

*A discursive analysis of accounts of breast
cancer screening, risk and prevention*

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Abstract

This thesis presents a discursive analysis of accounts of breast cancer screening, risk and prevention. Breast cancer is currently the largest form of cancer death for women in Australia (and many other Western nations), but the causes are unknown. Consequently, health promotion has tended to focus on the early detection of the disease. Despite this focus, the currently available techniques for early detection of breast cancer continue to be subject to research and debate. For women at high risk of the disease due to a family history and, in some cases, a genetic predisposition, there is also discussion regarding the best course of preventative action. One option, prophylactic surgery (or the removal of healthy breasts), continues to be the topic of both medical and psychological research.

In addition to the ongoing medical research and debate around the topics of breast cancer screening, risk and prevention, there has been extensive sociological theorising around the increased societal emphasis on risk more generally. This emphasis on risk has been argued to be one feature of governance in modern liberal democratic societies. Particularly with respect to health-care in such societies, there has been argued to be a shift towards increasing individual responsibility for health and the management of potential illness. A focus on individual responsibility is not necessarily a key feature of contemporary public health approaches. Nevertheless, it has been suggested that the emphasis on risk management, in combination with the prevalence of 'lifestyle' diseases, has widened the gaze of public health, such that all aspects of individuals' lives are open to scrutiny and regulation. An inevitable consequence of such shifts is the placing of increased responsibility for health on to individuals.

The analysis in this thesis draws on a synthetic discursive approach to examine talk and text around the issues of breast cancer screening, risk and prevention, in light of these shifts in conceptualisations of health and health-care, and the medical debate surrounding detection and prevention techniques. In particular, three analytic chapters are concerned with three sets of data: media accounts of prophylactic

mastectomy; pamphlets promoting breast cancer screening; and women's focus group talk. The analysis focuses on the discursive themes, ideological dilemmas, and subject positions deployed in the data. The following analytic findings are discussed:

- the repeated positioning of individuals as 'patients without symptoms', who are required to engage in risk management in order to prevent their (inevitable) future illness;
- the positioning of women in terms of traditional notions of femininity and mothering;
- the construction of a dilemmatic relationship between individuals and medical experts, whereby individuals are positioned as responsible for their own health and illness prevention, while simultaneously being reliant on medical experts who are sometimes wrong;
- the negotiation and flexible management of notions of responsibility, emotion and health behaviours in women's talk.

The final chapter in the thesis considers implications of the analysis for public health and health promotion, and for a critical (public) health psychology.

Declaration

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and that, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference is made in the text.

I give consent to this copy of my thesis, when deposited in the University Library, being available for loan and photocopying.

Signed:

Date:

Shona Crabb

Publications

Work in this thesis has been peer-reviewed and published elsewhere:

Crabb, S. (2002). 'Fiona farewells her breasts': An account of breast cancer prevention in *New Idea. Proceedings of the 1st Australian Postgraduate Students' Critical Psychology Conference*, 62-77. Sydney: University of Western Sydney Press.

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Chapter 1

Introduction

1.1 A preliminary outline

This dissertation is broadly concerned with the topic of preventative health practices. Within contemporary Western cultures there is increasing emphasis on individual self-regulation and self-governance in many aspects of life, including preventative health behaviours and the management of health risks. More and more, individuals are being encouraged to monitor their bodies and their health with the goal of prevention and risk management; we are told to exercise, watch what we eat and drink, get check-ups (generally, and for specific parts of our bodies), and so the list goes on. My aim, in this thesis, is to explore and question some of the ways in which these preventative behaviours are currently understood, by examining the discourses that construct and surround them.

In particular, I am taking breast cancer screening as the focus of my analysis. Breast cancer is a widespread disease amongst Australian, and other Western, women and is currently reported as one of the largest causes of cancer death. At their most extreme, preventative strategies for breast cancer involve the surgical removal of healthy breasts in order to prevent the development of the disease. It is reported that increasing numbers of women are engaging in this radical preventative practice. The procedure and the women who engage in it have been topics of a developing literature, including some psychological studies examining motivations for

undertaking such dramatic preventative strategies, as well as coverage in the popular media.

