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In the Journals, January 2014

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By Aaron Seaman

Across the U.S., at least, the opening of 2014 has been one marked by a bit of frosty air. The following is a roundup of some current reading to help keep you warm while avoiding the winds of the polar vortex.

The current issue of journal [Critical Public Health](#) has two articles that may be of particular interest.

[Going beyond the clinic: confronting stigma and discrimination among men who have sex with men in Mysore through community-based participatory research](#)

Robert Lorway, Laura H. Thompson, Lisa Lazarus, Elsabé du Plessis, Akram Pasha, P. Fathima Mary, Shamshad Khan, and Sushena Reza-Paul

Community-based participatory research (CBPR) has gained considerable popularity in recent decades given its ability to address social inequities, improve health outcomes and enhance community participation and ownership with respect to various health-related interventions. This paper describes the engagements of a community of self-identified men who have sex with men, most of whom also identified as male sex workers, in a long-term iterative and systematic process of knowledge production, reflection, and action. The project took place in 2006 in Mysore, South India, under the larger umbrella of an HIV intervention formed by the University of Manitoba and the sex workers collective known as Ashodaya Samithi, funded by the Bill & Melinda Gates Foundation (Avahan). CBPR is revealed as uniquely suited for tackling stigma and discrimination as subjects of scientific inquiry and as key methodological obstacles. As the community cultivated their own analysis around stigma, the concept became a key rallying point for increasing equity with respect to access to health services for this community. CBPR proved highly effective in mobilizing community participation and increasing access to sexual health services, over the long-term, because it was supported by and was able to feed community insights into a much larger infrastructure that sought to mobilize sexual minorities. More broadly, by highlighting various positive

effects arising from CBPR, we have sought to further emphasize the greater possibilities of public health practitioners working more democratically with disenfranchised and highly stigmatized communities.

[Still blaming the consumer? Geographies of responsibility in domestic food safety practices](#)

Angela Meah

Drawing upon qualitative and ethnographic data collected in the UK, this paper discusses how public discourses and concerns about food safety are negotiated into everyday domestic kitchen practices. While many participants demonstrated 'behaviours' or 'practices' which could be seen to contravene or fall short of official guidelines, this does not necessarily indicate 'ignorance' or lack of responsibility on the part of consumers. Indeed, when explored in detail, participants presented a range of reasons for engaging in what the UK Food Standards Agency regard as 'risky' practices. Their explanations point toward an understanding of the distribution of domestic responsibility in which a number of stakeholders are implicated, while simultaneously acknowledging their role as final arbiters of food safety in the home.

From the journal [Health](#), we have several new offerings:

[Young people and health: Towards a new conceptual framework for understanding empowerment](#)

Grace Spencer

In recent times, empowerment has become the focus of much work with young people amidst increasing concerns about their health. Empowerment is often offered as a 'solution' to such concerns, with the uncritical assumption being made that empowerment unproblematically results in positive health outcomes. While much of the health promotion literature advocates 'empowerment', it often does so without offering a clear conceptualisation of the word itself or indeed addressing the thorny theoretical tensions surrounding the concept's root word of power. In light of this omission, this article offers a more theoretically informed conceptualisation of empowerment and considers the relationship to young people's health. This article outlines a more dynamic and

generative conceptualisation of empowerment than hitherto articulated in the literature, informed by Lukes' multidimensional perspective of power. Drawing on findings from an ethnographic study on empowerment and young people's health, this article develops six conceptually distinct forms of empowerment (impositional, dispositional, concessional, oppositional, normative and transformative). Data were collected from 55 young men and women aged 15–16 years through group discussions, individual interviews and observational work in a school and surrounding community settings in England. Crucially, these six new forms of empowerment capture and synthesise individual, structural and ideological elements of power that differentially, and sometimes inconsistently, shape the possibilities for young people's empowerment. Of significance is the way in which these different forms of empowerment intersect to (re)produce relations of power and may offer different possibilities for health promotion.

