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Article Title: Virtual Special Issue on feminism and the sociology of gender, health and illness

Year of publication: 2008

Link to published version:

http://www.blackwellpublishing.com/shil_enhanced/virtual2.asp

Publisher statement: "The definitive version is available at www.blackwell-synergy.com".

Feminism and the sociology of gender, health and illness
Virtual special edition
Hannah Bradby

This editorial considers how the study of gender and health has played out in the pages of the *Sociology of Health and Illness* over the past quarter century, paying particular attention to how a theory of gender has informed empirical work and the relevance of gender studies for the feminist challenge to sexism and the patriarchal order. Work in this journal on gender and health has considered the invisibility of women, grappled with the conflation of sex and gender and interrogated polarised binary thinking, attempting to use sociological approaches to the body and novel post-structural metaphors to analyse both gendered roles and their relationship with gendered bodies and states of health and illness.

A querying of the routine division of the sexes into distinct realms, culturally, socially and economically, whereby women are consistently less valued than men, underlies the development of feminism. Feminist politics depends on a premise that collective and concerted action can change the under-valuing of women and equality between the sexes is a legitimate social goal (Humm, 1992:1). Feminist activism seeks to win for women the rights that men take for granted. Feminist theory seeks to explain how disparities between men and women have been normalised and maintained and why, even once women have been granted formal rights to equal treatment in the workplace, home and courts, gendered discrimination persists. Feminist theory turns on the suggestion that the unwarranted conflation of sex with gender justifies sexist assumptions with the inferiority of women, or at least their unsuitability for particular social roles, justified with reference to embodied sex differences. While biological distinctions between male and female can be seen in morphological, hormonal and functional differences, particularly after puberty, as a mammalian species we are relatively undifferentiated by sex and characteristics associated with sex such as musculature, facial hair and height, exist on a spectrum. The routine conflation of sex, imagined as two opposed categories, with gender, works to keep the polarised, binary gendered division intact as a cultural category.

The feminist sociological challenge to biologically justified sexism is to show that gender roles are culturally ascribed and socially acquired. Masculinity is a trait that is theoretically independent of maleness and men learn how to perform male gender roles, just as women learn to adopt a feminine practice. Feminism emphasises the differentially valued readings of male and female bodies and delineates the processes that have led to the establishment, maintenance and reinforcing of gendered roles.

Invisible women

An early article by Juane Clarke (1983) provided a feminist challenge to the sociology of health and illness, by focussing on masculinity's tendency to render women and women's concerns invisible (Clarke 1983: 12). For this author,

medicine's contribution to the myth of female frailty that both disqualified women as healers and rendered them highly qualified as patients had helped to reduce women's visibility (Clarke 1983: 64). Developing ideas of female frailty, Ellen Annandale and Judith Clark's (1996) analysis of the gendered nature of readings of the body suggested that women could not be well because of their disadvantaged cultural position and men could not be ill. The movement which has come to be identified as second wave feminism asserted the equality of men and women, or, more radically, argued for the superiority of women on the grounds of their association with the natural.

In some respects the invisibility of women and women's issues has been overcome, in that it is difficult 'to recall the time when gender relations were not regarded as a legitimate focus for sociological study' (Maynard 1990: 269). And yet, while gender is now a standard variable in sociological analysis, there remain important areas of health practice and health policy where the workings of gender have been hidden from analytic view. Apart from as prostitutes, women were largely invisible in the early discussion of the epidemiology of AIDS, despite the significant nature of the risk to health world wide, as an article by Janet Holland and colleagues (1990) argued. As women began to appear as more than just promiscuous women, they became the target of a public health expectation that they should take responsibility, not only for their own bodies and reputations but also for policing men's health (Holland et al. 1990: 347). Brown and Minichiello's article pointed out that the focus on converting women's passivity into assertiveness has been such that any impact of male sexuality on, for instance, condom use has frequently been overlooked (1994: 232). Feminist analysis of negotiations over sexual encounters between men and women emphasises the determinate influence of inequalities in gendered power and yet this finding had failed to inform public health interventions (Holland et al. 1990: 348) despite the contention that traditional male and female sexual roles and behaviours presented a significant health risk in the context of heterosexuality (Brown and Minichiello 1994: 248).