There is also a substantial literature relating to the other preventative and screening practices women engage in with relation to breast cancer. In particular, the degree of debate, and the lack of consensus, in the medical, psychological and public health literature regarding the techniques that are currently available for the early detection and prevention of breast cancer is striking. Furthermore, a central feature of many of these debates is the issue of *risk*. In medical and psychological literature, and in the wider culture, this concept tends to be spoken about as a real, measurable entity. However, the concept of 'risk' itself is controversial, and is the subject of widespread scholarly debate (see Lupton, 1999; O'Doherty, 2006; Petersen, 1997; Petersen & Lupton, 1996). In particular, it has been suggested that

what are identified as 'risks', by 'experts' as much as lay people, are understood as inevitably the outcome of sociocultural processes. Further, such risks tend to serve certain social, cultural and political functions (Lupton, 1999, p.2).

This is not to argue that there may not be any identifiable or preventable dangers but, rather, that those dangers which we come to understand as 'risks' are best understood as socially and historically constituted.

Having been informed by this background, the research presented in this thesis has, therefore, been concerned with providing a discursive analysis of talk and text

relating to breast cancer screening, risk and prevention. The analysis has focused on the constructions and accounts that are flexibly deployed in language around these issues, as well as considering potential implications of such constructions. In this chapter, an introduction to the relevant areas of literature will be provided (they will be discussed further in later chapters), the aims of the thesis clarified, and an overview of the chapters to follow presented.

1.2 An introduction to breast cancer screening, prevention and risk management

Breast cancer is currently reported as the largest cause of cancer death amongst women in Australia (Australian Institute of Health and Welfare & Australasian Association of Cancer Registries, 2004), as in other Western nations. The most recent available data reported that, in 2001, over 11, 000 Australian women were diagnosed with breast cancer, and just under a quarter of this number died from the disease (Australian Institute of Health and Welfare, 2005a; National Breast Cancer Centre, 2004). Breast cancer mostly affects women over 50 years of age, and the chance of being diagnosed increases with age. The lifetime chance of developing breast cancer is currently reported as being approximately one in eleven (National Breast Cancer Centre, 2004). The mean age at diagnosis in 2001 was reported as 60 years, with the disease affecting younger women at much lower rates (Australian Institute of Health and Welfare, 2005a). Less than 1 per cent of the people diagnosed with breast cancer are men (Australian Institute of Health and Welfare, 2005b).

Little is known about the causes of breast cancer. Consequently, medical research and health promotion strategies have tended to focus on 'risk factors', and on determining the best means by which women might prevent the disease or detect its early occurrence. Currently, a number of 'risk factors' for breast cancer are commonly discussed in the medical and public health literature. These include gender and age (breast cancer occurs primarily in women over the age of 50); a history of benign breast disease; a family history of the disease (particularly in a first-degree relative, such as a mother or sister); a particular inherited genetic mutation; cancer history elsewhere in an individual's body (including previous breast cancer); and some behavioural and lifestyle factors, such as age at first pregnancy, diet, weight, age at first period, age at menopause, alcohol intake, smoking status, and use of hormonal drugs (The Cancer Council SA, 2004).

To detect the early occurrence of breast cancer and, thus, potentially prevent death from the disease, all women (especially those with any of the above risk factors) are encouraged to screen for the disease (National Breast Cancer Centre, 2004; The Cancer Council SA, 2004). Screening is generally defined as the process of looking for disease in healthy people who have no symptoms of disease. The recommended means of breast cancer screening vary slightly between countries and organizations, and have also shifted over the period in which the present research has taken place. Generally, recommendations include mammography (depending on a woman's age) plus breast self-examination and/or clinical breast examination, or what is more frequently being referred to now as 'breast awareness' (e.g., BreastScreen SA, 2003; National Breast Cancer Centre, 2004; The Cancer Council SA, 2004).

As mentioned, however, there is public and academic controversy surrounding these various techniques that aim to detect and manage risk of breast cancer (see, e.g., Baxter & The Canadian Task Force on Preventive Health Care, 2001; Langlands, 1998; Meiser, Butow, Barratt et al., 2000; Meiser, Butow, Friedlander et al., 2000; Nekhlyudov & Fletcher, 2001). For example, there is no consistent 'expert' opinion regarding the efficacy of mammography, nor concerning which groups of women should be targeted for screening using this technique. Similarly, debate surrounds the possible benefits and detriments of breast self-examination.

Women with a family history of breast cancer, and those who are categorized as being at 'high risk' due to the results of genetic testing, have been a focus of interest in both the psychological and medical literatures, as well as in the popular media. Guidelines for the management of these women's 'increased risk' of breast cancer have centred around three main preventative options: (1) a strict regimen of surveillance (breast self-examinations, clinical examinations and frequent mammography); (2) a preventative chemotherapeutic agent; and (3) bilateral prophylactic mastectomy (removal of healthy, non-symptomatic breasts). The relative effectiveness of these options, and the advantages and disadvantages of each, remain topics of investigation and debate. However, reports suggest that preventative surgery, in particular, is considered the preferred option by increasing numbers of women (Hallowell, 1998; Meiser, Butow, Friedlander et al., 2000; Stefanek, Helzlsouer, Wilcox, & Houn, 1995).