[Sidestepping questions of legitimacy: How community representatives manoeuvre to effect change in a health service](#)

Sally Nathan, Niamh Stephenson, and Jeffrey Braithwaite

Empirical studies of community participation in health services commonly tie effectiveness to the perceived legitimacy of community representatives among health staff. This article examines the underlying assumption that legitimacy is the major pathway to influence for community representatives. It takes a different vantage point from previous research in its examination of data (primarily through 34 in-depth interviews, observation and recording of 26 meetings and other interactions documented in field notes) from a 3-year study of community representatives' action in a large health region in Australia. The analysis primarily deploys Michel de Certeau's ideas of Strategy and Tactic to understand the action and effects of the generally 'weaker players' in the spaces and places dominated by powerful institutions. Through this lens, we can see the points where community representatives are active participants following their own agenda, tactically capitalising on cracks in the armour of the health service to seize opportunities that present themselves in time to effect change. Being able to see community representatives as active producers of change, not simply passengers following the path of the health service, challenges how we view the success of community participation in health.

[The best laid plans? Women's choices, expectations and experiences in](#)

[childbirth](#)*Claudia Malacrida and Tiffany Boulton*

The past decades have seen a drastic increase in the medicalization of childbirth, evidenced by increasing Caesarean section rates in many Western countries. In a rare moment of congruence, alternative health-care providers, feminist advocates for women's health and, most recently, mainstream medical service providers have all expressed serious concerns about the rise in Caesarean section rates and women's roles in medicalization. These concerns stem from divergent philosophical positions as well as differing assumptions about the causes for increasing medicalization. Drawing on this debate, and using a feminist and governmentality framing of the problem, we interviewed 22 women who have recently had children about their birthing choices, their expectations and their birth experiences. The women's narratives revealed a disjuncture between their expectations of choosing, planning and achieving as natural a birth as possible, and their lived experiences of births that did not typically go to plan. They also reveal the disciplining qualities of both natural and medical discourses about birth and choice. Furthermore, their narratives counter assumptions that women, as ideal patient consumers, are driving medicalization.

[Surviving men's depression: Women partners' perspectives](#)*Joan L. Botorff, John L. Oliffe, Mary T. Kelly, Joy L. Johnson, and Joanne Carey*

While men's gendered experiences of depression have been described, the perspectives of women partners who are affected by men's depression have received little attention. Women partners were recruited to explore how men's depression impacts them and its influence on gender regimes. Individual interviews with 29 women spouses were coded and analysed. Although idealized femininity positions women as endlessly patient and caring, our findings reveal significant challenges in attempting to fulfil these gender ideals in the context of living with a male partner who is experiencing depression. The strain and drain of living with a depressed man was a key element of women's experiences. Four sub-themes were identified: (1) resisting the emotional caregiver role, (2) shouldering family responsibilities, (3) connecting men to professional care and (4) preserving the feminine self. The findings suggest that men's depression has great potential to dislocate heterosexual gender regimes, and attention to gender relations should be included to ensure

successful care management of men who experience depression.

[Revaluing donor and recipient bodies in the globalised blood economy: Transitions in public policy on blood safety in the United Kingdom](#)

Helen Busby, Julie Kent, and Anne-Maree Farrell

The clinical use of blood has a long history, but its apparent stability belies the complexity of contemporary practices in this field. In this article, we explore how the production, supply and deployment of blood products are socially mediated, drawing on theoretical perspectives from recent work on ‘tissue economies’. We highlight the ways in which safety threats in the form of infections that might be transmitted through blood and plasma impact on this tissue economy and how these have led to a revaluation of donor bodies and restructuring of blood economies. Specifically, we consider these themes in relation to the management of recent threats to blood safety in the United Kingdom. We show that the tension between securing the supply of blood and its products and ensuring its safety may give rise to ethical concerns and reshape relations between donor and recipient bodies.

[Becoming men: Gender, disability, and transitioning to adulthood](#)

Barbara E. Gibson, Bhavnita Mistry, Brett Smith, Karen K. Yoshida, David Abbott, Sally Lindsay, and Yani Hamdani

Children and youth with progressive conditions are living longer, and there is increased interest in designing programs that will assist them with “transitioning” to adulthood. Almost none of the transitions research to date, however, has attended to the experiences of disabled boys in “becoming men,” nor has there been critical conceptual work problematizing notions of “normal” adulthood or theorizing the complex, diverse, and gendered experiences of transitioning. In this Canadian study, we investigated the intersectionality of gender, disability, and emerging adulthood with 15 young men with Duchenne muscular dystrophy. Participants created audio diaries and photographs that were explored in in-depth interviews. Using a Bourdieusian lens and Arthur Frank’s notion of the narrative habitus, we examined how participants re/negotiated identities in everyday practices. Our analysis suggested that disability, masculinities, and generational (life stage) identities intersected through “narratives of nondifference,” wherein participants worked to establish identities as typical “guys.” Within limited fields of school and work,

participants distanced themselves from the label of “disabled” and discussed their successes and challenges in terms of normative developmental trajectories. We suggest that the pursuit of “normal” is reproduced and reinforced in health and social programs and closes off other narratives and possibilities.

