists often write about the body in specialised publications such as the *Psychology of Women Section Review* and *Feminism and Psychology*, but we felt that the topic might also be of interest to the broad readership of *The Psychologist*. We have chosen four articles, concerned with masculinity, childbirth, sexuality, and public health policy, to give some idea of the range and diversity of the debate.

We will set this debate within the context of an aim of the Psychology of Women Section: to challenge stereotypical assumptions about women and minority groups. We seek to encourage psychological research that challenges negative assumptions about minority groups, and highlights oppressive treatment of minority groups or by mental health practitioners.

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For decades feminists have noted the ways in which women's bodies are treated as commodities and objectified. However, since the 1990s attention has begun to be paid to aspects of masculinity and men's bodies as well. Two of the articles consider psychological research into how different media represent women's and men's bodies, and how this may impinge on an individual's behaviour and practice. The article by Karen Henwood, Rosalind Gill and Carl Mclean reviews theoretical issues in research on male embodiment. It explores the way masculinity and the male body are represented in the media, and considers different ways of looking at men's relationship to their bodies in contemporary life and culture. In her article Karen Ciclitira critiques experimental and qualitative research on the effects of pornography on viewers, and she illuminates some of the difficulties of researching sexuality.

Feminists and critical theorists have highlighted common assumptions about binaries such as mind/body and individual/society, and more recently have sought to show how the way we talk and think about our bodies cannot be separated from our physical experience of them. In this special issue all the authors acknowledge these tensions, exploring both psychological and physical aspects of 'embodiment', drawing on social constructionist theory (e.g. Gergen, 2001) while also taking into account the fact that bodies are physical objects, with all that this entails.

Social constructionist research aims to analyse power relations that impact upon the ways in which individuals live their lives (Burr, 1997). This requires an engagement with ways of thinking that are culturally and historically specific, and a questioning of standard assumptions that differentiate between bodies in terms of disability, race, gender and sexuality. However, there is no one type of psychology that could be described as social constructionist. Danziger (1997)

distinguishes between those who focus on issues of power and subjectivity, drawing on the work of the philosopher Foucault, and others who focus on discourse and social processes, showing how words and images do not simply describe or reflect, but actually create people's different understandings of the world.

While the ways we think about our bodies are enmeshed with social and cultural practices, we are also engaged with the physicality of our bodies. The import of this emerges particularly clearly in Jane Weaver's article about childbirth. Although social constructionist theory leads us to recognise the pervasiveness of discourse and representations, in the case of childbirth it is impossible to ignore the ramifications for women's bodies as well as their minds.

In contrast to realist/materialist approaches used in traditional psychology, social constructionism acknowledges the crucial influence of social environment, history, cultural backgrounds, and structures of power on the way people think and talk about their actions and experiences. Social constructionist research in psychology has shed much light on bodily issues such as anorexia, premenstrual syndrome, and sexuality. From such work, new directions have evolved for understanding and researching the body, health, and gender.

However, as Catherine Swann argues in the final article, applied psychologists working in these fields find that social constructionist theory and research do not always easily transpose to interventions and practice. Nor do they give sufficient weight to physical and health issues which are very meaningful for the clients or populations who experience them. What women and men experience as their health and ill health, their gender, and their bodies, exists on an interface between social and material realms. The reality of a physical experience cannot be uncomplicatedly re-theorised as a social construction.

Health is a common underlying theme in all four contributions, with those by Jane Weaver and Catherine Swann explicitly addressing the influence of biomedical health policies on the way women and men view and treat their own and others' bodies. In considering the question of choices available for women in childbirth, Jane Weaver illustrates how medical discourse has had the sometimes unfortunate effect of encouraging women to undergo unnecessary and risky surgical interventions when giving birth. Childbirth involves two (or more) bodies, those of the child and the mother, and gives rise to a complex interplay between the psychological and the physical.

At the same time, as Catherine Swann discusses, there remains the potential for stronger links between public health policy and health psychology. The government currently seeks to acknowledge, or at least pays lip-service to, the social, environmental, psychological and economic aspects of health. To engage productively with policy and contribute to key issues such as the reduction of inequalities in public health, psychology needs to progress from binary positions towards a workable framework that encompasses the connections between health and its broader determinants.

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The changing man



KAREN HENWOOD, ROSALIND GILL *and* **CARL MCLEAN** *on 'transgressing gender' through talk about masculinities and the body.*

IN recent times there has been a proliferation of interest among psychologists and gender theorists in men and masculinity (e.g. Edley & Wetherell, 1995) and the body (e.g. Stam, 1998). This reflects public debate in the UK (and in other post-industrial, Westernised societies) about gender issues, changes in society (e.g. in the domains of family life, work, leisure and consumption) and their impact on men. We need to understand the significance of the 'gendered body' in everyday life, but we must also remain fully aware of culturally changing aspects of men and masculinity. Such changes are likely to be neglected if it is simply assumed that people's social positions and subjectivities have a fixed origin in naturally or socially determined 'gender difference'.

Until very recently the implications of research into social change, gender, masculinities and the body have been poorly understood. This has been extremely disadvantageous in many policy and practice arenas. There has been a tendency, for example, to draw on gender stereotypes when dealing with differences between women's and men's health outcomes (Watson, 2000) – where men's health has been poorer, the explanation has been in terms of men's risk taking and abnegation of personal responsibility for health. By contrast, many social commentators, gender researchers and psychologists would now stress the importance of linking changing expectations and representations of men to issues of men's health and well-being (e.g. Mcqueen & Henwood, in press).

Our purpose here is to give the theoretical background to the issue of 'male embodiment', now so firmly part of the broader social scientific, psychological and popular social commentary agendas. Investigations into this issue address the interface between sociocultural relations and meanings attached to masculinity, men and the body, along with how men make sense of their embodied experiences and changes to their position in society. Research into embodiment, therefore, seeks to maintain a cultural and material focus when addressing sociological, cultural or psychological questions.

Throughout, one of our major concerns is with exploring the issue of 'gender transgressiveness'. Is there any suggestion that the cultural boundaries containing and differentiating female and male bodies are being relaxed, and is this bringing to light new ways of being and living?

Why study men and the body?

Investigations into gendered (including male) embodiment are informed by efforts that have been made in the fairly recent past to 'problematise' gender (for example see Burman *et al*., 1999). The 'problematic of gender' is now widely appreciated – at least within cultural and social frameworks for conducting psychological research. It involves deconstructing the commonsense assumptions held within particular cultures about what it is to be a woman or a man. In the past it has often been assumed that 'maleness' provides the universal standard for human thought and action (Middleton, 1992; Wetherell & Griffin, 1991). This has deflected attention away from the normative standards of masculinity, and restraints on deviating from them, that are now under scrutiny (Segal, 1990).

One of the most significant barriers there has been to conducting research on men is the belief that nature defines what it is to be male or female. This obscures the way the distinctions we tend to make implicitly guide our view of what is natural. Ingrained cultural dichotomies construct maleness and femaleness as a difference between culture and nature, mind and body, rationality and emotion, autonomy and dependence, control and empathy. They assume that there is a single, true, male or female nature. Extensive work has now been done by cultural analysts illustrating how even the most compelling of these dichotomies hide more than they highlight (e.g. MacCormick & Strathern, 1992; Smith, 1996).

