

Material discourses of health and illness

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Discourses of pregnancy and childbirth

Anne Woollett and Harriette Marshall

INTRODUCTION

In this chapter we examine critically discourses of pregnancy and childbirth, drawing on two main sources of accounts. The first comprises booklets distributed to pregnant women at antenatal clinics and which hence have an official status. These were *The Baby Book* (1988) whose editors and advisors identify themselves as medical practitioners and *The Pregnancy Book* (1984) published by Health Education Council, which draws on the research of social scientists as well as medical practitioners. The other major source of accounts comprises interviews about their pregnancy and childbirth with women from a variety of social and cultural backgrounds living in the UK. They included Asian women who participated in a study of parenting in a multi-ethnic community, described more fully in Woollett and Dosanjh-Matwala (1990) and Woollett et al. (1995) and with white women interviewed as part of a study of the expectations and experiences of women expecting twins (Woollett and Clegg 1989). Asian women were interviewed by an Asian psychologist and the interviews were conducted in the women's preferred language. All were tape-recorded, and then transcribed and translated if necessary. Extracts from the booklets and the interviews are used to illustrate the analysis.

These sources are analysed using social constructivist and discursive approaches to identify general themes, differences and contradictions as well as omissions in accounts (Potter and Wetherell 1987; Banister et al. 1994). Two major discourses are identified: medical/biological discourses which are drawn on in the booklets addressed to women and in the accounts of women themselves, and psychological discourses which position women's embodied experiences of pregnancy and childbirth within the experiences of individual women, the meanings of pregnancy, and women's relations with partners.

Biological-medical accounts draw on a variety of interrelated discourses such as 'monitoring health/normality', 'detection of abnormality' and 'medical intervention' with the expressed purpose of delivering 'healthy' babies.

In doing so, pregnancy and childbirth are presented as both 'natural' and 'normal' biological and physiological events, and as 'illness' requiring medical management and intervention. Psychological accounts draw on a variety of discourses which position in terms of women's identities, lives and development. Biological-medical and psychological accounts, and the discourses on which they draw, are contrasted with the accounts of feminists and researchers taking the perspective of women, and those of consumer groups such as the National Childbirth Trust (NCT). These position pregnancy and childbirth as embodied experience with social and cultural significance, and resist the regulation of women's readings of their childbearing bodies. Lastly we draw on diverse discourses to examine the ways in which nausea and sickness are constructed.

BIOLOGICAL-MEDICAL DISCOURSES

Monitoring normality/health

The predominant discourses of pregnancy and childbirth position them as biological and medical events. This incorporates a variety of different and, at times, contradictory accounts. One account views pregnancy as a 'normal/healthy state' and antenatal care as monitoring 'normality/health'. Bodily changes in pregnancy and childbirth are taken as being part of a 'normal' unfolding of a physical process which is marked by physiological changes such as the cessation of menstruation, nausea and sickness, increases in women's weight and size, and the movement of the fetus. This account is employed in *The Pregnancy Book* (1984), which starts by delineating women's 'sexual organs' and the process of conception and physiological changes in pregnancy, using drawings of a diagrammatic, disembodied mother and baby (pp. 2-6, 9-12). Pregnancy and childbirth are taken to be essentially 'healthy' and antenatal care is portrayed as monitoring progress, as in the following extract (p. 27):

Throughout your pregnancy you will have regular check ups. . . . This is to make sure that both you and the baby are fit and well, to check the baby is developing properly. . . . These check ups also give you a chance to get answers to the questions and worries that are bound to crop up at different stages of your pregnancy.

As this extract illustrates, the emphasis is on 'checking' with medical procedures constructed as essentially facilitatory, providing health professionals with the information to be sure that everything is going 'well' and to address women's questions and concerns. Women draw on this account of monitoring normality/health, as in the following extracts from interviews with Asian women expecting their first child:

Interviewee . . . All they did was to check your weight, take blood samples, check your tummy, check your blood pressure. Mostly they used to check my weight because I didn't put on too much weight. . . . They were worried about why I wasn't putting on weight so I had to have a lot of scans to see if the baby was normal.

Interviewer What were the hospital visits for?

Interviewee To have everything checked, to see if everything's alright. Well blood test and they checked the baby with that machine to hear the heart beat. And scans. I had a urine test every time.

However, many women find that their antenatal care does not deliver knowledge or reassurance and it is difficult to obtain the results of tests, as in the following extracts from two Asian women:

Interviewer What were the tests for?

Interviewee Don't know why we had the tests. I never asked for the results. There probably wasn't anything wrong with me so they didn't tell me. They don't give you the results of the tests unless there is anything wrong: you have to ask. They could be a bit more helpful. They could tell you rather than wait for you to ask because some Asians there they don't know how to speak and they won't push for anything.

Women recite off lists of tests, but as in these extracts, there was often little engagement with the process and little detailed knowledge of what the results might signify, as Reid (1990) reported. While some women complained that they wanted more information and argued that women need to be assertive, others left things to the medical professionals, assuming they would be told if something was wrong.

Regulating normality

A closer examination of accounts of antenatal care suggests that tests are used not only to 'monitor normality', but have a more regulatory role. They would seem to be used normatively, to make comparisons with what are considered biological and physiological 'norms' about pregnancy and childbirth. Taking as an example women's weight gain, the booklets provided for pregnant women in some respects present a relaxed line on this. For example, *The Pregnancy Book* (p. 40) gives information about average weight gain, which suggests 'normal' variability rather than a set of norms:

An average total weight gain in pregnancy is 22–28 lbs, or 10–12.5 kg. But weight gain varies a lot from woman to woman. It is not usually anything to worry about, but if you are concerned, talk to your doctor or midwife.