The journal [Health and Place](#) has an interesting article on the attempt to eradicate tuberculosis in the Cook Islands:

[Partnerships for health: Decimating tuberculosis in the Cook Islands, 1920–1975](#)

Debbie Futter-Puatia, Linda Bryderb, Julie Parka, Judith Littletona, and Phyllis Herda

How did the Cook Islands manage to achieve a significant reduction in tuberculosis from a high rate in the early 20th century to low rates by 1975? With the mid-century invention of effective drug therapy there was a widespread belief around the Western world that TB could be eradicated. The Cook Islands was one place which almost reached this goal. Based on primary and secondary historical and anthropological research, we argue that the geo-political emplacement of the Cook Islands and development of multi-scale partnerships were crucial to success. Our research indicates the value of understanding and engaging with local community networks and culturally appropriate partnerships in dealing with health issues.

The articles in the most recent [Journal of the History of Medicine and Allied Sciences](#) range from discussions of typhoid to Body World, re-examinations of the Lourdes medical cures to family planning to the origins of MASH.

[Scientific Strategy and Ad Hoc Response: The Problem of Typhoid in America and England, c. 1910–50](#)

Anne Hardy

In the early twentieth century, death rates from typhoid in European cities reached an all time low. By contrast, death rates in America were six times as high, and the American public health community began a crusade against the disease in 1912. In the

1920s, hopes for greater control of the disease focused not just on sewers and drinking water supplies, but on the newly established scientific means of immunization, the supervision of food-related pathways of infection, and the management of healthy carriers. The management of carriers, which lay at the core of any typhoid control program, proved an intractable problem, and typhoid remained a public health concern. America and England both struggled with control of the disease during the interwar period. Coming from different starting points, however, their approaches to the problem differed. This paper compares and contrasts these different public health strategies, considers the variable quality of support provided by bacteriological laboratories, and demonstrates that “accidental” typhoid outbreaks continued to happen up to the outbreak of World War II.

[“Skinless Wonders”: Body Worlds and the Victorian Freak Show](#)

Nadja Durbach

In 2002, Gunther von Hagens’s display of plastinated corpses opened in London. Although the public was fascinated by Body Worlds, the media largely castigated the exhibition by dismissing it as a resuscitated Victorian freak show. By using the freak show analogy, the British press expressed their moral objection to this type of bodily display. But Body Worlds and nineteenth-century displays of human anomalies were linked in more complex and telling ways as both attempted to be simultaneously entertaining and educational. This essay argues that these forms of corporeal exhibitionism are both examples of the dynamic relationship between the popular and professional cultures of the body that we often erroneously think of as separate and discrete. By reading Body Worlds against the Victorian freak show, I seek to generate a fuller understanding of the historical and enduring relationship between exhibitionary culture and the discourses of science, and thus to argue that the scientific and the spectacular have been, and clearly continue to be, symbiotic modes of generating bodily knowledge.

[Forward Surgery and Combat Hospitals: The Origins of the MASH](#)

Sanders Marble

The U.S. Army adopted forward surgical hospitals (SHs) during World War I on the advice of the British and French armies. The purposes were not just to save lives, but to benefit the military by returning more patients to duty and reducing the size of the

hospital system through fewer infections and shorter hospital stays. The Army examined the utility of the units at the end of the war and retained them for any future conflicts, but opposition also survived. The question was the utility for the Army: was it worth making a substantial investment, and reducing care for other wounded soldiers, for the most grievously wounded, perhaps 1 percent of the total? Devising an effective way to organize forward SHs was a problem in the interwar years and early in World War II (WWII). But from the late 1930s, the Army never reexamined whether it should provide forward surgery, only how to do so, including pushing surgeons even further forward on the battlefield. At the end of WWII, the Mobile Army Surgical Hospital (MASH) was created to perform the mission, although the MASH was only the latest format.