The association between maleness and rationality offers an illuminating example. This association has fostered acceptance of masculinity as 'naturally' representing the universal human standard, but is now seen as one of the primary ways gender insinuates itself into and reinforces a hierarchical social order (Frosh, 1995). It may be considered as appropriately masculine for men to eschew their emotions, ignore pain, and generally treat their bodies as instruments under their

control. But pro-feminist and anti-feminist analysts alike have pointed to the cost to such men if they are treated as throwaway commodities in militarist societies (Farrell, 1994; Mac An Ghaill, 1996). Healthcare professionals have begun to decry the lack of body awareness and inattention to health among men, and have sought ways to rectify this (as is the case, for example, with prostate and testicular cancer; see Peterson & Lupton, 1996). Psychotherapy researchers repeatedly emphasise how myths and fantasies of male supremacy and indestructibility (Sayers, 1995) depend upon a defensive dualism that positions (male) rationality and control as threatened with engulfment by women's desire or vulnerability (Frosh, 1994). All these points undermine claims to the natural superiority of 'rational man'.

Psychologists, along with other social scientists who theorise masculinity, are now looking at men in fresh ways. Instead of arriving at explanations for men's conduct based on assumptions, they question what it means to be a man (Ferguson, 1993). Recent dramatic societal changes (e.g. the casualisation and feminisation of work, moves from production-based to consumption-based economies, and changing expectations of sexual relations and family life) have raised questions about their potentially 'destabilising' effects on men's identities (Frosh, 1995). Investigations are under way into how different representations of masculinity (e.g. as 'lads' or 'new men' in popular magazines and other mass media) compete to retain or gain a position of dominance by actively subordinating other ways of being men (e.g. Edley & Wetherell, 1997). Psychological research is now showing a new sensibility that is critical of dominant constructions of masculinity while empathising with men's psychological distress (Frosh, 1997; Mcqueen & Henwood, in press).

These new directions have come about as researchers have embraced the principle of 'transgressing', or stepping outside, the traditional boundaries of gender. In the past social convention may traditionally have distracted men's attention away from their bodies. In fact, gender researchers who have explored the effects of the ways in which women's bodies are treated as objects and commodities have viewed men as enjoying considerable psychological benefits by virtue of their gender (Bordo, 1992). However, we are now living in changing times, raising the possibility that men too may increasingly be defined through their bodies. Our research (e.g. Henwood *et al*., 1999) has aimed to mine interviews in an effort to 'map the psychologies of men', investigating what significance being physically embodied has for men.

Patterns of consumption, lifestyle choices and media representations of men now often focus upon men's appearance and the male body. Bodycare products are being successfully marketed to men (witness the success of the Lynx brand). Working out in the gym and generally taking exercise have become highly popular leisure activities. Media advertising routinely depicts in positive ways youthful, toned, muscular male bodies or focuses on style in men's clothing and physical appearance. What do these contemporary changes signify in the cultural context of men's lives? Are the messages they convey gender transgressive? Is there any evidence that changes are occurring at the level of men's psychologies?

Two theoretically differentiated approaches to linking men and the body are necessary to address such questions. On the one hand, it is necessary to consider how men's bodies are treated as 'objects' that are gazed upon by sections of society (especially within the advertising, fashion and leisure industries) and, as society becomes increasingly consumer-led, by a far wider spectrum of other people and by individual men. As 'objects of consumption' the worth of men's bodies is determined in a similar way to 'commodities' displayed in shop windows: less by their functional value (what they enable men to do, such as by way of physical work or other forms of economic labour) and more by their sign value (where the image they present stimulates or promises to satisfy people's needs, wants and desires).

On the other hand, it is necessary to investigate men's experiences as 'embodied subjects', whose sense of selfhood and of the body is constructed through a wide range of ways of engaging with the world and with everyday life. The focus here is more on the relational activities in which men engage (e.g. with family and friends), as well as the connections they make between their present and past life and their ways of envisaging the future. Ussher (1997) and Yardley (1997) discuss different theoretical approaches to embodiment and how they translate into psychological research on the

body. However, they do not specifically address masculinities and the body.

The exemplary male body as an 'object of consumption'

A major anchor point for investigations into stability and change in society's ways of depicting men is to ask how far images of the muscular, fit, smooth and toned male body are 'aspirational'. Are psychological identifications being created between the way men see (or wish to see) themselves, and the depicted images? What might such identifications tell us about men's aspirations, fears and desires? (Mort, 1988; Nixon, 1996).

One suggestion is that such images represent men seeking to literally embody the physical strength, hardness and power associated with the traditional masculine ideal, signalling distance from traditional cultural ideas about femininity and female embodiment. The contemporary preoccupation with abdominal stomach muscles has been discussed precisely in these terms by Baker (1997). He argues that this preoccupation is a way for men faced with decline in physical labour and increasing leisure time, and a related increase in girth, to 'at least hold on to the outward appearance of masculinity through developing a lean, taut, muscular body' (p.20). If the softness and roundness of women's bodies are viewed as the apotheosis of assumed femininity, then men's aspiration for abdominal tautness may be offering them a means to affirm male–female difference.

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White and Gillett (1994) have, likewise, commented on the muscular body as an attempt at literally embodying traditional masculine ideals. They argue that the presentation of muscular masculinity as a cultural ideal may be a form of resistance to alternative masculinities that contest power hierarchies among men. The now extensive cultural iconography associated with 'new men' (e.g. as involved fathers and caring partners) suggests that there has been some societal realignment in men's identities and the positions they occupy in gender and power relations. However, not all men will be able to identify with the available alternatives. Wresting back previously held advantages encoded in depictions of men's bodily strength (in terms of self-mastery, vigour and potency) may, therefore, lie behind the revival of cultural ideals of fit, muscular masculinity.

Other commentators have begun to question whether muscular masculinity should necessarily be seen as representing a form of identity to which men aspire. Instead, a preoccupation with bodily tautness and hardness may represent a temporary nervousness on the part of men about a declining belief in prevalent 'myths' about male achievement and 'performance' (Hill, 1997). A further, rather different, picture has emerged from analyses of the irony surrounding characters embodying muscular masculinity in the media (e.g. those enacted by Arnold Schwarzenegger). Here the possibility has been raised that such images may be reflecting or prompting

self-awareness of, or nostalgia for, what is, after all, an unsustainable ideal for the majority of men (Morgan, 1993).

Our study (Henwood *et al*., 1999) investigated how men viewed images of the exemplary male body in magazines, their own and other people's gym use, and many other aspects of body adornment such as tattooing, piercing and bodycare products now marketed to men. A wide range of highly differentiated responses came to light, including the idea that a fit, muscular body can represent an aspirational ideal or an achievable goal in the quest for male identity. However, the majority of responses fell outside this frame, suggesting that men are affected in a range of complex ways by the regulatory regimes for gender and body image maintenance that hold sway in contemporary culture.

On occasions the image of the objectified male body was perceived as narcissistic and rejected as dangerously transgressive of gendered cultural expectations of masculinity. The person in the image was judged to present a softness and vulnerability of a kind that might incite others (and especially men) to violence against him.

The bulk of responses fell somewhere in between taking an aspirational and rejecting stance towards the image. Interviewees seemed to be negotiating difficult challenges posed to self-identity by body image – comments were made about feeling pressured by such images, resentful about their disproportionate appeal, angry at their unfairness, and yet reluctantly capitulating to their standards of perfection.