However, this relaxed presentation is undermined by using women's weight gain as an indicator of 'normality', with greater or lesser weight gain given as a reason for doing further tests, as in the case of the woman in an earlier extract who was given a scan because she was not gaining 'sufficient weight'. Another woman reports that it was discovered she was pregnant with twins after she was sent for a scan 'because I was too large for dates'. This implies that weights are being compared with a 'norm', in spite of any lack of evidence about the universal appropriateness of such norms or their predictive value (Oakley 1979; Reid 1990; Raphael-Leff 1991; Phoenix 1990).

Comparing women against a set of 'norms' implies that there is a right way in pregnancy, and contradicts statements about all pregnancies being different and there being no rules. Women draw on biological-medical discourses in their accounts of bodily changes and increasing weight in the later months of pregnancy, as Wolkind and Zajicek (1980) report, and as in the following extracts from interviews:

The pregnancy was fine, my health was OK, but I had put on too much weight.

I got a lot heavier. I used to get tired a lot, even when sweeping a room.

However, closer examination suggests that women's accounts position weight gain largely in terms of their identities and sense of themselves and its impact on their lives. Weight gain and bodily size were often discussed in terms of women's ability to do everyday things such as getting to sleep, look after older children and fulfil their domestic roles, as in the following extract:

I think because it was my second and I had him [first child], he was about one and half, it was difficult to attend to him, like give him a bath, especially in the later months. Sometimes I had trouble feeding him. I used to feel really tired by the end of the day, and it was difficult to bend over and give him a bath.

Some of the women expecting twins discussed the ways in which the weight of two babies could accentuate other problems, as in the following extract:

I feel uncomfortable. And when I'm in the bath, and things like that. I can't get out. And getting up from lying down is awkward. I wasn't very happy at all with my figure at the beginning. I really saw myself as being maternal, the mothering figure. When I started changing shape and everything I really didn't like it at all.

In this extract, the woman expresses dissatisfaction with her 'mothering figure'. Wolkind and Zajicek (1980) also found that women disliked their pregnant shapes, even when they were pleased to be pregnant. The booklets provided at the antenatal clinic emphasise the importance of eating well in

pregnancy, but do not address women's embodied experiences as they get larger and fatter, even though these are issues of major concern to women (Wiles 1994).

Health and illness

Within biological-medical accounts, pregnancy and childbirth are constructed as both 'health' and 'illness'. While acknowledging their 'normality' and 'naturalness', pregnancy and childbirth are treated and managed as potentially problematic, and hence as 'illness'. 'Normality' and 'health' come to be defined only in retrospect (Hewison 1993). The booklets provided for pregnant women have sections labelled 'problems' which range from 'normal/healthy' symptoms such as morning sickness and tiredness to more medically significant problems such as swollen ankles and pre-eclampsia. The potentially problematic nature of childbirth is used to argue for the benefits of hospital delivery:

The advantage of a hospital birth is that both expertise and equipment are on hand in case they are needed. If something goes wrong during labour (and no-one can be 100 per cent sure that it won't) then you don't have to be moved. A Caesarean delivery, for example, can be done on the spot if need be. In the same way, if there is anything wrong with the baby when it is born, hospital facilities can be life saving. The baby can be cared for immediately without vital time being lost in a journey to hospital.

(*The Pregnancy Book* 1984: 19)

While the risks of 'normal delivery' are emphasised, those associated with medicalised childbirth are either not discussed or are presented in terms of 'disadvantages' rather than risks, as in the case of epidurals:

Also since you can no longer feel your contractions, the midwife has to tell you when to push rather than you doing it naturally. This means it can take longer to push the baby out.

(*ibid.*: 50)

Feminist researchers and consumer groups such as the National Childbirth Trust are critical of the ways in which pregnancy and childbirth are constructed and managed as if they were illnesses – that is, being largely hospital-based and with the routine use of drugs and surgical procedures (Stoppard 1995; Oakley 1979; Kitzinger 1990). They are also critical of the depersonalisation of pregnant and birthing women, as 'bodies' or 'reproductive systems', arguing that this is used to justify medical views of women's passivity and their exclusion from decision-making processes (Oakley 1980; Hewison 1993).

This tension between pregnancy and childbirth as 'illness' and 'health',

and ideological struggles between biological-medical discourses and those of feminist and consumer groups over the nature and management of pregnancy and childbirth, are also found in women's accounts. Women distinguish between aspects of pregnancy which they see as needing to be medically managed and 'normal/healthy' symptoms of a pregnant body. In the following interview, a woman expecting twins makes a clear distinction between a medical account and her own account of pregnancy:

Interviewer How do you think your pregnancy went?

Interviewee It depends. If you take it clinically, medically, it was wonderful. Otherwise it was bloody awful. I complained every day about it. Because I was so well with [first child] I didn't know one could be so ill when one is pregnant. I just didn't expect it. I was sick for the first 4 months, then I had pain in the ribs . . . I couldn't eat and couldn't walk. I couldn't sleep in the end. I just couldn't enjoy myself at all. Clinically it was OK: I didn't have to go into hospital, and I didn't have high blood pressure, swollen ankles, anaemia, what else didn't I have. . . . But I felt awful.