[“Breaking the Chain of Poverty”: Family Planning, Community Involvement, and the Population Council–Office of Economic Opportunity Alliance](#)

Jennifer Nelson

The Office of Economic Opportunity–Population Council program is an example of a mid-twentieth-century federal government/private foundation cooperative effort to place family planning and maternal health at the center of a fight against entrenched poverty. These joint efforts were the trend in family planning and maternal health provision by the 1960s and had two overlapping but also contradictory goals. The first was to provide contraceptive services to poor women to reduce the numbers of poor children, thus relieving the poor of added mouths to feed. Popular fears of a population explosion, mounting welfare rolls, and an increase in the numbers of African Americans receiving welfare fueled this goal. The second aim, however, was to expand comprehensive maternal health services to help reduce poverty by increasing poor women’s involvement in and control over the health institutions that could have significant impact on their lives. While the first goal pivoted on encouraging poor women to bear fewer children, the second sought to integrate poor women into community healthcare delivery systems.

[The Lourdes Medical Cures Revisited](#)

Bernard François, Esther M. Sternberg, and Elizabeth Fee

This article examines the cures recorded in Lourdes, France, between 1858, the year of the Visions, and 1976, the date of the

last certified cure of the twentieth century. Initially, the records of cures were crude or nonexistent, and allegations of cures were accepted without question. A Medical Bureau was established in 1883 to examine and certify the cures, and the medical methodology improved steadily in the subsequent years. We discuss the clinical criteria of the cures and the reliability of medical records. Some 1,200 cures were said to have been observed between 1858 and 1889, and about one hundred more each year during the “Golden Age” of Lourdes, 1890–1914. We studied 411 patients cured in 1909–14 and thoroughly reviewed the twenty-five cures acknowledged between 1947 and 1976. No cure has been certified from 1976 through 2006. The Lourdes phenomenon, extraordinary in many respects, still awaits scientific explanation. Lourdes concerns science as well as religion.

[Religion and Medicine, Again: JHMAS Commentary on “The Lourdes Medical Cures Revisited”](#)

Jacalyn Duffin

There is a special issue of [Medical Anthropology](#) this month, entitled “Turning Therapies: Placing Medical Diversity,” which you can read more about [here](#).

[Philosophy, Ethics, and Humanities in Medicine](#) has posted three new articles online for January.

[A principled and cosmopolitan neuroethics: considerations for international relevance](#)

John R. Shook and James Giordano

Neuroethics applies cognitive neuroscience for prescribing alterations to conceptions of self and society, and for prescriptively judging the ethical applications of neurotechnologies. Plentiful normative premises are available to ground such prescriptivity, however prescriptive neuroethics may remain fragmented by social conventions, cultural ideologies, and ethical theories. Herein we offer that an objectively principled neuroethics for international relevance requires a new meta-ethics: understanding how morality works, and how humans manage and improve morality, as objectively based on the brain and social sciences. This new meta-ethics will simultaneously equip neuroethics for evaluating

and revising older cultural ideologies and ethical theories, and direct neuroethics towards scientifically valid views of encultured humans intelligently managing moralities. Bypassing absolutism, cultural essentialisms, and unrealistic ethical philosophies, neuroethics arrives at a small set of principles about proper human flourishing that are more culturally inclusive and cosmopolitan in spirit. This cosmopolitanism in turn suggests augmentations to traditional medical ethics in the form of four principled guidelines for international consideration: empowerment, non-obsolescence, self-creativity, and citizenship.

[The phenomenological-existential comprehension of chronic pain: going beyond the standing healthcare models](#)

Daniela Dantas Lima, Vera Lucia Alves, and Egberto Ribeiro Turato

A distinguishing characteristic of the biomedical model is its compartmentalized view of man. This way of seeing human beings has its origin in Greek thought; it was stated by Descartes and to this day it still considers humans as beings composed of distinct entities combined into a certain form. Because of this observation, one began to believe that the focus of a health treatment could be exclusively on the affected area of the body, without the need to pay attention to patient's subjectivity. By seeing pain as a merely sensory response, this model was not capable of encompassing chronic pain, since the latter is a complex process that can occur independently of tissue damage. As of the second half of the twentieth century, when it became impossible to deny the relationship between psyche and soma, the current understanding of chronic pain emerges: that of chronic pain as an individual experience, the result of a sum of physical, psychological, and social factors that, for this reason, cannot be approached separately from the individual who expresses pain. This understanding has allowed a significant improvement in perspective, emphasizing the characteristic of pain as an individual experience. However, the understanding of chronic pain as a sum of factors corresponds to the current way of seeing the process of falling ill, for its conception holds a Cartesian duality and the positivist premise of a single reality. For phenomenology, on the other hand, the individual in his/her unity is more than a simple sum of parts. Phenomenology sees a human being as an intending entity, in which body, mind, and the world are intertwined and constitute each other mutually, thus establishing the human being's integral functioning. Therefore, a real understanding of the chronic pain process would only be possible from a phenomenological point of view at the experience lived by the

individual who expresses and communicates pain.