A small but notable subset of responses mainly (but not exclusively) by gay men took a more sanguine view of the commodification, display and consumption of men's bodies, as it was seen to signal recognition of the beauty, physical attractiveness and homoerotic appeal of the fit, lean and muscular male body. Interestingly, however, gay interviewees did not always view such bodies as stimulating their desire if their hardness and tautness was viewed as intimidating and inaccessible.

This highly variable set of responses (for a full treatment see Gill *et al*., 2000) suggests that men today are able to take up different perspectives on the meaning and significance of gender and body images, depending on whether they are perceived to be re-inscribing, threatening, bolstering, extending or transgressing the regulatory power of cultural norms and ideals. Further differences and complexities in men's socio-emotional responses and sociopolitical meaning-making come to the fore when attention is paid to men as 'embodied subjects'.

Men as embodied subjects

Within society at large, and within research on health and illness, a commonplace view is that the 'physical body' constrains people's everyday activities and habitual ways of living. Men's health and well-being has now become part of this agenda, such that major illness conditions have come to be seen as potentially reaching into the most fundamental areas of men's experiences and lives. One of the areas that has come under examination is the effect of such illnesses on men's ability 'to affirm (their) masculine identity through the social body' (Watson, 2000, p.107).

Watson goes on to argue, however, that this general way of theorising about the body is a highly restrictive way of reading the significance of the body, since many different kinds of relationships can be established between the physical and social body. One possibility, for example, is that less importance may be conferred upon maintaining physical fitness (e.g. through routine gym use) than fulfilling other social personae and roles. Certainly this is how participants in Watson's in-depth qualitative study of the ways in which Glaswegian men viewed their lives, health and well-being judged the significance of their own bodies. They eschewed the prioritisation in health promotion messages of individuals' responsibility for controlling their diet and taking regular exercise, as they viewed such messages as appropriately targeted only at the health and body practices of younger men. When evaluating their own bodies they did so in terms of their pragmatic ability to fulfil the everyday tasks and roles in which they were involved, as fathers, husbands or partners, and employees:

> *…you come home and get into a routine. There's nothing happening to my body. A few years ago I wasn't like this. Now I've got kids. I've got responsibilities and no gallivanting.* (Watson, 2000, p.91)

Within the literature on men's health and embodiment, then, the discussions that have occurred have involved an extensive critique of the dissociation of body theory from the way embodiment is lived as part of everyday experiences. We have picked up this idea in our research, asking men not just how they viewed public images of the male body, but about their everyday, embodied experiences. What was it like for them as they grew up (experiencing bodily changes) through adolescence? What were their relationships like with others (especially intimates)? What were their experiences of work, their hopes for the future, and the expectations of fatherhood?

Two interrelated themes – men's desire for self-protection and their ways of relating to their own and other people's vulnerabilities – emerged as highly salient. Talk about growing up often involved the expression of worries about embarrassment and exposure by developing bodies. Engaging in fitness and exercise regimens was viewed by some interviewees as a means of self-protection from habits and lifestyles that were otherwise self-destructive (alcohol and drug abuse). Intimate relationships and connecting with others were desired as another form of self-protection. A smaller but contrasting subset of comments suggested that men desired connection with others not as a means of protection for themselves, but as a way of better understanding other people's (and especially young children's) vulnerabilities.

So, as with their responses about images of the male body, when men were asked about their experiences as embodied subjects, their responses did not strongly suggest a pattern structured around fixed gender roles, but rather a set of differing perspectives on the themes they mentioned and that seemed to matter to them. If there was a dominant set of concerns, it was that the men saw themselves and their bodies as bound up in cycles of self-destructiveness and a desire for protection from self-harm. But it is difficult to see this as articulating a privileged perspective of rational detachment from their bodies. Although some comments from interviewees might suggest that they enjoyed a sense of entitlement to protective relationships with intimate others (invariably their partners or

wives), others showed men dependent for their sense of well-being upon their bodies, and others showed them desiring connections with vulnerable others. The latter comments in particular run counter to the idea of men seeking succour from others to enjoy the fruits of male privilege.

Conclusion

This article set out to consider the relevance of cultural shifts towards greater attention to male embodiment for attempts to understand men's psychologies. The messages to come out of research on this issue do not provide clear-cut answers to difficult questions such as 'Are men today changing?' However, they are invaluable in opening to scrutiny some of the range of ways in which (changing) images of the male body are viewed, along with some of the different ways in which it is possible for male embodiment to be experienced. Recent investigations into male embodiment argue against any attempt to provide a singular impression of what it might mean for men today to possess a 'male psychology'. Rather they seek to build up, through detailed theoretical examination and empirical investigation, a more complex and contradictory picture of men's embodied thoughts and feelings, and of what this might tell us about men's psychologies as a sociocultural and sociopsychological issue.

In her latest book Bordo (1999) provides probably the most critical but empathic account of male embodiment to have emerged out of the burgeoning literature on the topic to date. Along with the shift that has occurred in contemporary society towards treating men's bodies, like women's, as objects of consumption and desire, she argues that men also need to be

'Who would have thought… that men would come to share…an obsessiveness about bodily appearance?'

treated as 'flesh and blood creatures'. Who would have thought, with the passage of double standards and moves to greater equality between the sexes, that men would come to share with women an obsessiveness about bodily appearance and self-image? Men, women and society in general may be benefiting from a release from myths of male stoicism, self-containment and autonomy, and the associated over-inflation of the benefits associated with occupying privileged positions.

But both advantages and disadvantages seem to flow from this. On the downside, we now see men 'agonising over relationships: pining and weeping, neurotically analysing, self-scrutinising, pulling covers over their heads, and over-eating – just like women'. A significant compensation is that it is now possible to appreciate how 'needy' men can be, 'that they really do come from the same planet as women', and that 'we're all earthlings, desperate for love, demolished by rejection' (Bordo, 1999, p.297).

Bordo's conclusions resonate closely with our own way of reading the claims that are being made for, and with men's own accounts of, their bodies, experiences and lives. Women, men and society at large may stand to gain by acknowledging the aesthetic and erotic qualities of men's bodies, and attending to the relationship between male embodiment and health. However, men in general are having to learn about the pleasures and pains associated with experiencing such transgressive forms of 'embodied subjectivity'.

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The birthing body

JANE WEAVER *asks if psychologists add anything to the debate over the rising caesarean section rate.*

OVER the past 20 years there has been a growing rhetoric concerning women's choices in, and control over, childbirth. This rhetoric is exemplified, and was to some extent intensified, by the *Changing Childbirth* report (Department of Health, 1993), the findings of a government-appointed expert committee, which advocated women's involvement in their care during pregnancy and birth.

To a large extent this extension of controllability to service users parallels what has happened in various other areas of patient care, for example in the use of analgesia (Morgan & Puder, 1989) and in coping with medical procedures (Ludwick-Rosenthal & Neufield, 1988). However, in certain ways childbirth is different.

Firstly, the issues around childbirth usually involve two (or more) people, not one. If a woman takes control of the way her birth is managed, she is making decisions that might have implications not only for her own well-being but also for that of her baby (or babies, in the case of multiple birth). Consequently, women who do not accept received obstetric opinion about the optimal management of their particular case run the risk of finding themselves accused of wilfully making choices for their own psychological benefit while jeopardising the physical well-being of the fetus.