Women are committed to childbirth as 'normal' and 'natural' but also to the delivery of 'safe and healthy' babies and hence to medical intervention if and/or when things 'go wrong'. In many respects they express themselves in language similar to that used in the booklets provided at antenatal clinics, as in the following extract from a woman hospitalised prior to the birth of her twins:

I feel I am happy here [in hospital], because if anything goes wrong, I'm here. At home there's no-one. They are at school, and my husband's out at work, and I'm frightened that they'll come so quick there will be no one to help me.

The tensions between childbirth as 'health' and 'illness' can also be seen in accounts of pain and its management. Accounts which position childbirth as 'natural/healthy', construct pain as a 'normal' accompaniment to a 'natural' function whose outcome is welcomed, rather than as signal of 'illness' which needs to be managed by means of medical intervention, such as anaesthesia. While pain is unpleasant, the avoidance of pain is not the main objective for many women, especially those who are more informed, who have non-medical strategies for coping with pain or who express a desire not to 'miss out on' the experience of childbirth (Green et al. 1990), as in the following extract from a woman expecting twins:

The only picture I get [about delivery] is that I want to have a natural birth, and not a Caesarean. I want to see everything and I don't want to be knocked out and then wake up half an hour later.

In contrast other women constructed pain as interfering with their own and their partner's enjoyment of childbirth and expected doctors to provide pain relief for childbirth as they would for 'other illnesses' (Green et al. 1990; Woollett et al. 1983):

I wanted assurance that they weren't going to let me suffer. I don't want to suffer more than I have to. . . . They give pain killers when they decide you are in too much pain, not when you decide you are in too much pain. . . . What worries me about childbirth is that I don't like to give up control of my body to someone else, and the minute you go into hospital that's what you do.

As the woman in this extract argues, agreeing to pain relief means that women's control over their deliveries is given over to medical professionals. Not losing control is an issue for some women and first-time mothers are somewhat less likely to report having felt in control than mothers having subsequent children (Green et al. 1990). But control operates in complex ways and it is often not easy for women to reach decisions with which they are comfortable, as in the following extract from an interview with an Asian woman:

I couldn't speak English so they called a woman to explain that I had to give birth. I was very frightened at first, my husband was at work and I wanted them to wait for him. The woman [interpreter] said it might be too late by then and she wasn't sure whether she was going to be available later on. The doctors said they weren't forcing me to give birth and it was my decision. But then I thought in my heart that if I said no I might cause a problem for the baby and myself. So I said they should do whatever their hearts tell them to do.

Detection of abnormality and medical intervention

The rationale for 'monitoring normality/health' in pregnancy and childbirth is to detect abnormality and to intervene medically to ensure the delivery of 'healthy babies', as argued in *The Pregnancy Book* (p. 31):

Just having your blood pressure checked, though it only takes two minutes, would be worth going – and waiting – for, because like the other checks done at the clinic, it tells you that your pregnancy is going well. If it shows that all is *not* [their emphasis] well, then something can be done about it straightaway.

Biological–medical accounts assume that medical intervention is of benefit for mothers and babies, even though the scientific evidence for such benefits is sometimes lacking (Schwarz 1990), as is recognised in a recent Department of Health report (1993: 9):

It has to be acknowledged that some of the interventions of recent years, for example fetal heart monitoring, have gained acceptance because of the assumption that they would increase the likelihood of a safe outcome. It is important that benefits are proven rather than assumed.

Moreover, the medical interventions available are limited: in pregnancy medical management often does not go beyond monitoring (albeit by means of some highly sophisticated techniques). Interventions such as bed rest are often hard to distinguish from medically disparaged 'old wives' tales', and those based on scientific knowledge (e.g. thalidomide and DES) have not always been demonstrated to be either safe or effective (Raphael-Leff 1991; Garcia et al. 1990).

With childbirth, there are more treatments and interventions available. These include drugs and procedures such as episiotomies and caesarean sections to induce or accelerate labour and delivery, and ways of relieving pain such as epidurals. Their effectiveness and longer-term impacts are sometimes questioned by professionals and others who point to negative outcomes, as medical procedures developed to solve one problem can generate others which require further medical intervention. So, for example, forceps delivery are more common following epidurals, and postnatal discomfort and infections following episiotomies and caesarean sections (Cartwright 1979; Garcia et al. 1990; Rothman 1989). One woman points to the impact of stitches following an episiotomy:

It was a normal delivery and everything. It was the pain I couldn't stand. I had stitches. They cut you because the head was big. . . . They cut so the head comes out easier. But another ten, fifteen minutes of hard work would save you a lot of trouble afterwards. The stitches are really bad afterwards. Three weeks after you can't walk, you can't get up, it hurts to sit up to breast-feed.

There is recognition of tension between biological–medical accounts and ones which attempt to engage with a broader notion of 'quality of experience' for women. The Department of Health report *Changing Childbirth* (1993: 9) argues that not only do interventions need to be evaluated in terms of traditional measures of risk assessment, but they also have to be set against considerations of the 'quality of experience' for women:

There was strong emphasis on the need to ensure that care was designed around the needs of the individual woman and the choices she might wish to make. . . . Women want healthy babies and also to be healthy themselves after they have given birth. But this incorporates their desire to experience pregnancy, childbirth and the early days of parenthood as positive and fulfilling. . . . However the issue of safety used as an overriding principle, may become an excuse for unnecessary interventions and technological surveillance which detract from the experience of the mother.