Given the continuing debate surrounding these practices, the research presented in this thesis aims to contribute to the literature in this area by providing an analysis of

the ways in which breast cancer screening, risk and prevention are discursively constructed and accounted for in a range of talk and text. This analysis has also been informed by sociological theorising around the increasing emphasis on ‘risk’ in contemporary democratic (typically, Western) nations. I will briefly introduce this literature now.

1.3 The new public health and ‘risk’

As can be seen from the previous brief review, the notions of risk and risk management are central in research and practice around breast cancer, as well as in public health practice more generally. Sociological theorising about the increased societal emphasis on risk suggests that this focus is typical of a general shift in conceptualisations of health and health-care in modern liberal democratic societies (Bunton, 1997; Nettleton, 1997; Petersen, 1997; Petersen & Lupton, 1996). In advanced liberal societies like those of present-day Europe, the United States and Australia, an emphasis on the existence of rational, autonomous individuals has emerged (Rose, 1989). Governance in such societies is argued not to be “domineering, repressive or authoritarian” in nature (Petersen & Lupton, 1996 p.12) but, instead, involves the production of subject positions for citizens as active, ‘informed’ societal members who self-regulate and self-govern in line with the aims of the State – such as achieving a “healthy, happy, and productive population” (Nettleton, 1997, p.211). As such, matters of health and health-care are argued to become the responsibility of individual citizens, who have “right and a duty to maintain, contribute to and ensure ... their health status” (Nettleton, 1997, p.208).

The concept of risk is central in this conceptualisation of health and in producing “more self-regulating and productive” citizens (Petersen & Lupton, 1996, p.12). In order to take active responsibility for their health, individuals are increasingly enjoined to be aware of risks. In this way, assessment and management of risks has become an important part of the modern citizen’s management of self (Bunton, 1997). As a consequence, risk factors themselves come to be understood as “diseases to be cured” (Nettleton, 1997, p.215); they become something that individuals, as active responsible citizens, must do something about in order to ensure their future health.

Finkler (2000) has suggested that as a result of the increasing dominance of genetic explanations for disease, or what she calls the ‘ideology of genetic inheritance’, all bodies have come to be understood as potentially unhealthy or ‘at risk’. The line between health and illness, then, is becoming increasingly blurred. Furthermore, even healthy individuals can become positioned as “perpetual patients without symptoms” (Finkler, 2000, p.58) given their ‘at risk’ status and the medical interventions (increasingly) employed to manage such a condition (Petersen, 1997). These changes in the ways health and illness can be understood have also led to shifts in the conceptualisations of the sites of concerns about health. Health concerns can now be seen as being central to all aspects of an individual’s life, as opposed to being confined to specific times and places, such as in a hospital when an individual is ill (Bunton, 1997; Nettleton, 1997). When the site of health concerns was conceptualised as being primarily located within doctor-patient interactions, responsibility for health could be located with the doctor or ‘expert’. However, in advanced liberal societies, with the infiltration of health into all aspects of life, there

is a shift in focus to the individual's responsibility to manage his/her own health and, correspondingly, for managing health risks. A focus on breast cancer risk, and particularly genetically-indicated risk (and associated risk-management techniques such as prophylactic mastectomy), can be seen as a contemporary public health issue that exemplifies the shifts in conceptualisations of health and health-care in modern liberal democratic societies (Bunton, 1997; Nettleton, 1997; Petersen, 1997; Petersen & Lupton, 1996).

In the final sections of this chapter, I revisit the aims of the thesis, given the introduction provided here, and also look ahead to the contents of this thesis, summarising the main contribution of each chapter.

1.4 Aim of the research

The aim of the research presented here is to provide a discursive analysis of talk and text relating to breast cancer screening, risk and prevention, given the prevalence of the disease, the debate that surrounds the techniques currently available to prevent and detect the disease, and the sociological theorising around the contemporary emphasis on risk and individual responsibility for risk management.

This thesis therefore provides an analysis of empirical data from three different contexts: (1) media texts, (2) health promotional campaign material, and (3) women's focus group talk. The analysis will investigate the ways in which language is used flexibly to negotiate and construct issues of risk and responsibility for health - issues that are of interest in sociological theorising around health-care in modern Western societies, as well as in the areas of public health and health promotion. A

further aim is to consider potential implications of the broad discourses and linguistic practices surrounding issues of breast cancer screening and prevention: for example, in terms of the subject positions that are typically made available for members of advanced liberal societies (and, in particular, for women).