Such fears were demonstrated in the development of the notion of maternal–fetal conflict during the court-ordered caesarean cases (Chavkin, 1992). These legal cases, occurring mainly in the USA and the UK, involved a series of situations where hospitals sought judicial permission to impose caesarean sections on women who refused them, with the predicated aim of preserving the life of mother or child, or sometimes both (Fovargue & Miola, 1998; Michalowski, 1999). The cases came under heavy criticism for their paternalistic overtones. It is well recognised in English law that a competent adult has the right to withhold consent to medical treatment. However, the court-ordered caesarean cases were often based on reservations about the extent of this right when it involved a pregnant woman and therefore also a fetus. The subtext could be read either as pregnant women somehow being less competent than other adults, or as their not being entitled to the same rights as everybody else (Weaver, 2002).

Secondly, it is argued that pregnancy and childbirth are not 'illnesses' but natural bodily processes (Batra & Lilford, 1996). If anything, this strengthens the case for consumer choice. However, in many maternity units a medical model tends to prevail, focusing on the potential for childbirth to go wrong and thus making it justifiable to monitor the whole procedure closely.

An alternative social model of childbirth, while acknowledging that things can go wrong, emphasises the holistic nature of birth as a psychological, spiritual and social experience as well as a physical

one. It recognises that many women and infants have been saved by appropriate medical intervention. However, it questions the extent to which such technological regimes should prevail, arguing that the side-effects of prophylactic obstetric management can and do create more complications than the interventions themselves prevent (Wagner, 1994). Nevertheless, the problem remains that it is often impossible to predict how labour and birth would have gone if a different level of management had been applied. Thus it is very difficult to arrive at a consensus as to what does constitute an appropriate level of monitoring and intervention.

One of the most radical childbirth interventions is caesarean section. It is radical because it circumvents vaginal birth altogether. It is also a surgical procedure, and as such was considered in the past to be beyond the remit of choice for the pregnant woman. However, recent reports suggest that women do sometimes choose caesarean birth (Jackson & Irvine, 1998), and it is the context in which this choice is made that forms the subject of this article.

Caesarean section

Caesarean section is now safer than ever before. As a surgical procedure it is, nevertheless, associated with higher levels of maternal mortality than vaginal birth. It also carries physical risks to both mother and baby. These risks include those associated with abdominal surgery, such as deep vein thrombosis, adhesions, trauma to the ureters, bladder and bowel, and haemorrhage. Other complications include wound infection, urinary tract infection and endometriosis in the mother, and lung disease in the newborn infant (Hillan, 1999; Rennie, 1999). It is also associated with negative psychological maternal responses, such as disappointment, anger and lowered self-esteem, as well as delayed mother–infant bonding (Hillan, 1999).

This is not to argue that vaginal birth is risk-free. It has been associated with psychological morbidity related to fear or loss of control (Menage, 1993). It can also result in severe perineal damage leading to dyspareunia or anal sphincter involvement (Sultan & Stanton, 1996). Nevertheless, the caesarean section rate in England and Wales has risen from 9 per cent in 1980 to 15.5 per cent in 1994/5 (Department of Health, 1997). Most recent data suggest a current rate of around 21 per cent (Thomas & Paranjothy, 2001) – a worrying increase.

Although it is easy to pinpoint individual cases where mother and child have undoubtedly benefited, there is no convincing evidence of a fall in perinatal or maternal mortality as the caesarean rate has risen (Enkin *et al*., 1995). As a result, the rising caesarean rate has been labelled a public health issue with ramifications for the physical and psychological health of mothers and babies as well as for expenditure and use of resources within the NHS (Chapple, 1999).

Psychological issues

Caesarean section begins to be of psychological interest when explanations for the rising rate are proffered. Such explanations include obstetricians, fearful of litigation, trying to maintain control; images of birth that depict it as a hazardous process, normal only in retrospect, and better circumvented by medical intervention; or consumer demand, perhaps to avoid the pain of labour or for the convenience of knowing exactly when the baby is going to be born (Amu *et al*., 1998; Kitzinger, 1998). As far as consumer demand is concerned, some authorities accuse professional women of being 'too posh to push', using their educated background to argue for the operation, and perhaps their wealth to pay for it, thus avoiding the perceived indignity of vaginal birth and possibly turning caesarean section into a lifestyle choice (Hinsliff, 2001). However, although at least one private hospital is reported to have a caesarean section rate of 44 per cent ('Good birth guide', 2001), many obstetricians report an increase in requests for caesarean section from women from almost every background.

Despite the evidence that women are becoming more deeply involved in decisions around caesarean section, it is often unclear how far, if at all these decisions are associated with obstetric indications (Churchill, 1997; Mould *et al*., 1996; Wilkinson *et al*., 1998). It is likely that women sometimes choose the operation because they find themselves in a situation where, although there is no unambiguous obstetric indication for surgical intervention, there is some likelihood that things might not go smoothly and that an emergency caesarean might be the outcome. Many women fear the trauma and uncertainty of an emergency operation and will choose to go to theatre sooner rather than later to pre-empt this. It has been suggested that obstetricians might also be tempted to err on the side of surgery in situations of uncertainty (Robson, 2001). Other women might choose the operation because they have personal concerns about their ability to give birth unaided, perhaps because of a family history of problems or previous difficult birth experiences (Hinsliff, 2001). The problem is clouded by the fact that many caesarean sections are performed not for a single reason, but for a set of issues working together. Sometimes the picture is confused, with different indications for the operation being given afterwards by childbearing women and their obstetricians (Graham *et al*., 1999).

To better understand the rising caesarean rate, the Royal College of Obstetricians and Gynaecologists has recently carried out a large-scale audit of hospitals across England to explore rates against demographic data and information about the reasons given for the operation (Thomas & Paranjothy, 2001). However, the Maternity Care Working Party, a body of concerned professional and consumer groups, has also called for smaller scale qualitative studies to investigate and

understand the way in which the issue of choice and caesarean section impinges upon both childbearing women and professionals. Such research can be viewed in at least two ways. It can be seen as a way of putting 'flesh on the bones' of the statistical data, expanding upon issues that require more than a tick in a box to be fully understood. Or it can be seen as a way of exploring talk about the issues against a background recognition that language does not simply represent the world but also operates within it. Such talk, it could be argued, would be used not so much to justify what was happening but to construct events in a certain way.

Because of the confused messages being propagated about childbirth, such a process is important. Media images, both fictional and documentary, often seem to prefer the dramatic and unusual to the straightforward and common (Clement, 1997). Childbearing women struggle to reconcile images of childbirth as something natural, and vaginal birth as the ideal way for a baby to arrive in the world, with images of vaginal birth as something difficult, even hazardous, to be avoided if at all possible (Weaver, 2000).

Understanding how birth is 'positioned', how it is depicted when women talk to each other and discuss choices with obstetricians, is critical to understanding how and why decisions are being made for caesarean section. If birth is constructed as a risky business, the rhetoric around a caesarean section as a means of imposing control and ensuring safety begins to make sense. Medical intervention, appropriate only when there are problems, is wholly justifiable when giving birth is considered to pose a problem. Counselling about the risks of a caesarean operation takes a low profile when non-caesarean childbirth is characterised as even more risky. This perhaps helps to explain why so many women argue that they are not informed about risks, whilst obstetricians assert that they discuss these in all but the most immediate of emergency cases (Gamble & Creedy, 2001).