[Should assisted dying be legalised?](#)

Thomas D. G. Frost, Devan Sinha, and Barnabas J. Gilbert

When an individual facing intractable pain is given an estimate of a few months to live, does hastening death become a viable and legitimate alternative for willing patients? Has the time come for physicians to do away with the traditional notion of healthcare as maintaining or improving physical and mental health, and instead accept their own limitations by facilitating death when requested? The Universities of Oxford and Cambridge held the 2013 Varsity Medical Debate on the motion “This House Would Legalise Assisted Dying”. This article summarises the key arguments developed over the course of the debate. We will explore how assisted dying can affect both the patient and doctor; the nature of consent and limits of autonomy; the effects on society; the viability of a proposed model; and, perhaps most importantly, the potential need for the practice within our current medico-legal framework.

[Public Culture](#) has two items that might well prove interesting to Somatosphere readers: an essay by Mara Buchbinder and Stefan Timmermans, entitled “[Affective Economies and the Politics of Saving Babies’ Lives](#)”; and [an interview](#) with Peter Galison by B. R. Cohen.

In addition to its special section on [STS and Disability](#), [Science, Technology, & Human Values](#) has additional content worth checking out, including an editorial, “[The Vilnius Declaration](#),” by Edward J. Hackett on the EU’s Horizon 2020 research funding program for collaboration between the social sciences and humanities and science and engineering, the Vilnius Declaration, and the role STS researchers can play. In addition:

[Hybrid Management Configurations in Joint Research](#)

Rik Wehrens, Marleen Bekker, and Roland Bal

Researchers are increasingly expected to deliver “socially robust knowledge” that is not only scientifically reliable but also takes into account demands from societal actors. This article focuses on an empirical example where these additional criteria are explicitly

organized into research settings. We investigate how the multiple “accountabilities” are managed in such “responsive research settings.” This article provides an empirical account of such an organizational format: the Dutch Academic Collaborative Centres for Public Health. We present a cross-case analysis of four collaborative research projects conducted within this context. We build on (and extend) Miller’s notion of “hybrid management.” The article shows that the extended concept of hybrid management is useful to study the different accountabilities encountered in such settings. We analyze how the collaboration developed and which conflicts or dilemmas arose. We then focus on the different hybrid management strategies used in the collaboration. The empirical material shows how the different aspects of hybrid management feature in various configurations in the four projects. We highlight that hybrid management strategies may be used by different groups or at different moments, may reinforce or contradict each other, and may be more or less effective at different points in time.

[Knowing Patients: Turning Patient Knowledge into Science](#)

Jeannette Pols

Science and technology studies concerned with the study of lay influence on the sciences usually analyze either the political or the normative epistemological consequences of lay interference. Here I frame the relation between patients, knowledge, and the sciences by opening up the question: How can we articulate the knowledge that patients develop and use in their daily lives (patient knowledge) and make it transferable and useful to others, or, ‘turn it into science’? Elsewhere, patient knowledge is analyzed either as essentially different from or similar to medical knowledge. The category of experiential knowledge is vague and is used to encompass many types of experience, whereas the knowledge of the ‘expert patient’ may be assumed to have the shape of up-to-date medical information. This paper shows through a case study of people with severe lung disease that patient knowledge can be understood as a form of practical knowledge that patients use to translate medical and technical knowledge into something useful to their daily life with disease. Patients coordinate this with homegrown know-how and advice from fellow patients, weighing different values – of which ‘taking good care of one’s body’ is but one – that may conflict in a specific situation. These practices result in sets of techniques that may be made useful to others. The paper argues for two alternatives to state-of-the-art medical research to turn patient knowledge into science: ethnographies of

knowledge practices (how patients know) and the collection and making accessible of techniques (what patients know).

I have pulled a few articles that caught my attention from the January issues of [Social Science and Medicine](#) (although, given their prolific production schedule, its always worth perusing the full issues on your own!).