Papers appearing in the journal have shown that it is not only novel threats to public health where gendered thinking remains difficult to interrogate. Although significant numbers of women die from heart attacks, albeit at a later age than men, Carol Emslie and colleagues showed that heart disease is widely seen as a men's problem (Emslie et al 2001: 224). Where men and women present similar symptoms, men are more likely to be diagnosed with heart disease and women's symptoms to be attributed to age. This contrast is analysed by these authors as part of a gendered cultural symbolism whereby men are associated with culture and the failure of their body parts rests on explanatory metaphors around mechanical failure, whereas women's proximity to the 'natural' makes a more organic, quiet death appropriate and acceptable (Emslie et al 2001: 227). In contradiction to earlier feminist concerns that women were culturally locked into a category of frailty, these analyses suggest that for some disease categories it is

women's vulnerability that cannot be seen, rather than their illness that is excessively visible.

Polarised opposition

The acceptable and widespread nature of gender as a variable in sociological analysis, together with its absence in specific areas of diagnosis and health policy, as described above, is perhaps explained by the lack of theoretical development in what gender means. Feminist theory has 'often been used tacitly in research on gender and health' such that 'interpretive frameworks are implicit rather than explicit' and 'women's' health is discussed without reference to patriarchy as a theoretical justification of women's disadvantage (Annandale 1990: 62). Research that measures or describes the inferiority of women's health compared with men's without reference to a theoretical position can have the effect of reinforcing a categorical difference between the genders, thereby identifying women as the authors of their own misfortune. Researchers' concentration on medical problems affecting women, such as childbirth, breast cancer and menstruation has, ironically, reinforced women as the vulnerable 'weaker sex'.

In an article on doctor-nurse relations Karen Davies observed that one of the difficulties in theorising gender is that in western society it is a primary social category which we automatically and unconsciously categorise any specific other with whom we must relate (Davies 2003: 729). A social relationship with a person of indeterminate gender is less tolerable than ambiguity around age, sexuality, class or disability. The potential for women to conceive and bear new life has played an important role in maintaining the binary division of gender, since it homogenizes all women as mothers, and locks women into reproduction as central to everyone's lives, echoing medicine's determinacy (Annandale and Clark 1996: 29). Thinking premised on a binary division between men and women, between male and female has the unfortunate effect of 'universalising and valorising' gender differences. A focus on the abnormalities of women's reproductive health means that, at the same time as sociology criticises biomedicine's pathologisation of women, it also replicates its problematic (Annandale and Clark 1996: 32), allowing women's health problems to stand for the broader issue of gender and health.

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The combination of the social centrality of gender, underpinned by a focus on biological difference, has made sexist thinking difficult to deconstruct, despite the widely shared feminist understanding of women's experience as socially constructed rather than built directly upon biology or the materiality of the body (Annandale and Clark 1996:19). The availability of safe contraception and the receding social pressure for women to marry and reproduce has lent weight to a feminist aspiration to treat men and women as social actors subject to gender prejudice as a means of discrediting fixed sex roles. Research appearing in the journal has shown that it is empirically as well as theoretically possible to disaggregate biological sex from social gender roles. Using social survey

methods to measure dimensions of gender in men and in women, Ellen Annandale and Kate Hunt show that high 'masculinity' has been associated with better health for men and women, such that masculinity clearly carries rewards for both men and women (Annandale and Hunt 1990: 43).