Conclusion

At present it is difficult to determine the exact place of maternal choice in the decision to carry out a caesarean section. It is also necessary to ask not only whether women are receiving caesarean sections when they would be better off without them, but also whether there are still women and babies who fail to get the operation when they would benefit from it either physically or psychologically. In the past there has been a tendency for the operation to be over-used on women from certain social backgrounds and under-used on others (Oakley & Richards, 1990).

Caesarean section is only comparatively safer for mother and baby when they are faced with obstetric risks greater than the potential complications posed by the procedure. Although the explanation for the rising caesarean section rate is likely to be a complex one, it is undoubtedly partly a response to fears felt by both mothers and professionals. The way these fears are used in talk about childbirth needs to be better understood before any steps can be taken to address the public health issue of why one fifth of childbearing women now seem unable, or perhaps unwilling, to give birth vaginally.

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Researching pornography and sexual bodies

KAREN CICLITIRA *considers women's experiences of viewing pornography and the consequences for their body image and sexuality.*

PORNOGRAPHY is increasingly hard to avoid in everyday life. Psychologists have looked into the question of whether pornography affects people's behaviour and attitudes; but have psychologists addressed the topic in a sufficiently complex fashion, or have they neglected to consider ways in which women and men critically respond to pornography? This article outlines some of the problems with traditional psychological research in this area, and goes on to consider different methods of exploring pornography's influence on individuals' sexuality and on how they view their bodies.

The rise of porn

The word *pornography*, derived from a Greek compound meaning 'the depiction of whores', came into common use in the first half of the 19th century. Historically, pornography has mainly involved the depiction or description of bodily features and acts, aimed at arousing corresponding bodily reactions. But *pornography* is an elusive term with a range of meanings, dependent not only on cultural, social and historical contexts, but also on individuals' own experiences and beliefs (Kendrick, 1997). The term is currently used to describe a huge range of sexual representations: written and pictorial images and behaviours, from erotic fiction to representations of penetrative sex and bestiality. For the sake of clarity, I will use the words *pornography* and *porn* to refer to mainstream heterosexual pornography – sexually explicit (visual and written) materials designed to sexually excite viewers or readers.

The pornography industry has grown enormously since the 1980s, spurred by the advent of the video market and 'adult' television channels. The 1990s saw further technical developments in the production and manufacture of porn videos and films, accompanying a huge expansion of specialised genres such as amateur, gay, bisexual, fetish, lesbian and transsexual pornography. New technologies such as interactive online audio and video, DVD, and CD-ROMs have been eagerly exploited by the industry. Sex is regularly reported to be the most sought out topic on the internet (Freeman-Longo & Blanchard, 1998), with porn sites, dedicated newsgroups and chatrooms now continuously available online.

Although sex has been successfully commodified for the growing couples' and women's market, the majority of pornographic films and magazines continue to be made primarily by men for male consumers. The conventions of mainstream pornography continue to be geared towards the presentation and maximum visibility of the female body, with far less emphasis on the male body (Juffer, 1998). Mainstream erotic fiction, such as Virgin's *Black Lace* series (launched in 1993), is promoted as an alternative to pornography and aimed particularly at female readers. Female *Black Lace* editors claim to offer a new discourse of female pleasure for women. Although this genre claims to validate women's sexual pleasure and to promote female subjects, much of it perpetuates the crude formulas of mind/body, male/female dualism, with the female protagonists constituted in terms of submission to men's erotic needs and fantasies (Sonnet, 1999).

'Most research has centred on the supposition that consuming…pornography will have negative effects'

Experimental research on porn

For years experimental psychologists have been asking whether viewing or reading sexually explicit material has any effect on behaviour. Most research has centred on the supposition that consuming and viewing pornography will have negative effects on users (e.g. Malamuth, 1987; Trotter, 1999), with few researchers considering the question of whether any benefit may be derived from pornography by either women or men.

Researchers' apparent bias regarding the negative effects of pornography has influenced (and is influenced by) the way pornography is defined. Psychologists have attempted to clarify the issue of definition by distinguishing between 'non-violent pornography', 'violent pornography' and 'erotica' (e.g. Check, 1992). Content analyses of pornographic magazines and films have sought to discriminate between different kinds of depictions, for instance distinguishing non-violent pornography from erotica by using generally pejorative epithets (such as 'objectifying, 'degrading' or 'dehumanising') to characterise the former. However, terms like 'violent', 'degrading', and 'humiliating' are often used with no acknowledgement that such descriptions are subjective and contextually relative (e.g. Cowan & Dunn, 1994). Imprecise and widely varying definitions pose insuperable problems for those who seek to identify different kinds or levels of pornography.

Most psychological research has focused on the attitudinal and behavioural effects of pornography on sample populations of largely white, middle-class male undergraduates (see Linz & Malamuth, 1993, for an overview). Participants are assumed to be heterosexual, and the pornographic material considered has been that produced by and for heterosexual men. Research questions have included whether viewing pornography causes men to be more sexually aggressive to women, whether it affects men's attitudes to women and sex, and whether it affects women and men differently. Researchers have also tried to establish causal links

between the circulation of pornography and the incidence of sexual crimes, sometimes confusing correlation with cause and effect (e.g. Russell, 1992).

Inadequacy of the experimental approach

Such research rarely acknowledges that social behaviour cannot be induced and measured in the same way as physiological arousal. Because sex is primarily thought of as a physical behaviour, it is often mistakenly treated as a purely natural phenomenon that can be reduced to its biological components and measured (Hardy, 1998). Lynne Segal (1998) and others have criticised the way psychologists suppose that aggression in a laboratory can be simply equated with aggression outside the laboratory. Experimenters who measure the aggression demonstrated by participants exposed to sexual imagery cannot assume that what happens in the laboratory is relevant to sexual crimes: pre-exposure anger, rather than any reaction to the exposure itself, may be the cause of aggression (Howitt & Cumberbatch, 1990).

No laboratory experiment will accurately reproduce the normal setting of the kind of behaviour under study, be it an individual viewing pornography in the bedroom or leafing through pornographic magazines in a newsagent. Moreover, the experience of looking at an image in a laboratory without stimulating oneself sexually is bound to differ significantly from using the same image to achieve orgasm. Such a physical and emotional experience is usually central to an individual's use of pornography, but many factors, not least ethical, would prevent the replication of such an experience in the laboratory (Brannigan & Sheldon, 1987).

Research 'findings' have tended to be contradictory and simplistic (see Howitt & Cumberbatch, 1990). Most researchers have accepted that their studies on the effects of pornography cannot be conclusive. Some have retracted or weakened claims of, for example, having 'found' that viewing pornography causes men to be violent. Others have concluded that only pornography which combines violence and sex can be shown to be harmful, and then only in terms of its immediate effects in a laboratory (e.g. Donnerstein *et al*., 1987; Zillmann, 1989).

Pornography and its effects have been a central concern of different varieties of feminism. Intense contention between feminists about matters such as censorship, the porn industry, and whether pornography has harmful or positive effects, demonstrates the wide divergence of views on the subject. Anti-pornography feminists have carried out experimental studies that focus on women's experiences and attitudes to porn (e.g. Cowan *et al*., 1989; Senn, 1993), and have published testimonies from women who have claimed to suffer harm from working in the industry or viewing pornography (Russell, 1993). Conversely, anti-censorship feminists have published testimonies of women who claim to derive positive benefit from these activities (Matrix, 1996), but no experimental research has been undertaken in this area.