It is important to note, at this point, that my aim in these analyses is not to criticise attempts to prevent illness, nor to recommend whether women should, or should not, screen or engage in preventative behaviours for breast cancer, or any other diseases. Indeed, my conclusions and implications are not directed towards influencing or changing women's behaviour at an individual level. Instead, I hope that by examining talk and text surrounding these behaviours, and exploring discursive patterns that emerge in several specific contexts, this research can go some way towards making visible, and questioning, taken-for-granted notions that may be implicit within understandings of risk. I also hope to illustrate some ways in which notions around risk and prevention are socially constructed. Furthermore, the thesis will explore and question potential implications of the increasing emphasis on 'risk' in relation to breast cancer, and health practices more generally.

My central aim therefore is to examine language used in relation to breast cancer screening, risk and prevention in particular contexts - to represent an extreme form of prevention in the media, to encourage women to screen in health promotional material, and that is used by women themselves use to account for their screening practices (or lack thereof) - and to consider the implications of such representations.

1.5 Overview and structure of thesis

In this chapter I have introduced the issues of analytic concern, and the research questions that will be addressed in this thesis. The next chapter, *Chapter 2*, outlines the methodological and analytic approach adopted to conduct the research: broadly speaking, a synthetic discursive approach. The methodology will be discussed in detail and, where relevant to this research, my position on a number of current debates will be outlined.

In *Chapter 3*, I expand on the background presented in the current chapter, reviewing relevant literature and previous research concerned with breast cancer screening, risk and prevention, as well as public health and sociological theorising about contemporary health-care. Specifically, I discuss risk management and preventative health-care options for women in relation to breast cancer (including points of debate in the medical, psychological and public health literature), and examine how such strategies can be understood as located within a history of public health. Furthermore, I locate these risk management strategies within a broader theoretical context, which would suggest that the increased societal emphasis on risk is typical of a general shift in conceptualising health and health-care in modern democratic societies. The aim here is to provide a context for the analysis to follow in Chapters 4-6.

Chapter 4 is the first of the analytic chapters in this dissertation, and focuses on a detailed discursive analysis of two popular media accounts of prophylactic mastectomy. Specifically, the analysis aims to explore some ways in which this procedure was constructed, and in which women undergoing the procedure were

positioned in two contrasting reports. The media have been argued to have a powerful influence on public understandings of health and illness and, consequently, the constructions of women, risk and health that are presented in accounts of prophylactic mastectomy such as those analysed in Chapter 4 may have broader implications for preventative health-care.

Chapter 5 takes data from a different, but also influential, source as its focus for analysis: health promotional material advocating breast cancer screening for women. Specifically, this chapter provides a discursive analysis of a sample of promotional pamphlets and aims to examine ways in which these materials position women as both 'at risk' of breast cancer, and as responsible for the management of their risk.

Chapter 6 is the final analytic chapter. It centres on data collected in focus group discussions conducted with asymptomatic women aged 50 and over (the age at which women are eligible, and targeted, for mammographic screening in South Australia). Given current debates surrounding the range of available screening and prevention techniques, and recent theorising about shifts in understandings of health and health-care, the aim in this chapter is to explore the ways in which women themselves talk about such issues. Also of interest here is how the flexible negotiation and construction of issues relating to responsibility, risk and prevention can be seen in talk-in-interaction.

Chapter 7 is the concluding chapter of the dissertation. Here, I summarise the findings of the analyses in Chapters 4, 5 and 6, and consider implications of the research for approaches within public health and health promotion, as well as for a

critical public health psychology that has as its aim the development and maintenance of a critical, reflexive and ethical approach to health research.

In the next chapter an introduction and examination of the methodological and analytic approach taken in this thesis is presented.

Chapter 2

Methodological and analytic approach

2.1 Introduction

The aim of this chapter is to introduce the methodological and analytic approach adopted in this thesis: a synthetic discursive approach. I will provide here a background to this approach, and highlight features that I take as central to my analysis of talk and text in this thesis. I will also discuss how such an approach is useful for questions relating to health and illness, such as those asked in this thesis. Finally, I will provide some discussion of the data analysed in Chapters 4-6, in light of the discursive approach that will be taken to the analysis.