The ability to think about gender as a quality or condition independent of sex is rare. A more common response to the feminist deconstruction of gender as a social role has been to study men's bodies as a site of disease (as in John Oliffe's (2006) article on androgen deprivation therapy) and the role of masculinity in illness (Robertson 2006). One outcome of studying men and masculinity has been to present men as a disadvantaged group in need of an urgent public health campaign to address their needs (Courtenay 2000). In this context gender becomes collapsed onto biological sex and the term is effectively a euphemism for sex. The assertion of one sex's need for health care over and above the other sex is not a constructive means of furthering the understanding of gender and health.

In the early 1980s, Juane Clarke lamented that there could be 'no adequate, systematic theory-building as of yet because of the conceptual indeterminacy in the definition and problems in the measurement of illness and gender' (Clarke 1983: 77), suggesting that significant re-conceptualization was required. More than a decade on and, more hopefully, feminist theory was said to be 'in the midst of significant change' (Annandale and Clark 1996: 38).

Post-structuralism has offered one route for a re-conceptualization of gender that keeps bodies, including bodily difference, in the analysis without collapsing gender onto sex and without making sex determinate. If bodies are 'only knowable through the discourses that constitute them' then they cannot be reduced to an unproblematic biological base on which gender is inscribed (Annandale and Clark 1996: 20). Gender differences are understood to be created through hierarchical opposition, such that the category 'women' is meaningful in reference to 'men'. Feminism's aim to destabilize or overturn such oppositions (Annandale and Clark 1996: 21) offers the possibility of a novel and less fixed gendered regimen.

Undoing polarities

More recently in *Sociology of Health and Illness* Karen Davies has taken health care professionals in a hospital setting as a means of examining the active performance and subjectivity of the continual creation, maintenance and contesting of gender relations in daily life (2003: 720). The concept of the body is central to examining the doing of dominance and deference by doctors and nurses between whom, despite changes, gendered relations hold sway. Davies argues that bringing in the body gives access to complex multiple relations at work at the cross roads of gender, profession, hierarchy, bureaucracy allowing

analysis to identify where gender relations can be contested and change introduced (Davies 2003: 737).

New metaphors to dislodge binary gendered thinking are needed: if bodies can be envisaged as networks, it becomes difficult to think of 'problems in fertility' belonging specifically to women (Annandale and Clark 1996: 37), rather than to parents or couples. Annandale and Clark suggest cyborg imagery as a means of deconstructing duality and challenging theoretical positions which view science and technology as amounting to little more than male demonology (1996: 38).

The ability of cyborg imagery to explode binary thinking was disputed in a paper by Rona Campbell and Sam Porter (1997), and it has not become a hallmark of research in this journal, although the place of gender in understandings of science and technology has been considered. Cathy Charles and colleagues (1998) considered the extent to which women perceived that they had options with regard to treatment for breast cancer, how they understood the risks and benefits of various options and the role they wanted for themselves and their oncologist in decision-making. The paper documents how women developed their own constructions of scientific information on treatment risks concluding that most women wanted shared decision-making so that their physicians' skills and experience would contribute to making the 'right' decision and avoiding the 'wrong' one (Charles et al 1998: 90). In this context divisions between health care professionals and recipients of services seem to have emerged as more important than gender.

Health inequalities

The study of inequalities in morbidity and mortality is a central aspect of this journal's substantive work, where a productive multi-disciplinarity has been brought to bear on problems which are both social and theoretical. Interrogating the long standing observation that women live longer lives, but are more beset by symptoms compared with men and evaluating the contribution of employment and domestic responsibilities to rates of mortality and morbidity has been an ongoing project. In response to the feminist challenge, this work has sought to develop theories of gender as well as develop the evidence base on inequality based on a variety of social characteristics, including gender and class.

The rise in the proportion of women in the workforce made possible a study by Sara Arber and colleagues (1985) of the content and quantity of women's work and stress and the effects on their health. Subsequently, Mel Bartley and colleagues argued that of the numerous studies of women's apparent excess morbidity undertaken, all too many have treated women as an undifferentiated category and concentrated on mental illness so as to confirm an association between paid employment and better mental health among women (Bartley et al 1992: 376).