The combination of inadequate definitions, the inadequacies of decontextualised experimental research and the biases of researchers limit the terms of the debate surrounding porn. Such problems are further exacerbated by the neglect of sociocultural and historical factors that inevitably influence how pornography is viewed, defined, produced and distributed. The social construction of sexuality and the way individuals think of their bodies are complex matters. We cannot know, for instance, what effects the widely available, sexually explicit media representations have on individuals, and how they view and treat their bodies as a result. Researchers rarely consider the extent to which individuals analyse and critically respond to pornography, and how it may shape the way they view their bodies and their sexuality. Porn-users' personal histories, the context of pornography use, and the fantasies involved in porn-viewing, are all areas that have been largely ignored by experimental psychological researchers.

Sexuality research and qualitative methods

Outside the discipline of psychology, sex researchers (e.g. sociologists John Gagnon and William Simon) have long been questioning the idea that sexual behaviour can be measured in the laboratory, and have recognised the importance of considering the context rather than focusing on biological aspects. A report produced in the US by the Sexuality Research Assessment Project advocated the greater use of qualitative methods for examining the experiential and subjective aspects of sexuality, and for illuminating the social

and cultural context that informs this experience (Di Mauro, 1995). Since the 1980s psychologists (in particular feminist psychologists) have increasingly employed qualitative methods to carry out research, concerning themselves with individuals' sexuality and acknowledging the importance of context and sociocultural factors (e.g. Hollway, 1994; Kitzinger, 1995). Feminist researchers have also been responsible for theoretical and methodological developments of qualitative research. They have recognised the importance of taking into account the subjectivity of the interviewer and interviewee, and taking serious account of the way individuals describe their life experiences (e.g. Harding, 1987; Henwood *et al*., 1998).

Various qualitative methods have been used to collect data on a wide range of issues relating to sexuality. Some psychologists advocate using focus groups, which enable participants to discuss their sexual experiences more freely in their own words, and allow for the discussion of unanticipated issues (Frith, 2000). Other researchers have advocated in-depth one-to-one interviews as an effective means of gathering data on sensitive topics (Oakley, 1981). Computer-assisted self-interviewing has been used as a means to encourage participants to disclose information of a personal nature (e.g. Turner *et al*., 1997).

However, experimentalists criticise research on personal narratives as being merely anecdotal and not generalisable (Donnerstein *et al*., 1987). Qualitative researchers, alert to the flaws of positivist techniques, are nonetheless prepared to highlight weaknesses in their own research. Burman and Parker (1993) have listed objections that include issues of power and control over other people's words, the difficulties of identifying when there are different discourses operating or when contexts alter meaning, the difficulties of carrying out and demonstrating sufficiently rigorous data analysis, and a concentration on language that can result in the neglect of the material basis of oppression. Much pornography is still produced by economically powerful organisations, and most visual porn continues to show the bodily functions and fluids of real people. Social constructionist researchers who use qualitative methods risk neglecting economic and material realities, including such complex issues as the way emotion may be incorporated within the body (Plummer, 2000). Qualitative researchers have the difficult task of incorporating material aspects in a meaningful way within their research.

Porn in social constructionist research

While there has been relatively little qualitative or social constructionist research on porn consumption, some criminologically oriented studies have focused on the use of pornography by convicted sex offenders. Interviews with offenders in clinical and prison settings have suggested that pornography may be a factor in their sexually abusive acts – but as with experimental research, it is not possible to be definitive about cause and effect. In fact, sexual deviance is usually reported to have developed earlier than exposure to pornography, and offenders may actually have had less experience of pornography in adolescence than non-offenders. Such offenders invariably report having been abused as children, and believe that this experience has played an important role in their own abuse of others (see Howitt & Cumberbatch, 1990, for an overview).

Apart from studies of convicted offenders, a few more general qualitative studies of male porn-consumers have been carried out. Simon Hardy's (1998) UK study included a textual analysis of mainstream soft-core pornography magazines, and interviews with 24 heterosexual men about their consumption of such material. Hardy argued that the way participants interpreted and responded to pornography was mediated by individual meanings. He also reported some common threads: most said that their partners disapproved of, or were indifferent to, their porn use; and those with disapproving partners either stopped viewing pornography or hid it from their partners. This research suggested that the use of pornography, rather than simply making men more aggressive towards female partners, may create problems with intimacy in such relationships.

Some qualitative studies of women's experiences of sexual violence have included the question of porn use, and suggested that women's negative experiences of sex are sometimes connected with pornography (e.g. Kelly, 1989; Russell, 1992; Silbert & Pines, 1984). A small number of qualitative studies have taken a more specific focus on women's views about pornography (e.g. Boynton, 1999; Cowan *et al*., 1989) and on women's accounts of their experiences of pornography (Ciclitira, 1998; Senn, 1993). Pornography and pornographic texts have also been subjected to analysis by academics from political, legal, psychoanalytical and ethnographic viewpoints (e.g. Dworkin, 1994; Kipnis, 1999; Williams, 1991).

In response to the limited psychological qualitative research on women and pornography, my research (Ciclitira, 1998) has considered historical, sociocultural, and political factors underlying the production, consumption and interpretation of different pornographic texts. Pornography was not predefined: participants were asked for their own definitions of what constitutes pornography. In interviews with 34 women (four self-described as lesbian, six as bisexual, and 24 as heterosexual) topics addressed included women's earliest experiences of viewing pornography, their current porn viewing and reading habits, their views on censorship, and their views on the effects of pornography and media on their self-image and body images, sexual fantasies and behaviour.

The interviews were designed to encourage women to talk about pornography freely. The sample included

women who regularly consume pornography, as well as some strongly opposed to its production and consumption. These women's accounts (unlike much of the theory) showed how women's views, experiences and feelings about pornography are variegated, individual and complex. The study explored how pornography is seen as a factor in the social construction of women's sexuality and the way they view their bodies. For example, more than half of the participants claimed that viewing porn had affected their sexual behaviour, fantasies, and how they felt about their bodies. It also showed that pornography can serve to increase as well as to limit options for women's sexuality.

Conclusions

Interpreting the multifaceted meanings of pornography from pornographic texts and interview data cannot be an exact science, but sexually explicit images, written texts and interview data can be analysed to uncover ideological assumptions and cultural conventions. Language and discourse, often the focus of qualitative research, are powerful tools for constituting human subjectivity. It is primarily through language that power and social control are exercised, language being constitutive of social identities, social relations, and systems of knowledge and belief (Fairclough, 1995). Researchers must accept that meanings and language are fluid, and that there is no direct correspondence between language and practice. Qualitative research also demands that researchers be aware and make explicit their own status and subjective inclinations.

It seems highly unlikely that psychologists will ever be able to measure the exact 'effects' of viewing pornography, or that they will be able to generalise these 'effects' from research participants to the general population. However, it is possible to carry out informative research that is based on broader concepts than measurement and prediction. Rather than dismiss qualitative methods as unscientific, researchers should, while remaining alert to their drawbacks, continue to use and develop such methods to research topics such as human sexual behaviour.