2.2 Synthetic discursive approaches

The analysis presented in this thesis is informed by a synthetic approach to discourse analysis (Edley, 2001; Wetherell, 1998). Such an approach aims to integrate features of the two dominant strands of discursive research: broadly speaking, those influenced by post-structuralism, and those by conversation analysis. In the following sections, I will examine features of this synthetic approach to analysis.

2.2.1 Language as constructive and action-oriented

My analysis of accounts of breast cancer screening, risk and prevention takes as its starting point the constructive and action-oriented nature of language. As such,

specific features of the accounts were explored with a focus on investigating their “orientation to action and the resources ... out of which they are constructed” (Hepburn, 2000, p.607). That is, the analysis focuses on what the text is doing, accomplishing, and constructing rather than treating accounts merely as reports or descriptions of real events, objects or attitudes events.

This approach to language is typical of a discursive, or discourse analytic, methodology (see Edwards, 1997; Edwards & Potter, 1992; Hepburn, 2000; Potter, 1996b; Potter & Wetherell, 1987, for extended discussion of discursive approaches to analysis). However, there are different levels at which language can be understood to be constructive and action-oriented, and these correspond with different traditions of discursive research. For example, language can be seen to do things at a local, micro level – people use it to achieve particular ends in particular conversations, and particular contexts. Research that focuses on this micro level of action includes conversation analysis, and discursive approaches influenced by conversation analysis (e.g., some types of discursive psychology). Language can also be understood to be active and constructive at a broader level. Particular ways of talking can be understood to be culturally and historically situated, and drawing on these ways of talking can be seen to be constructive of the social world in which we live, and the values, prejudices and understandings that make up that social world. Post-structuralist and Foucauldian approaches to research focus on the constructive nature of language at this broader, macro level.

The analysis in this thesis, as mentioned, draws on a synthetic approach, informed by the work of researchers such as Wetherell (1998) and Edley (2001) (others who have

drawn on this synthetic approach include Abell & Stokoe, 2001; Riley, 2002; Seymour-Smith, Wetherell, & Phoenix, 2002; Willott & Griffin, 1997). From this synthetic perspective, it has been argued that the division of discourse analysis into two competing theoretical camps is not particularly helpful, suggesting instead that the two approaches to analysis are complementary. Indeed, there is much overlap and variation within the range of approaches to understanding (and researching) the ways in which language accomplishes social actions. As Burman and Parker (1993, p.3) write

these approaches are united by a common attention to the significance and structuring effects of language ... a concern with the ways language produces and constrains meaning, where meaning does not, or does not only, reside within individuals' head, and where social conditions give rise to the forms of talk available.

As such, the analysis in this thesis, as with other discursive research, is compatible with a social constructionist epistemology, taking language as constructive of, and shaped by, social realities.

A synthetic form of discourse analysis takes as its base this focus on the “significance and structuring effects of language” (Burman & Parker, 1993), and draws on both theoretical factions of discursive work. These contrasting approaches can be seen to provide a “twin focus” (Willig, 2001, p.105) for discursive research, allowing an analysis that can concentrate simultaneously on the flexible and contextual use of talk at a micro level, as well as the broader social context in which

it is produced. In the following sections, I will briefly examine each of these approaches to discourse analysis and highlight the key elements they contribute to synthetic discursive approaches, and the analysis in this thesis.

2.2.2 Post-structuralist influences on discursive approaches

Post-structuralist theory is not easily summarised, and it is not my aim to give a comprehensive account of it here. However, it is a powerful influence in synthetic approaches to discursive work (including my own) and, as such, it warrants mention.

Broadly speaking, discursive analysis that is influenced by post-structuralist theory takes into account the historically- and culturally-shifting, rather than fixed, nature of meanings or truths that are constructed in language (Wetherell, 1998). Further, such analysis is concerned with the subjectivities, or subject positions, that are (re)created through such truths, and with how power is intimately connected with, and implicated in, the discursive (re)production of truths and subjectivities (Foucault, 1980). Thus, post-structuralist theory critiques the notion of scientific objectivity – that we can systematically gather facts about the world, and about people, that exist outside discourse, power and broader cultural understanding. Power, in this sense, is not conceptualised as something that one group or individual has and exerts over another. Rather, power is embedded in those truths and ways of being, of which we are all a part. Discourse becomes the site at which these truths, power structures and ways of being, are reproduced and challenged¹ (Foucault, 1980).

¹ ‘Discourse’ here refers to social systems of meaning, including both linguistic and non-linguistic elements (Wetherell, 1998).