This ideological shift in the management of pregnancy and childbirth is paralleled by some changes in the medical management of pregnancy (such as a reduction in the number of recommended antenatal clinic appointments), and postnatally (by the reduction in the time women spend on postnatal wards). These also draw on economic discourses and concerns with cutting costs (e.g. Hundley et al. 1995). However, these reductions in medical management of pregnancy and childbirth have to be set against the increasing use of scans and tests in pregnancy (such as amniocentesis) to monitor the normality of pregnancy and make decisions about interventions.

Taking a passive-patient role

There are a number of psychological consequences for women of the medical management of pregnancy and childbirth. One is that women are assigned to a passive-patient role, drawing on discourses of women as bodies to which pregnancy and childbirth happen (Raphael-Leff 1991) with decisions about delivery made largely by health professionals. However, there is increasing rhetoric about childbearing women as active consumers of maternity services and partners in decision-making. This can be seen in the following extracts:

It is very important for you to feel in control of what is happening to you. So throughout your labour, don't hesitate to ask questions and to ask for whatever you want. You are working *with* [their emphasis] the midwife or doctor, and they with you.

(*The Pregnancy Book* 1984: 49)

The woman must be the focus of maternity care. She should be able to feel that she is in control of what is happening to her and able to make decisions about her care, based on her needs, having discussed matters fully with the professionals involved.

(Department of Health 1993: 8)

Despite increasing reference to 'quality of experience' and to women as 'partners' in the childbearing process, there is still little evidence for substantive changes in biological-medical accounts. These draw on the scientific basis of obstetrics to claim precedence over other accounts and provide health professionals with a powerful rationale for regulating the child-bearing process (Schwarz 1990; Hewison 1993). In addition, they continue to marginalise other accounts through claiming a monopoly over concerns for safety and the health of the mother and child. Individual women (and groups such as the National Childbirth Trust) who question medical interventions are positioned as selfishly putting their own ideology before the 'safe delivery' of the child (Kitzinger 1990; Oakley 1980; Green et al. 1990). These tensions are articulated in *Changing Childbirth*:

Although a good outcome to a pregnancy is desired by the woman, her family, and the professionals who care for her, we found situations where there appears to be a conflict. We heard that some professionals appear to believe that occasionally women seem to care more about their own well-being than they do about the health of their unborn child. Some mothers, on the other hand, described unsympathetic doctors and midwives who used 'safety' as a reason to try to impose arrangements or interventions which the mothers found unhelpful and disturbing.

(Department of Health 1993: 9)

Women do resist the medical management of their pregnancies and deliveries and negative definitions of themselves and their wishes for more woman-centred approaches (Green et al. 1990) by, for example, disclaiming the radical nature of their views in terms such as 'I'm not a nature freak, but . . .' (Griffin 1989). They also resist exclusively biological-medical accounts, as evidenced by their criticisms of practices and decisions which are made without reference to their psychological and social situations. This is illustrated in the following extract from an interview in which a woman resists the advice of health professionals as impractical in her circumstances:

I was told by the doctors to have plenty of bed rest. They wanted to admit me to hospital but I thought when I get there all I'll be doing is lying in bed all day, so why not rest at home and look after the first child too. If I went in, who would have looked after my other child because my husband goes to work? That's why I decided to stay at home and did less work and got bed rest.

However, women are also presented in biological-medical accounts as more active and as having an important role to play in ensuring their own and their babies' health and development – as, for example, in advice to women about what to eat during pregnancy. In the following extract from *The Pregnancy Book* (pp. 13–15), links are made explicitly between what a woman eats or takes into her body and the development of her baby:

A poor diet, some drugs, certain illnesses, smoking, alcohol, these and other things can hold back the baby's development or even cause abnormalities. . . . You need to make sure that from conception onwards you will be providing your baby with all the nutrients needed for healthy development. So eat a *variety* [their emphasis] of foods to get a range of nutrients. The best guide to healthy eating is to keep down the amount of sugar and fat you eat, and to step up the amount of fresh fruit, fresh vegetables and cereals.

Here women seem to be offered a more active role as partners with health professionals in ensuring an optimal outcome for their pregnancies. However, closer examination of the advice indicates the extent to which it

draws on notions of 'good' patients as passive recipients of medical information and is used to regulate women by positioning them primarily as containers of the fetus (Raphael-Leff 1991). This is done through a lack of engagement with women as active decision-makers or with the implications of advice about what women eat. There is, for example, no discussion of the costs of 'healthy' foods, or how women might change their eating habits in the face of resistance to 'healthy' eating from other family members and advertising from the food manufacturers (Charles and Kerr 1988; Worcester 1994).

By concentrating on 'healthy' eating, biological-medical accounts avoid having to engage with evidence about the influences on the health of mothers and babies of factors such as poverty, inadequate housing, and chronic ill-health (not to mention the risks of medical interventions in pregnancy and childbirth). Ignoring the evidence that low birth weight is more common in poorer families individualises its causes, and encourages women to 'blame' themselves if their babies are small or ill (Rocherson 1988; Phoenix 1990; Oakley 1992).

PSYCHOLOGICAL DISCOURSES OF PREGNANCY AND CHILDBIRTH

Until this point our analysis has focused primarily on biological-medical discourses which serve to construct pregnancy and childbirth as a site for monitoring and intervening in the pursuit of the healthy delivery of a baby. It has been argued that women's accounts of their experiences and those of feminist and consumer groups draw on contrasting discourses and point to contradictions and omissions in the biological-medical discourse. These alternative accounts can be characterised as drawing on psychological discourses which position pregnancy and childbirth within the remit and experiences of individual women. They draw on a variety of theoretical positions within psychology (including psychoanalytic and social identity theories) to address women's psychological development, readings of their child-bearing bodies, women's identities as pregnant women and as mothers, and women's lives and relations with others.