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Public health and the gendered body

CATHERINE SWANN *examines the contribution that psychology can make to public health theory and practice.*

LIKE other areas of the discipline, the study of health psychology has undergone a quiet revolution in recent years. The crisis in social psychology (Parker, 1989) and the postmodern challenge to scientific orthodoxy have profound implications for how we think about health and illness. Instead of viewing health and illness as naturally occurring biological events, the 'turn to language' instigated by social psychologists allows us to examine how these things gain their sense of being real through shared cultural and social understandings (Stainton-Rogers, 1996).

A number of critical strands have developed in health, social and gender psychology, including one that can be broadly labelled *constructionist*. The collection of approaches that cluster under this heading all take issue with the way in which 'the body' and 'reality' are constructed within Western culture as quantifiable, material givens, their existence distinct from, and largely unaffected by, social and historical context. Helen Malson, for example, adopts a post-structuralist approach to examine the different discourses that constitute anorexia and the 'thin woman' in Western culture (Malson, 1998). Constructionist approaches are being usefully adopted across the spectrum of health psychology, including experiences of cosmetic surgery (e.g. Davis, 1996), vertigo (Yardley, 1999), and sexual health (Breheny, 2001).

Constructionist research has the potential to make a considerable contribution to work on health; for example, by allowing us to examine the significance of gender on the experience of health and illness, making health and health care a more democratic process, or by giving underrepresented and minority groups a voice through standpoint and qualitative methodology (see, for example, Swann, 1997). But putting this research into practice and using it to inform the development of policy and the way in which we practise health is not clear-cut or straightforward.

In this article I draw on constructionist theory to examine the way in which

'Constructionist approaches are being usefully adopted across the spectrum of health psychology'

'bodies' and 'gender' are constituted in public health policy. I consider the implications of this approach for work directed towards reducing gender inequalities in health, given the tensions that exist between constructionist accounts and the lived experience of health. I intend to bring strands from a number of different debates together, and perhaps to play devil's advocate against notions of the centrality of the body to the way we think about health. I conclude by reviewing some emerging areas of research in public health that suggest potential for a new psychology of public health and opportunities for health psychology to engage more visibly and effectively with health policy.

Public health

It might be helpful to begin by placing health psychology in the context of public health. A more comprehensive definition of what constitutes public health was provided by the report of the Committee of Inquiry into the Future Development of the Public Health Function (1988), which preceded a major reorganisation of the National Health Service in 1989. The report describes public health as:

> *…efforts to preserve health by minimising and where possible removing injurious environmental, social and behavioural influences, but also the provision of effective and efficient services to restore the sick to health, and where this is impracticable to reduce to a minimum suffering, disability and dependence. Such an all-embracing concept…could be deemed to include not only the provision of clinical and related services such as dentistry, pharmacy etc but also questions relating to the economic and social origins of health.* (p.6)

These days, the public health workforce under this broad definition spans a wide range of public services, including local authorities, health authorities and the NHS, central government and policy units, the voluntary sector and beyond. Equally, whilst there are public health consultants and non-clinical public health specialists situated within the NHS, public health is by the above definition a multidisciplinary endeavour, embracing (amongst other things) medical practice, epidemiology, sociology, psychology, environmental health, social policy and health promotion. Public health specialists, whatever their discipline, will be concerned with the monitoring of health and illness, the development of health-improving policies and interventions with programmes evaluating their effectiveness, and with carrying out research to improve understanding of the broader determinants of health.

In 1992, after consultation with the workforce, the Conservative government

published the first public health strategy, *The Health of the Nation* (Department of Health, 1992). This reviewed the state of the health of the public in England and set targets for health improvement in a wide range of disease areas, providing for the first time a national framework upon which practice could focus.

The Health of the Nation was superseded by Labour's *Saving Lives: Our Healthier Nation* (Department of Health, 1999), the current public health strategy for England. This strategy located health in the context of a far broader range of influences, setting targets for disease reduction, and identifying roles to be played by the different agencies and institutions involved in public health.

***Health of the Nation* assumed that health or illness exists independently of cultural context and structure and sought to change individual behaviour such as eating**

Gender and health

I join this debate as a public health psychologist with a particular interest in gender and health inequalities. There are good reasons for my interest: gender differences in health outcomes are repeatedly observed across developed countries. Traditionally, feminist analyses have focused on the overrepresentation of women in morbidity statistics, on the exclusion of women from medical practice and research, and on gender-specific health issues such as pregnancy and menstruation. More recent mainstream work has examined how gender affects health in the case both of women and men.

The highly influential Acheson Report (Acheson, 1998) focused on biologically based inequalities in health between men and women (e.g. prostate cancer and childbirth), differences in health probably unrelated to biology (e.g. the overrepresentation of young men in suicide and accidental death statistics), and between-sex variations in wider aspects of health such as mental and social health. Mortality, whether from coronary heart disease, accidents or suicide, was found to be higher for men than women across all age groups.

Blanket statistics regarding women's morbidity were found, on closer examination, to conceal more complex differences in health between the sexes. For example, there are slightly higher levels of long-standing illness in male children, and young boys are 30 to 40 per cent more likely to have consulted a general practitioner for serious medical conditions. Women have higher morbidity from mental health problems, and higher levels of disability (Acheson, 1998; Department of Health, 1996). Additionally, mortality and morbidity statistics tend to be weighted against lower socio-economic groups, making the less well-off more vulnerable to ill health regardless of their sex. However, little if any attention is paid to the distinction between sex differences (those related to biological sexual characteristics) and gender differences (those that may be said to be caused or influenced by broader cultural and social aspects of biological sex – culture-bound, learned characteristics as opposed to 'innate' ones), and there is still much work to be done in this area for women and men.

Worldwide, inequalities are more pronounced. Of the 1.2 billion people living in poverty, 70 per cent are female; there are twice as many women as men in the world's 900 million illiterates. Iron deficiency anaemia and protein-energy malnutrition are significantly higher in women than men (making them especially vulnerable to communicable diseases); and half a million women die every year from pregnancy-related complications (WHO, 2000). If there were to be 23 fatal air accidents involving jumbo jets across the world in a single week there would be a public outcry. However this equates to the weekly number of female deaths from pregnancy and birth, the majority of which could be prevented.

At the same time, these statistics mask cross-cultural differences in gender constructions that affect health behaviours. In some parts of the world, social roles and cultural norms prohibit women from seeking health care; whereas in others, cultural constructions of masculinity position health-seeking behaviour as 'women's work', making men less likely to seek treatment (Cameron & Bernades, 1998; WHO, 2000). A deeper understanding of cultural and social aspects of gender and health behaviours is needed to address these issues, internationally as well as within the UK.

Reading the body in public health policy

Public health policy and national public health strategies such as the *Health of the Nation* and *Saving Lives: Our Healthier Nation* have powerful and direct effects on both individual and community experiences of health. They dictate who 'practises' public health, on or with whom it is 'practised', whose health needs improving, and how it might best be improved.