[Medicalizing to demedicalize: Lactation consultants and the \(de\)medicalization of breastfeeding](#)

Jennifer M.C. Torres

This paper uses the domain of breastfeeding in the U.S. and the work of International Board Certified Lactation Consultants to refine the concept of medicalization–demedicalization. Given lactation consultants’ origins and current role in maternity care, they provide a unique lens on these processes because they are positioned at the crossroads of medicalization and demedicalization. Using 150 h of ethnographic observation and 39 interviews conducted between 2008 and 2012, I identify aspects of medicalization–demedicalization in the work of lactation consultants according to four dimensions: medical definition, medical control, pathology, and medical technology. Lactation consultants work to demedicalize breastfeeding by challenging the construction of breastfeeding pathology and limiting intervention. At the same time, they hold a position of medical control and medicalize breastfeeding by reinforcing a medical definition and using medical technology to treat breastfeeding problems. However, lactation consultants are not only working toward demedicalization and medicalization simultaneously, but are also medicalizing to demedicalize. Their position of medical control over breastfeeding provides them with a certain measure of authority that they can use in their efforts to depathologize breastfeeding and limit medical intervention. These findings build upon previous research that has identified cases of medicalization and demedicalization occurring simultaneously and draw attention to the need for an understanding of medicalization–demedicalization as a continuous process. Furthermore, the concept of “medicalizing to demedicalize” provides a novel contribution to the literature.

[Creating the ‘dis-ease’ of high cholesterol: A sociology of diagnosis](#)

[reception analysis](#)*Maja Jovanovic*

Using a sociology of diagnosis approach, this paper discusses the implication of high cholesterol being promoted as a disease rather than a risk factor for cardiovascular diseases. Drawing on data collected during the spring/summer of 2012 from 49 in-depth interviews with women over the age of forty concerned with high cholesterol in Ontario, Canada, I explore participants' understanding of the issue of high cholesterol as a disease. More specifically, I examine where blame and responsibility for high cholesterol are placed and if they vary by women's class background. My findings reveal that all the participants believed in and internalized the diagnosis of high cholesterol. However, the disease is blamed on 'lifestyle choices', and individual responsibilities, while women's awareness of the social determinants of health varies by class. I argue the sense of urgency surrounding high cholesterol is worrisome and the sole focus on lifestyle choice as both the cause and solution to high cholesterol is problematic for three reasons: it assumes that individual responsibility is adequate; it minimizes the socioeconomic constraints women face on a daily basis; and it reinforces the idea that individuals can be blamed for their health problems.

[The pharmaceuticalization of sexual risk: Vaccine development and the new politics of cancer prevention](#)*Laura Mamo and Steven Epstein*

Vaccine development is a core component of pharmaceutical industry activity and a key site for studying pharmaceuticalization processes. In recent decades, two so-called cancer vaccines have entered the U.S. medical marketplace: a vaccine targeting hepatitis B virus (HBV) to prevent liver cancers and a vaccine targeting human papillomavirus (HPV) to prevent cervical and other cancers. These viruses are two of six sexually transmissible infectious agents (STIs) that are causally linked to the development of cancers; collectively they reference an expanding approach to apprehending cancer that focuses attention simultaneously "inward" toward biomolecular processes and "outward" toward risk behaviors, sexual practices, and lifestyles. This paper juxtaposes the cases of HBV and HPV and their vaccine trajectories to analyze how vaccines, like pharmaceuticals more generally, are emblematic of contemporary pharmaceuticalization processes. We argue that individualized risk, in this case sexual

risk, is produced and treated by scientific claims of links between STIs and cancers and through pharmaceutical company and biomedical practices. Simultaneous processes of sexualization and pharmaceuticalization mark these cases. Our comparison demonstrates that these processes are not uniform, and that the production of risks, subjects, and bodies depends not only on the specificities of vaccine development but also on the broader political and cultural frames within which sexuality is understood.

The journal [Sociology of Health & Illness](#), has several new articles this month:

[Negotiating identity at the intersection of paediatric and genetic medicine: the parent as facilitator, narrator and patient](#)

Rebecca Dimond

This article identifies a significant transformation in the role and identity of parents accompanying their child to clinic. This shift is a product of the intersection between paediatric and genetic medicine, where parents play a critical role in providing information about their child, family and ultimately, about themselves. To provide a context for this matrix, two broad areas of sociological inquiry are highlighted. The first is explanations of the role a parent plays in paediatric medicine and the second is the diagnostic process in paediatric genetics and the implications for parent and child identities. Drawing from an ethnographic study of clinical consultations, attention is paid to the changing role of parenthood and the extended role of patienthood in paediatric genetic medicine.