Pregnancy is constructed within psychological accounts as an important transitional period and as a key life event as women acquire new identities and move from childlessness to motherhood (Wolkind and Zajicek 1980; Ussher 1989; Phoenix et al. 1991). Women make sense of, and impute meaning to, the bodily changes associated with pregnancy and childbirth. For example, *The Pregnancy Book* draws on psychological and social science discourses to examine women's readings of their pregnant bodies, as in the following extract (p. 22):

From the minute you know you are pregnant, things begin to change.

Your feelings change – feelings about yourself, about the baby, about your future. Your relationships change – with your partner and also with parents and friends. . . . But you are still yourself, and you still have to get on with your life, whether pregnant or not. For this reason adjusting to the changes that pregnancy brings isn't always easy.

Researchers within social science and feminist traditions, drawing on the perspective of women and their readings of their bodies, challenge the body-mind dualism and biological-medical discourses of pregnancy and childbirth as decontextualised bodily events (Oakley 1980; Marck 1994; Woollett et al. 1991; Ussher 1989). In their accounts, women draw on a variety of readings of the body and feelings and ideas about themselves – their desires for their pregnancies, increasing awareness of their bodies, whether pregnancies were wanted and planned, and the implications for their social relationships, as in many of the extracts given earlier, and in the following extract from an interview:

Interviewee It went quite smoothly, I can't complain. I had morning sickness but I coped with it. It was just one of those things you have and you put up with.

Interviewer Any things you did or didn't do because you were pregnant?

Interviewee Just obvious things like not lifting heavy things and not pushing furniture around. Apart from that, no. I was very healthy throughout my pregnancy. But then again, I'm not one of those people who sit back and say 'Oh, I'm pregnant, I shouldn't do this and I shouldn't do that'. I did most of the things I would normally do. I would go dancing and would go out if I had a chance to. I didn't stop eating anything. I carried on working until I was seven-months pregnant. . . . I sometimes used to get depressed.

Interviewer What made you feel like that?

Interviewee At that time my husband and I were drifting apart. Just because of our different way of looking at things. . . . Maybe I wanted more attention from my husband . . . maybe I expected him to give me more attention.

Women's readings of the pregnant body are complex and often contradictory when, for example, their sense of their body-as-pregnant and the psychological reality do not match – such as when they find a wanted pregnancy difficult, as in the extract above, and an unplanned pregnancy enjoyable, as in the following extract:

This pregnancy was totally unexpected. Suddenly one day it started to move. I just cried and cried. It was a shock because I had started work. We couldn't afford another one. It was exciting. I like being pregnant. That doesn't mean I'm going to have more. It's nice being pregnant apart

from the first four months. It's nice and a lovely feeling when the baby moves inside you. I think that's when the excitement starts. It's lovely to feel something inside you and it's yours. You get to know it.

Pregnancy and childbirth impact upon women's psychological development as they come to know themselves through their pregnant bodies and deal with new feelings and emotions, especially those around dependency and independence, autonomy and connection (Raphael-Leff 1991; Smith 1992; Michaels and Goldberg 1988; Ussher 1989). While women may be pleased to be pregnant and anticipate with pleasure their connectedness with, and nurturance of, a dependent child, others are concerned about the loss of independence and autonomy and how they will cope with the constraints and responsibilities of motherhood (Ussher 1989; Woollett et al. 1991; Wolkind and Zajicek 1980), as in the following interview extract:

After we got married my husband and I used to go out and about together a lot, having a good time. If I had become pregnant just after I got married, I wouldn't have been able to have that fun and go out with friends.

Women deal with the emotional and psychological issues around pregnancy and childbirth in diverse ways. While some women discuss pregnancy and childbirth in highly charged emotional terms, others are very matter of fact suggesting that becoming pregnant and motherhood are assumed and expected and do not need elaboration (see Woollett 1996; Woollett et al. 1991). Women's feelings and concerns often change during the course of pregnancy, as their focus moves from getting pregnant, to being pregnant and then to looking ahead to having a baby and becoming a mother (Raphael-Leff 1991; Breen 1989; Marck 1994). Women's feelings and agendas may not coincide with medical timetables for scans and tests. Many women appreciate the information they receive from tests, but others prefer to recognise that they are pregnant at their own pace and to become close to their baby only once they are confident that the pregnancy is established (Raphael-Leff 1991), as is the case in the following extract:

With this one I didn't mentally accept it and couldn't get to know it until near the end. I thought, 'Who is this inside me?' right up until the end. But with the others I loved them while they were inside. It's not that I don't love this one but it took me longer to adjust.

Pregnancy and childbirth as relations

Psychological accounts position the mother-child relationship as the *key* relationship for children and for mothers, which begins in pregnancy (Breen 1989; Marck 1994). Women's accounts draw on psychological and psycho-analytic discourses to examine the development of their relationship with

the baby as a separate and independent being and their construction of the baby's subjectivity (Marck 1994; Everingham 1994). Women begin to think about making space in their lives – as well as in their bodies – for a baby, and what the child growing inside them is like, although their accounts focus largely on the child's gender (Breen 1989; Woollett and Dosanjh-Matwala 1990; Rothman 1989; Marck 1994). For some of the Asian women interviewed the gender of the child they were carrying was of considerable interest, as in the following extract:

It went quite smoothly. It was quite interesting knowing that something is growing inside you and whether it is going to be a girl or a boy. It's all rather nice actually. It was OK and I wasn't worried.