In his analysis of 'governmentality', Foucault (1991) suggested that the body as a cultural construct was invented at the beginning of the 18th century, as health, illness, birth and death began to be recognised as powerful political and economic forces. The constructionist perspective denies that there is one 'reality' to which we all subscribe, and looks instead to break down the elements of culturally specific ideas. Bodies become objects of political control and surfaces on which power operates, being, as it is, interested in the distribution and control of resources (Gastaldo, 1997). Discourses of risk and moral danger are the means by which behaviours and bodies are constrained. The way we talk about and represent public health issues, or attempt to

influence and constrain behaviours – for example, public health campaigns and surveys – are the principal methods by which such discourses of moral danger or risk are conveyed and validated (Williams & Bendelow, 1998).

Transforming bodies

Policy and practice stemming from the 1992 *Health of the Nation* strategy was most often aimed at changing individual behaviours, a 'personal hygiene' approach to health (see Williams & Bendelow 1998), that divorces the individual body from its social and physical environment. In other words, it assumes that health or illness exists independently of cultural context and structure. Health education was proposed as the key to changing behaviours that placed bodies at risk, such as smoking, drug use or risky sexual activities, since a simple causal relationship between knowledge and behaviour was assumed (for a more detailed argument, see Lupton, 1995). Within this model of health, health behaviours are assumed to be prompted by knowledge (and perhaps other factors such as self-efficacy or personality type), meaning that in effect the body is positioned as being separate, and at risk, from the self (Ogden, 1995). Little attention is paid to other contextual factors that may affect health.

Likewise, much of health psychology since its inception in the mid-1970s has been concerned with the construction and testing of models of individual health behaviour, elaborating on the body/mind divide, and overemphasising the role that personal behaviour plays in determining health (Marks, 1996). A public health psychologist operating within these assumptions would be concerned with refining the variables in models of health behaviour in order to predict health outcomes. This 'splitting' or dualism between mind and body reflects widespread cultural assumptions – Descartes articulated the pervasive body/mind dualism by asserting 'I think, therefore I am' an equation now firmly embedded in our conceptual repertoire.

Critical approaches within social and feminist psychology have tended to take issue with these assumptions, arguing that the material givens of things like the body, health, or gender are in fact, socially constituted – experienced and understood through a complex system of sociocultural concepts, representations and constructions. Additionally, as can be seen in the other contributions to this special issue, bodies are gendered – fixed within the confines of beliefs and representations about men and women in our culture.

The last decade of the 20th century saw a significant shift in the way that the body was written into public health policy. *Saving Lives* marks the embrace of a 'new public health paradigm' in England, shifting the focus of public health activity away from individuals' behaviours, and looking instead at broader determinants of health: socio-economic, cultural and environmental conditions, living and working conditions, social and community influences, lifestyle factors, and biological givens such as age and heredity.

From a constructionist perspective, the body is no longer simply at risk from the self, as risk and danger are potentially everywhere (Williams & Bendelow, 1998). Indeed, the body is no longer the central object of public health discourse. Constructs of community, groups and networks are gradually edging towards the centre stage of public health action. The focus of analysis for public health interventions has shifted from the individual to the community, dissolving the boundaries of individual bodies and writing into existence populations and groups that did not previously hold a priority status in English health care. This growing concern with inequalities in health (see Acheson, 1998) serves to emphasise that although risk is all around us, not every body is equally vulnerable.

'The lived experiences of reproduction, illness and corporeality cannot easily be dismissed as social constructions'

The challenge for a new psychology of public health

One of the first challenges for a new psychology of public health (and perhaps for the broader discipline of psychology) lies in identifying a method of putting constructionist analyses of gender and the body into practice. These analyses have been fruitful for the development of new ways of understanding the body, health and gender and for fostering a number of energetic debates, new methodologies and theories.

Although constructionist arguments have provided us with new insights and given underrepresented or vulnerable groups a much-needed voice in research and theory, they do not easily lend themselves to interventions or practice (Ussher, 1992). What we experience as our health, our gender, and our bodies, exists on an interface between social and material realms – the lived experiences of reproduction, illness and corporeality cannot easily be dismissed as social constructions.

On the other hand, can we expect constructionist approaches to provide the whole answer? I would argue that practitioners must by necessity inhabit a theoretical middle-ground, between the critical and the pragmatic. Constructionist approaches allow us to ask new questions and reframe the answers to old ones.

For example, the importance currently ascribed to reducing health inequalities, and the vulnerability of particular groups and populations to ill health, might lead us to assume that the gendered nature of bodies is no longer problematic, since we are more concerned with communities of people (e.g. those in the lower socio-economic groups, members of black and minority ethnic groups, men, women or the elderly). Sex, and to an extent the relative cultural and social indicators of biological status contained within gender, is so visible that we might often be tempted not to look too critically at the way in which these categories are constituted.

However, on closer examination it could be argued that the structures, communities and contexts that are the focus or objects of the new public health are themselves gendered. The 1998 Acheson Report asserts:

> *Women's different positions in the labour market and in the home means that they live more home-based and community-based lives, where they provide for the health needs of vulnerable groups, including children and adults with long term needs for care.* (Acheson, 1998, p.105)

The family and community structures described are not naturally this way for women; instead, they reflect the social, psychological and economic barriers that exist to equitable parenting and caring arrangements. To interrogate and work towards reducing gender inequalities in health, we need to question the structures and processes as much as the 'bodies' and health outcomes themselves. There can be little doubt that the gender roles within these structures contribute to the mortality

and morbidity statistics cited earlier. The real question is, how do they act?

The increased familiarity of civil servants and public policy makers with the term *gender* should not necessarily be cause for comfort. *Gender* seems to be increasingly used as a categorical substitute for *sex*, or as a way of acknowledging the possible cultural impact of sex without having to critically theorise it. This rather casual use may have the effect of de-politicising the term and weakening the argument for new approaches to public health.

Another emerging area of work in need of careful scrutiny is that of social capital – the notional commodity of community engagement and cohesion. Trust and engagement have been proposed as factors that distinguish a less healthy population or group from a healthy one (see, for example, Putnam, 1993). Recent exploratory research suggests that discourses of gender, and the positions open within them for men and women to inhabit, can act as significant barriers to male participation in certain types of networks and community structures that are thought to produce social capital and promote health (Campbell *et al*., 1999). For example, new research (Sixsmith, *et al*., 2001) with socially deprived communities suggests that individual health experiences can be highly gendered, with health constructed in terms of hegemonic masculinities for men, and care-taking and parenting roles for women. Here, men tended to ignore their health in order to avoid appearing 'weak', whereas women tended to be positioned as health 'experts' and care-takers. Men from these communities were less likely to utilise support networks that could benefit their health, and less likely to self-monitor or actively care-take themselves.

These more collective levels of analysis – of families, communities and cultures – are still virtually unexplored by health psychology (Marks, 1996). The potential impact of social, psychological and community factors on health is considerable, and areas of work such as social capital represent a key opportunity for feminists and health psychologists to contribute. The notion that good health may be fostered through social support, reciprocity and engagement, rather than just biomedical interventions or social policy, has interesting possibilities for a new psychology of public health that could address issues of the body, gender and the lived experience of health or illness.

Areas of work might include further interrogation of the concept of community, and ways in which gender and psychological factors intersect with it; examination of the relationship between social capital, social support and health; and the development of new, participatory methodologies and interventions to promote social support and health. By learning from constructionist approaches to the body and individual health, and applying this critical gaze to broader cultural groupings, we can make our contribution to the new public health agenda in the UK, and also in the global arena.

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NB: The views expressed in this article are those of the author and not necessarily those of the agency for which she works.

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