[Chronic illness: a revisionist account](#)

David Armstrong

This article challenges the generally accepted thesis that the emergence and dominance of chronic illness over the last half century is due to the receding tide of acute infectious diseases and an ageing population. Instead, through an analysis of contemporary reports in the Journal of the American Medical Association, it is argued that the construct of chronic illness emerged as part of a new focus on the downstream consequences of disease and as a means of transferring what had been seen as the natural processes of ageing and senescence into an

explanatory model based on pathological processes. The widely accepted idea of an epidemiological transition in illness prevalence has served to conceal the ways in which medicine has extended its remit and suppressed alternative explanatory frameworks.

[Home as a hybrid centre of medication practice](#)

Kevin Dew, Kerry Chamberlain, Darrin Hodgetts, Pauline Norris, Alan Radley, and Jonathan Gabe

This article presents research that explores how medications are understood and used by people in everyday life. An intensive process of data collection from 55 households was used in this research, which included photo-elicitation and diary-elicitation interviews. It is argued that households are at the very centre of complex networks of therapeutic advice and practice and can usefully be seen as hybrid centres of medication practice, where a plethora of available medications is assimilated and different forms of knowledge and expertise are made sense of. Dominant therapeutic frameworks are tactically manipulated in households in order for medication practices to align with the understandings, resources and practicalities of households. Understanding the home as a centre of medication practice decentralises the role of health advisors (whether mainstream or alternative) in wellness practices.

[Decision-making and accountability: differences of distribution](#)

Dawn Goodwin

The cognitive and individual framing of clinical decision-making has been undermined in the social sciences by attempts to reframe decision-making as being distributed. In various ways, shifts in understanding in social science research and theorising have wrested clinical decision-making away from the exclusive domain of medical practice and shared it throughout the healthcare disciplines. The temporality of decision-making has been stretched from discrete moments of cognition to being incrementally built over many instances of time and place, and the contributors towards decision-making have been expanded to include non-humans such as policies, guidelines and technologies. However, frameworks of accountability fail to recognise this distributedness and instead emphasise independence of thought and autonomy of action. In this article I illustrate this disparity by contrasting my ethnographic accounts of clinical practice with the professional codes of practice produced by the General Medical

Council and the Nursing and Midwifery Council. I argue that a 'thicker' concept of accountability is needed; one that can accommodate the diffuseness of decision-making and the dependencies incurred in collaborative work.

[Everyday moral reasoning in the governmentality of HIV risk](#)

J. Cristian Rangel and Barry D. Adam

Drawing on the sociology of morality, this article analyses the social contexts, discourses and ethno-methods of everyday life that shape real-world decisions of gay men around HIV prevention. Through an analysis of the predominant narratives in an online public forum created for an HIV prevention campaign, this article explores the ways in which homosexually active men engage in everyday moral reasoning and challenge a neoliberal moral order of risk and responsibility. The article concludes that gay and bisexual men engage in forms of practical morality with their sexual partners and imagine larger communities of interest, love, companionship and pleasure. At the same time, they draw heavily from discourses on individual and rational responsibility, as well as narratives of romance and community, that shape forms of moral selfhood. Risk management techniques that are grounded in notions of rational choice and that are insensitive to the emotional worlds that these men inhabit create situations of risk avoidance but also inadvertently open them to new forms of vulnerability.

['I'm just a walking eating disorder': the mobilisation and construction of a collective illness identity in eating disorder support groups](#)

Jessica Powers Koski

The increasing visibility of support groups has prompted a flurry of sociological investigation, much of which explores how groups benefit participants. What researchers have failed to consider is the group itself. Bringing social movement theory to bear on the case of eating disorder support groups, this study seeks to explore how support groups attract and sustain adequate participation. Participant observation in an eating disorder support group reveals that broad diagnostic and prognostic frames, coupled with strong motivational framing and collective identification on the basis of a shared disordered self, promote support group participation. The very processes that enable support groups' successful mobilisation, however, simultaneously construct a collective illness identity, which in turn serves as the basis for participants' individual-level identity work. More specifically, support group

mobilisation processes construct eating disorders as highly consequential, highly symptomatic, chronic, rooted in the self, and uncontrollable. Such findings suggest that support groups may have unanticipated and potentially adverse consequences for participants and thus build on previous work highlighting the unintended health consequences of framing processes. Such findings further contribute to our understanding of how macro-social forces shape illness experience.