In a discursive analysis informed by post-structuralist theory, these notions around power and discourse shape the ways in which identities can be viewed in language. That is, what we take as essential, fixed or natural about people – for example, ‘truths’ about gender, identities or particular universal human attributes - is destabilised and critiqued (Hepburn, 1997). Alternatively, these aspects of people are viewed as subjectivities, or subject positions that are socially and historically located and made hegemonic (or otherwise) by particular ‘regimes of truth’. Furthermore, in rejecting the notion of a single truth, existing separate to discourse and able to be discovered through scientific methodology, post-structuralist theory allows for a plurality of truths. This includes alternative truths that challenge existing power structures and work to construct new possibilities for meaning and subjectivity, for example, with respect to gendered subjectivity (Gavey, 1989; Malson, 1998). Post-structuralist discourse analysis can therefore be described as being concerned with “the ways in which discourses as social practices construct particular truths, particular realities and subjectivities and thereby re-produce particular (gendered) power relations” (Malson, 1998, p.44).

Therefore, in taking up post-structuralist theory as informing a synthetic discursive approach, my analysis will treat accounts of breast cancer screening, risk and prevention “not as more or less objective but as versions which actively construct certain realities or representations of the world” (Malson, 1998, p.7). These certain ‘realities’ are tied to particular power relations and make particular ways of being available and dominant. At the same time, however, a synthetic approach to analysis is concerned with more fine-grained analysis of language in its local context.

2.2.3 Conversation analytic influences on discursive approaches

Much of discursive psychology (DP) – the term that has, increasingly, been given to discursive approaches that look specifically at the ways in which analysis of talk and text can inform theorising about psychological concepts (Edwards & Potter, 1992) - has been influenced by conversation analysis. Conversation analysis (CA) is an “analytically orientated discipline that developed out of ethnomethodology” (Potter, 1996b, p.43) and that investigates exactly how language is put together and used in interaction. CA-informed discursive work focuses on the action-orientation and constructive nature of language at a micro level, examining the structure and local function of talk at the point of turn-by-turn interaction, rather than at the broader level of the cultural and historical production of social meaning. The CA influence on DP, while emphasising different features of analysis from post-structuralist approaches, is not (necessarily) incompatible with the examination of truth, discourse and power discussed above, thus allowing for the ‘twin focus’ of a synthetic discursive analysis.

An important point that tends to differentiate various styles of discourse analysis is the degree to which context (and which kind of context) is deemed relevant in carrying out analysis of language. Discursive work influenced by CA tends to draw on very little context outside exactly what is oriented to by participants, with the aim of not imposing the researcher’s own agendas or understandings of what is relevant in any situation. This is in contrast to broader styles of analysis, such as those drawing on post-structuralist theory for example, which emphasise wider understandings. These broader approaches argue that the meanings drawn on in any piece of talk or text always come with a particular history of understanding and

cultural relevance/power. They highlight that the researcher is always situated within a particular culture and history and, therefore, never able to be 'objective' and focus solely on the talk.

In attempting not to impose context, CA-informed DP is concerned with the action-orientation of talk as *displayed* by the participants' orientation. That is, rather than the analyst speculating about the action-orientation and constructive nature of talk, language is seen to have a particular function, only if that function can be demonstrated as having an effect in the conversation being analysed. Similarly, rather than speculate on the relevance of variables such as gender, or race, in producing particular talk-in-interaction, conversation analysts are interested in such factors only if oriented to by the participants. In contrast, post-structuralist approaches to discursive analysis would highlight the historical and cultural implications and functions of talk, and the power structures that are produced and regulated by the broad discourses drawn on in the talk, that are (potentially) outside of the local turn-by-turn action-orientation.

There are clearly many differences between discursive research working from the conversation analytic tradition, and that informed by post-structuralist theory, despite their similar focus on language, and its constructive and action-oriented nature. Three major differences, as outlined by Potter (1996b) are as follows.

Firstly, the language that is of interest for analysis differs between the styles of work. Coming from ethnomethodology, CA takes everyday language and, specifically, talk-in-interaction as its focus, viewing such talk as the site at which people carry out

social life. Post-structuralist work, which is not so interested in the minute detail of the structure of talk but, rather, the broader discourses or regimes of truth that are produced and re-produced in language, has consequently tended to draw on a wider range of text for analysis, including literary and philosophical texts.