Women's accounts of pregnancy as a relationship often take the baby's movements *in utero* as a signal that the pregnancy and the baby are real. The impact of these movements may be less significant now that ultrasound scanning has become routine. Scans provide women with a visual impression of their baby and may encourage women to begin to relate to their babies (Raphael-Leff 1991; Reid 1990), as in the following extracts from interviews:

When I first found out I was pregnant I just cried because I thought it happened too soon, but when I had my first scan I was really happy. After that I felt good and enjoyed it because you start to develop a bond with the baby. So that was exciting.

When I had my first scan the man explained everything, like this is his leg, this is his foot, little hands, little head. I couldn't see his other leg and asked 'Where's his other leg then?' Then they pushed him round and showed me his other leg. It was quite nice. That's when you realise you are having a baby, when you actually see it on the scan.

However, in the following extract from *The Pregnancy Book* (pp. 29–30), while the emotional and psychological salience of scans are recognised, the main focus is on the information they provide and their value as part of the process of 'monitoring normality' of the unborn baby:

It can be very exciting to see a picture of your own baby before birth – often moving about inside your womb . . . an ultrasound scan can give a fairly accurate idea of the baby's age . . . can show the position of the baby and the placenta so both can be checked.

Fathers, pregnancy and childbirth

The birth of a child creates new relationships and requires women to renegotiate current relationships and, especially for women in stable heterosexual relationships, the relationship with the baby's father. Traditionally fatherhood was constructed largely in terms of financial

support of woman and children, but increasingly it is assumed that fathers will be involved in pregnancy, childbirth and parenting. Biological-medical and psychological accounts emphasise the value of fathering for men themselves and their development, as well as for the baby, with the result that fathers are the preferred, and often the main, support for women in pregnancy and childbirth (e.g. Beail and McGuire 1982; Lewis and O'Brien 1987).

In biological-medical accounts, the value of the involvement of fathers is evidenced by their substantial inclusion in *The Pregnancy Book*. They are pictured supporting and assisting women in labour and holding their babies after delivery. They are discussed in terms of offering support, their excitement about becoming a parent, being close to their baby, and, as in the following extract (p. 25), their gendered experience of pregnancy:

Adjusting to pregnancy and to the idea of a baby can be difficult when you don't feel any different. Men don't 'live with' their babies during pregnancy, so while they escape the nausea, the tiredness and the discomfort, they also miss that growing sense of the baby's real presence.

Psychological accounts also draw on discourses of the normality of sexual relations in pregnancy. Some women argue that bodily changes in pregnancy enhance their sexuality and sexual attractiveness but, as has already been suggested, this is by no means always the case (Antonis 1981). Sexual relations in pregnancy are sometimes affected by women's increasing size, and also by concerns about harming the baby, or by the 'presence' of the baby (Alder 1992). These concerns are addressed in *The Pregnancy Book* which seeks to reassure women that sexual relations are possible during pregnancy but also to point out that there are other ways of expressing intimacy and affection.

Women's accounts draw on psychological discourses about the value of the interest and involvement of fathers in pregnancy and childbirth. These may take the form of expressing feelings for the baby, interest in the pregnancy, and practical support in pregnancy and labour, as in the following extracts:

We both read the pregnancy book we got from the hospital, together. When my back was hurting he would massage it for me. We did the breathing exercises together. Near the labour stage he used to help me relax if I got tense. He used to help me with relaxing.

My husband was with me throughout labour and I found that he was a great help because I didn't get much support from the midwife. I'm glad my husband and I went through the breathing exercises together, he helped me a lot.

My husband was so happy at the hospital. When he [baby] was about to

be born, his head started to show a little and my husband was so happy. He had tears in his eyes when he first saw [the baby].

Expectations about fathers' involvement and especially their presence at delivery are such that sometimes it is their absence, rather than their presence, which women comment upon, as in the following extract:

The second time my husband had to stay at home to look after [older child]. We couldn't leave her with anyone. I did feel I should have had someone with me but you have to look to your problems. My husband wanted to be there the second time but he couldn't leave her.

Other social relations

Increasingly the involvement of fathers is normalised, but the role of other social relations including those between a woman and her parents, friends, work and employment relations, are less acknowledged and explored. Many women give up paid employment outside the home in the late months of pregnancy. For some, this results in a loss of financial independence as well as a loss of identity and social support, as in the following extract in which a woman compares the support at work with that from her extended family:

I thought that nobody really helped me, taught me, told me to do this and do that, that will help your pregnancy, to eat this and that . . . I used to eat salads and fruit a lot. At work they did take good care of me: 'Don't do this, don't do that. Eat this and eat that'.

Most accounts draw on discourses of the benefits of fathers' involvement. Men in this culture-historical period are often contrasted with men in other cultures and/or at other times where pregnancy and childbirth are constructed as highly gendered, indicating the extent to which pregnancy and childbirth are socially and culturally constructed (e.g. Lozoff et al. 1988; Homans 1982), as Oakley (1980: 5) argues:

Having a baby is a biological and a cultural act. In bearing a child, a woman reproduces the species. . . . Yet human childbirth is accomplished in and shaped by culture. . . . How a culture defines reproduction is closely linked with its articulation of women's position: the connection between female citizenship and the procreative role are social, not biological.