Disaggregation of women's work into domestic labour and paid employment confirmed that women with full and part time paid work were more likely to experience lower levels of physical and psychological symptoms than those who were housewives. Careful attention to the content and quantity of women's paid and unpaid work meant that statements about the benefits of paid work for women's health could be precisely circumscribed (Bartley et al 1992). With such detailed operationalisation of gender and of work variables, it became possible for similarities and differences within and across gender to emerge from other analysis appearing in the journal (Hunt and Annandale 1993: 660). Given the deeply gendered nature of our culture, it is difficult to 'control for gender'. For instance, Vivienne Walters and colleagues showed that, in the case of paid and unpaid work, even when occupying the same occupation, men and women have different work roles and aspects of that occupation may take on different significance because of different family responsibilities (Walters et al 1997: 340). The consistent finding that women have a greater risk of depression compared with men was confirmed in a paper by James Nazroo and colleagues to be largely the result of differences in roles and the stresses and expectations that go with them (Nazroo et al 1998: 326). This contributes to the case that it is the content and context of gendered roles that are important in explaining excess morbidity, rather than some inherent feature of women as a gender.

Work on gendered health inequalities can be criticised as having a Western focus. The inequities facing women in post-industrial wealthy countries have preoccupied research attention to the exclusion of global gendered injustices. In terms of the starkness of gendered inequalities in the health and longevity of women, compared with men, the majority world demands our attention. The world-wide toll in terms of women's raised levels of mortality and morbidity, confirms that limited or negligible access to political power, land-ownership, education, sexual self-determination and earning ability has detrimental bodily effects. This journal has begun to publish work on women's health in the majority world, for instance consideration of ante-natal services in Pakistan by Zubia Mumtaz and Sarah Salway (2007) and obesity in Morocco by Adina Batnitsky (2008).

Feminist sociology's efforts in developing a theory of gender that avoids polarizing binary oppositions in the study of health and illness is needed in conversation with disciplines such as development studies and anthropology which are currently engaged with the study of global health matters. The starkness of the health inequalities that affect the world's poor, who are disproportionately women, should not become an excuse to allow gender to become collapsed back a biologically justified notion of a female health deficit.

Conclusion

At its best, the research published in this journal uses innovative sociological ideas to recast problems of health policy and medical practice. The feminist effort to de-couple sex and gender has been important in developing conceptual and

empirical work around health inequalities, public health policy and understandings of illness causation. The success of this effort can be measured in the mainstream acceptance that gender is, in large measure, a matter of social and cultural construction. However, the reluctance of feminist theory to grapple with embodied aspects of sex difference in relation to gendered ideas, together with medical sociologists' fascination with obstetrics, gynaecology and midwifery, has perhaps left undisturbed a Victorian core of thinking that gendered illness patterns are a matter of reproductive physiology. In destabilising ideas about the fixity of a biologically determined sex difference, models associated with post-structural thought, such as networks and cyborgs, have yet to make their mark in our discipline's record of published research. This is notable, given that metaphors of machine-enhanced humanity and networked beings are not unusual in science fiction and fantasy in various media; indeed they make up a substantial part of the mainstream entertainment industry. The indeterminacy of definition and measurement noted by Clarke in 1983 has been overcome and the significant changes that Annandale and Clark noted to be in process in 1996 have moved our understanding forward, as amply demonstrated by the papers reviewed in this editorial. But the process of developing a sophisticated theoretical conceptualisation of gender that permits flexible empirical operationalisation and makes sense in the everyday gendered world is not yet finished. In fifteen years time, a review of papers in this journal will perhaps show that a further effort to find ways thinking about gender in combination with other sociological variables, and that admits the power of social constructionism as well as the fundamentally embodied nature of our experience of health and illness has taken place. However, as the generation of researchers who witnessed the urgency of the gender politics of the 1960s and 1970s retires, it is a cohort schooled in the cynicism of the 1980s and 1990s who must avoid the complacency of post-feminism in rising to this challenge.

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