Secondly, a focus on participants' orientation, as discussed, is central to analyses informed by CA. What is deemed relevant in analysis is what is consequential for the participants in the interaction and, therefore, CA focuses only on what is there, what is evident in the text. If the data to be analysed, however, is not talk-in-interaction (for example, if it is textual), as is often the case with discursive research working from paradigms other than CA, participants' orientation cannot be taken into account and, it has been argued, there is "less to hold the process of interpretation in check" (Potter, 1996b, p.68). However, on this point, it should be remembered that post-structuralist discursive analysis is not working from a position within which there can be understood to be a more 'correct' or 'true' interpretation or analysis of data and, as such, the 'problem' of not having participants' orientation to guide what is relevant for analysis is no longer an issue.

Thirdly, the motivation, particularly moral or political, for carrying out analysis has been argued to be different in CA and post-structuralist perspectives. CA has tended (although not exclusively) *not* to be interested in judging what is constructed about the world through language; investigating how the social world is ordered through language is thought to be of interest in itself. In contrast, for most researchers working from a post-structuralist perspective, "the *point* of looking at fact construction is to demonstrate the way particular representations of the world are

partial, related to interests or work to obscure the operation of power” (Potter, 1996b, p.69).

The synthetic approach drawn on in this thesis attempts to manage these tensions between post-structuralist and conversation analytic approaches to discursive analysis, arguing that these perspectives are complementary and can provide a more complete analysis than either in isolation (Wetherell, 1998).

2.2.4 A synthetic approach - critical discursive psychology

The analysis in this thesis is informed by the move towards a synthetic approach to discursive psychology, that integrates key features of both post-structuralist and conversation analytic approaches (Edley, 2001; Wetherell, 1998). It focuses on the action-orientation and specific features of language in its immediate context, as well as post-structuralist interests in the broader implications of language, and the realities and subject positions that are constructed as a result of the local or ‘micro’ context. In this section, I point out some features and concepts that can be seen as central in a combined approach to discursive analysis and that have, consequently, informed and influenced my analysis in this thesis.

There are strengths and weaknesses in both CA and post-structuralist styles of discourse analysis. As Wetherell (1998, p.395) has argued

[p]ost-structuralist theorists, with their more global view, rarely have their noses pressed up against the exigencies of talk-in-interaction. Rarely, are they called on to explain how their perspective might apply to what is happening

right now, on the ground, in this very conversation. Theoretical concepts emerge in abstract on the basis of often implicit assumptions about the nature of interaction, language or social life.

However,

[i]f the problem with post-structuralist analysts is that they rarely focus on actual social interaction, then the problem with conversational analysts is that they rarely raise their eyes from the next turn in the conversation, and, further, this is not an entire conversation or sizeable slice of social life but usually a tiny fragment (Wetherell, 1998, p.402).

A synthetic approach to discourse analysis, therefore, focuses on *both* the detailed organisation of language in its local context, *and* its broader context, in terms of historical, cultural and political power, and implications for subjectivity. That is, how different ways of constructing the world are flexibly deployed in language is investigated by taking the local interaction into question. Simultaneously, investigating the local interaction tells us something about the wider cultural ideologies at work (Edley, 2001). Nevertheless, the local context of talk and text is the site at which these ideologies are reproduced, maintained, challenged, rejected and alternatives constructed. Edley (2001) therefore refers to this analytic approach as a ‘critical discursive psychology’ – combining the ‘critical’ elements of post-structuralism, and the more conversation-analytically influenced ‘discursive psychology’. Informed by this perspective, the analysis in Chapters 4-6 aims to

consider the action-oriented and constructive nature of language at both local and broader levels.

In taking this style of analysis, however, I acknowledge that there is a danger in combining approaches - instead of getting the best of both worlds, if you like, the analyst risks opening her research up to all the criticisms that have been aimed at the approaches she hopes to synthesise. I am certainly not arguing that a synthetic discursive approach has dealt, completely, with the respective critiques of post-structuralism and conversation analysis. Rather, I hope that in attempting to employ a synthetic approach, I can contribute to the growing body of work in, and development of, a critical discursive psychology, highlighting theoretical and methodological shortcomings, but also strengths, and suggesting ways in which we might best improve our research.

For now, though, I will highlight some of the specific ways in which the critical discursive psychological perspective employed in this thesis approaches analysis. In particular, I am going to return to the three differences between post-structuralist and conversation analytic styles of discursive analysis that were outlined in the last section, and reflect on how, from a synthetic perspective, I have managed these differences in my analysis.

(1) *Sources of data*

As will be discussed in a later section (2.4), the sources of data that I have focused on in this thesis are varied. I have analysed some (non-‘naturalistic’²) talk-in-interaction, as well as some textual data. Given my synthetic approach to analysis, these data represent samples of talk and text appropriate for a range of analytic questions.