Cultural context

However, in spite of Oakley's (1980) assertion of the cultural significance of pregnancy and childbirth, this is not often examined in biological-medical or psychological accounts. As we have already argued, psychological

accounts draw on discourses about the intra- and interpersonal significance of pregnancy and childbirth, but the differing circumstances of women's lives and the cultural meanings of childbearing and parenthood tend to be addressed largely in stereotyped ways. So, for example, it is often assumed that 'Asian' fathers are not involved in childbearing and that 'Asian' women are supported by other women, although as the woman in the following extract argues, even when women live with their extended families, it cannot be assumed that they have the support of female relatives:

When you're pregnant you still have to do the housework. Even though my mother-in-law lives with us, she can't do much because she can't see very well. If I decide not to do the housework, who's going to feed my children? So I have to do everything myself.

There is little consideration of the evidence about the social and economic position of many Asian women who live in poor housing and/or inner city areas, or their experience of racist practices which might discourage them from seeking contraceptive or antenatal care (Rocherson 1988; Bowler 1993). An exclusive focus on the differences between racial-cultural groups means that diversity *within* cultural groups and the meanings and practices of pregnancy and childbirth within both the dominant culture and minority social groups or cultures are rarely addressed (Woollett et al. 1995; Marshall 1992; Homans 1982).

NAUSEA AND SICKNESS AS EMBODIED EXPERIENCES

We have examined biological-medical and psychological accounts and the discourses on which they draw to point to similarities and tensions between those discourses and those on which child-bearing women draw. To contrast these different accounts and discourses a case study of one aspect of pregnancy, that of nausea and sickness, is examined.

Nausea and sickness are common experiences of pregnancy in this culture (Wolkind and Zajicek 1980). Biological-medical accounts construe them as 'normal/healthy' symptoms and experiences of pregnancy which are considered especially common in the early weeks and months of pregnancy, although they sometimes occur throughout pregnancy, and are explained in *The Pregnancy Book* (1984: 43) as follows:

Nausea is very common in the early weeks of pregnancy. . . . The causes are not properly understood but the hormone changes taking place in early pregnancy are thought to be one cause.

There is, however, little discussion of how, given the universality of 'hormones changes . . . in early pregnancy' women's experiences of nausea and sickness vary so widely, why they are more common in first than in subsequent pregnancies, and in some cultures more than others.

Biological-medical accounts construct nausea and sickness as problems, and hence as 'illness', only when they continue after the early months and prevent women from gaining weight 'normally'. However, even when they seriously disrupt women's health and well-being, medical interventions are rarely offered, because of the vulnerability of the developing fetus. Instead, women are reassured that they are common symptoms of 'normal/healthy' pregnancy and are offered non-medical solutions and suggestions about diet to help them cope:

It's worth trying tricks like eating a dry biscuit before you get up in the morning. . . . Some women find that keeping to bland foods like white bread and potatoes helps. . . . Ginger is supposed to help.

(*The Baby Book* 1988: 26)

Eat small amounts of food. . . . Avoid the smells and foods that make you feel worse. . . . Distract yourself as much as you can.

(*The Pregnancy Book* 1984: 43)

In contrast, women's accounts indicate the extent to which nausea and sickness are positioned as part of women's embodied experiences of pregnancy. Over half of the women interviewed said they experienced nausea and sickness (Woollett et al. 1995), with some experiencing severe symptoms which restricted their activities, as in the following extracts from interviews:

It was very bad. For nine months I was sick every day. For three, four months I went off food. I couldn't eat, couldn't stand the smell, and I kept bringing up everything. . . . I used to get tired very easily. I was told to get as much rest as possible because of the [health] problem I had. . . . I started to eat apples for the first time in my life. I've never liked them before. We still met people as before, but I couldn't travel on long journeys because I felt sick.

It was very bad. I couldn't do any work all day. I was vomiting a lot. This went on for five months. I couldn't get up. I just used to lie down all day. When I used to go to my GP and tell him about it, he'd say that's how it's supposed to be. . . . I felt so weak. . . . I couldn't eat anything. I couldn't keep down our Asian food. . . . I usually keep busy with housework, like tidying. When I'm sick I can't do as much cleaning although it's on my mind that I must do it.

Because nausea and sickness were positioned as central to women's experiences of early pregnancy, women who did not experience them said they did not feel pregnant, as in the following extract:

There were no problems. I've never had morning sickness. I didn't feel I was really pregnant.

Nausea and sickness were closely linked in women's accounts with food

alleviating nausea and sickness, in similar ways to biological-medical accounts. Asian women drew on somewhat different discourses of food: they explained their food preferences not merely in terms of nausea and sickness, but also in terms of hot and cold foods in the Ayurvedic system of medicine and their cultural context, in which older women reproduced cultural knowledge and traditional practices about foods to be eaten in pregnancy (Homans 1982; Woollett and Dosanjh-Matwala 1990).

Nausea and sickness are more common in early pregnancy and are often taken as an early indication of pregnancy (Wolkind and Zajicek 1980). Psychological accounts take nausea and sickness, not merely as embodied experiences of pregnancy, but as having symbolic significance and indicating – for example – a rejection of pregnancy, although there is little evidence to support this view (Raphael-Leff 1991; Macy 1986; Wolkind and Zajicek 1980). Even though they are unpleasant, nausea and sickness do focus the attention of women, and others, on the pregnancy and women's body-as-pregnant (Raphael-Leff 1991; Wolkind and Zajicek 1980).