[Undoing gender? The case of complementary and alternative medicine](#)

Joslyn Brenton and Sinikka Elliott

Despite a rich body of sociological research that examines the relationship between gender and health, scholars have paid little attention to the case of complementary and alternative medicine (CAM). One recent study (Sointu 2011) posits that men and women who use CAM challenge traditional ascriptions of femininity and masculinity through the exploration of self-care and emotions, respectively. Drawing on 25 in-depth interviews with middle-class Americans who use CAM, this article instead finds that men and women interpret their CAM use in ways that reproduce traditional gendered identities. Men frame their CAM use in terms of science and rationality, while simultaneously distancing themselves from feminine-coded components of CAM, such as emotions. Women seek CAM for problems such as abusive relationships, low self-esteem, and body image concerns, and frame their CAM use as a quest for self-reinvention that largely reflects and reproduces conventional femininity. Further, the reproduction of gendered identities is shaped by the participants' embrace of neoliberal tenets, such as the cultivation of personal control. This article contributes to ongoing theoretical debates about the doing, redoing and undoing of gender, as well as the literature on health and gender.

[Men managing cancer: a gender analysis](#)

Lisa M. Wenger and John L. Oliffe

As researchers consider gendered patterns in men's prostate cancer experiences, little attention has been devoted to how men manage 'cancer', more generally. Drawing on the experiences of 30 Canadian men with a variety of cancer types, this article details how men engaged illness self-management and help-seeking activities with lay and professional support persons. Results indicate three broad responsive strategies: fortifying resources,

maintaining the familiar, and getting through. In these pursuits, the participants drew on a variety of performances to respond to social contexts demanding that men embody masculine ideals including strength, control, and stoicism. Considering gendered dynamics in how men manage the challenges of cancer, this article broadens understandings about men's cancer experiences by highlighting the drivers orienting participants' responsive efforts and challenging assumptions of help-seeking as essentially problematic for men in Western society.

[Managing sleep and wakefulness in a 24-hour world](#)

Catherine M. Coveney

This article contributes to literature on the sociology of sleep by exploring the sleeping practices and subjective sleep experiences of two social groups: shift workers and students. It draws on data, collected in the UK from 25 semi-structured interviews, to discuss the complex ways in which working patterns and social activities impact upon experiences and expectations of sleep in our wired awake world. The data show that, typically, sleep is valued and considered to be important for health, general wellbeing, appearance and physical and cognitive functioning. However, sleep time is often cut back on in favour of work demands and social activities. While shift workers described their efforts to fit in an adequate amount of sleep per 24-hour period, for students, the adoption of a flexible sleep routine was thought to be favourable for maintaining a work–social life balance. Collectively, respondents reported using a wide range of strategies, techniques, technologies and practices to encourage, overcome or delay sleep(iness) and boost, promote or enhance wakefulness/alertness at socially desirable times. The analysis demonstrates how social context impacts not only on how we come to think about sleep and understand it, but also how we manage or self-regulate our sleeping patterns.

[Knowledge is power? The role of experiential knowledge in genetically 'risky' reproductive decisions](#)

Felicity K. Boardman

Knowledge of the condition being tested for is increasingly acknowledged as an important factor in prenatal testing and screening decisions. An analysis of the way in which family members living with an inheritable condition use and value this knowledge has much to add to debates about whether and how

this type of knowledge could be made available to prospective parents facing screening decisions. This article reports on in-depth interviews (conducted between 2007 and 2009) with 61 people with a genetic condition, spinal muscular atrophy (SMA) in their family. Many participants reported that their intimate familial knowledge of SMA offered them valuable insights with which they could imagine future lives. Other participants, however, found themselves trapped between their experiential knowledge of SMA and their (often) competing responsibility to maintain the wellbeing of their family. Still, others established a hierarchy of knowledge to rank the authenticity of different family member's accounts of SMA in order to discredit or justify their decisions. This article highlights the way in which experiential knowledge of the condition being tested for cannot be unproblematically assumed to be a useful resource in the context of prenatal testing decisions and may actually constrain reproductive decisions.

Finally, the annual review issue of [Theory, Culture & Society](#) (December 2013) had a special section entitled "Naturecultures: Science, Affect and the Non-human." You can read the abstracts [here](#).

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Seaman A. In the Journals, January 2014. *Somatosphere*. 2014. Available at: <http://somatosphere.net/2014/01/in-the-journals-january-2014.html>. Accessed January 31, 2014.

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