Women's accounts of nausea and sickness are positioned largely in terms of women's lives, including their ability to cook for and feed their families. This is difficult when the food they are preparing makes them feel sick. Women had a number of ways of coping, such as a neighbour who cooked for them, or, as *The Pregnancy Book* suggests, trying to change family eating habits: 'If you are cooking for the family, choose menus that will suit *you* [their emphasis] as well as them' (p. 43). However, such advice is often of limited usefulness because it does not recognise the strength of social and cultural practices around food, and hence on the limits on women's ability to influence what their family will eat.

By positioning nausea and sickness as 'key' indicators of pregnancy, biological-medical and psychological accounts isolate them from other symptoms in pregnancy. This has the effect of negating the experiences of women who do not experience nausea and sickness and of giving less emphasis to other symptoms, in particular tiredness and symptoms associated with women's increasing weight and size. Unlike nausea and sickness, tiredness is experienced throughout pregnancy and has a significant overall impact on women's embodied experiences of pregnancy, as in the following extracts:

As this was my fourth I felt tired a lot. But I think that's because I was working . . . I tend not to feel ill, but other women feel as if they're ill. We [sister and self] weren't very big. I think if you are big it tends to slow you down.

It was all right. When you have two other children to look after the work becomes too much, but otherwise no problems. There was not much difference [in being pregnant], just that it seemed more hard work because of

the other two: take them to school, bring them home. You still have to do the same for them. You do feel tired.

Tiredness is probably given less attention because it fits less easily into dominant biological-medical discourses and is less susceptible to medical intervention than other symptoms, rather than because of its lesser significance for women (Popay 1992).

Nausea and sickness are frequent physical symptoms of early pregnancy but are constructed somewhat differently in the various accounts. Women's accounts draw on biological-medical discourses and hormonal changes, and also on their impact on women's lives and their embodied experiences of pregnancy.

CONCLUDING COMMENTS

In this chapter we have used discursive methods to examine and compare biological-medical, psychological discourses of pregnancy and childbirth. In doing so we have drawn attention to disparate and at times contradictory constructions of the nature of pregnancy and childbirth and the regulatory role of discourses in defining 'normality/health' and the management of pregnancy and childbirth.

We have argued that in constructing pregnancy and childbirth in terms of universality, and predominantly biological and individualistic experiences, current discourses are inadequate for accounting for and explaining women's readings of their child-bearing bodies. They fail to take sufficient account of two key factors identified as central in women's accounts. The first is diversity in women's experiences and the meaning of the pregnant body (own/other, this pregnancy/an earlier pregnancy, early/late pregnancy). The second is the social, cultural and ideological context in which women are pregnant and become mothers and the impact of pregnancy on their emotions, identities, lives and relationships.

Positioning pregnancy and childbirth within the framework of health and illness and their management as if they are illnesses, and the omission of diversity and the wider cultural context of pregnancy and childbirth, means that women experience maternity care as narrowly focused and ineffective for dealing with key aspects of their experiences. Women draw on some biological-medical discourses in their accounts, but such discourses are also resisted. The language of 'health' and 'illness' are rarely used to describe women's pregnancies and childbirth, which are constructed rather as physical manifestations or symptoms (sometimes unpleasant and troubling) of a 'normal/healthy' state.

Women's accounts and feminist research position pregnancy and childbirth within the context of women's lived experiences and personal knowledge, emphasising the ways in which women manage the different (and often

contradictory) demands of their pregnant bodies with domestic responsibilities and other relationships and responsibilities, and advice from health professionals. Their accounts contrast with biological-medical and psychological accounts which draw on narrower discourses of pregnancy and childbirth. These different discourses are of significance theoretically, and also practically in terms of the ways in which maternity care is managed.

Accounts and the discourses on which they draw are not mutually exclusive and change over time in response to cultural and ideological changes in the wider society. This can be seen in terms of changes in the provision of health care. With the emphasis on the patient as consumer and active participant in the decision-making processes, the management of pregnancy and childbirth are changing somewhat. However, for women the key task remains the negotiation of their readings of their pregnant bodies and the meanings of pregnancy and motherhood within the dominant framework of biological-medical discourses.

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Diet as a vehicle for self-control

Jane Ogden

INTRODUCTION

Dieting, overeating, anorexia and bulimia nervosa are in vogue in the late twentieth century. Research reports that everyone is dieting and that the prevalence and incidence of eating disorders are on the increase. Consequently, hospitals are opening specialist centres to accommodate this new clinical problem and self-help groups and those facilitated by professionals are proliferating. In parallel to these changes, experts have developed theories about the causes of these various forms of eating behaviour. Such theories are traditionally used to inform the reader about the nature of their object; theories are seen as unproblematic and as descriptions of 'reality'; theories of eating describe how eating 'really is'.

This chapter will examine primarily the status of theories about eating behaviour and suggest a more problematic concept of the relationship between theory and its object; such theoretical perspectives may not only be derived from data, but can themselves be used as data in order to examine changes in the way the object of theory is understood. From this perspective, theory no longer describes its object but begins to construct it. Therefore, as theory changes so its object changes in parallel.

In line with this premise, the chapter will then analyse changes in expert and lay theories about diet and eating behaviour over the past century. In particular, it will focus on changes in psychological and sociological approaches to diet, and suggest that the changing 'nature' of these theories reflects a shift in the concept of the object of these theories - the individual. Further, this analysis will outline the 'nature' of this changing individual and suggest that, whereas at the beginning of the century the individual was regarded as a passive responder to external events, in the middle of the century the individual became one who showed increasing agency and interacted with the outside world. The central proposition is that contemporary theories of eating behaviour describe and construct an individual who interacts with him or herself. Further, that this latter individual is characterised by self-control and a self to be controlled - an intra-active self.