(2) *Participants’ orientation*

Although participants’ orientation is central in my analysis of talk-in-interaction, I also have textual data in my sample, for which this analytic focus is not appropriate. However, the local or immediate context of the language used in textual data was considered, as well as the broader cultural constructions drawn on and perpetuated.

(3) *Moral and political motivation for research*

A synthetic approach to discursive analysis allows for a focus on the interactional business of talk, as well as post-structuralist concerns with power and subjectivities. Certainly, a central concern of, and motivation for, my analysis is to highlight the (potential) cultural and political implications of the language used in my corpus of data. In terms of my personal motivations, I am coming to this data as a feminist concerned with possible consequences of the continuing surveillance and monitoring of bodies, particularly women’s bodies. I am also interested in social interaction, and in the role language plays in ordering social

² I have not yet dealt with the debate surrounding ‘naturalistic’ and ‘contrived’ data. This will be discussed in section 2.4 below, but it should be noted, here, that the talk-in-interaction that I have analysed in this thesis is, arguably, not the everyday, ‘naturalistic’ data preferred by conversation analysts. Rather, it is recorded and transcribed focus group talk.

interaction. Additionally, I have a commitment to a social constructionist epistemology, in part for the possibilities this framework allows us, as critical psychologists, to take a moral and political stance in our research, and to critique disempowering discourses and practices. A critical/synthetic discursive psychological approach to research allows me to incorporate all of these motivations in conducting my analysis.

As described in the previous section, another important point that differentiates types of discourse analysis is the degree to which context (and which kind of context) is deemed relevant in carrying out analysis of language. In taking a synthetic approach to discursive analysis, I aim to focus my analysis on ‘what is there’ in the data itself and on the contexts made relevant in the language I analyse, as well as to situate the discursive practices demonstrated in my data within a broader historical and cultural context.

Specifically, then, in the analysis in this thesis, I will be examining samples of talk and text surrounding breast cancer screening, risk and prevention, for both the fine detail of how the language is structured and deployed – for example, the ways in which the language is being used, in specific ways, to be persuasive and to appear factual – as well as the historical and political context in which this talk and text is taking place – the available discourses that are drawn on, perpetuated and challenged in the language.

2.2.5 Analytic concepts in a synthetic discursive approach

Three key analytic concepts in a synthetic discursive approach, which are drawn on in the analysis in this thesis, are interpretative repertoires, subject positions and ideological dilemmas. Although these will be revisited where relevant in my analytic chapters, I will outline them here, to clarify the focus of a synthetic discursive approach.

(1) Interpretative repertoires

Interpretative repertoires are “recurrently used systems of terms used for characterizing and evaluating actions, events and other phenomena. A repertoire ... is constituted through a limited range of terms used in particular stylistic and grammatical constructions. Often a repertoire will be organized around specific metaphors and figures of speech” (Potter & Wetherell, 1987, p.149). Interpretative repertoires are “basically a lexicon or register of terms and metaphors drawn upon to characterize and evaluate actions and events” (Potter & Wetherell, 1987, p.138).

Interpretative repertoires are, in a sense then, building blocks of language – they are the linguistic resources available to us at any given time, or in a specific context, from which we can manage interactional business. Looking at the interpretative repertoires drawn upon in conversational data allows us to understand the ways of constructing the world, and the self, that are available culturally and historically. Particularly, by looking at those interpretative repertoires that are successful in managing interactional business (or not), we can begin to understand which ways of making sense are dominant and carry most weight. Such dominant, or hegemonic,

ways of understanding actions, events or people inevitably point to power implications – who is privileged by this way of making sense?

(2) Ideological dilemmas

Billig et al (1988) make the distinction between intellectual ideologies - which can be argued to fit with the more traditional notion of ideology and are coherent and consistent - and lived ideologies, which are thought to be “composed of the beliefs, values and practices of a given society or culture” (Edley, 2001, p.203). Lived ideologies are therefore the ways any society makes sense of the world – its common sense – and, in contrast to intellectual ideologies, are dilemmatic, contradictory and inconsistent. At the simplest level, the dilemmatic nature of lived ideologies can be seen in the maxims that make up our cultural ‘common sense’, for example, ‘too many cooks spoil the broth’ and ‘many hands make light work’. Billig et al (1988) drew on these examples, as well as many others, to highlight the conflicting and contradictory nature of ‘common sense’, and therefore to argue that lived ideologies are dilemmatic.

Furthermore, Billig et al (1988) argue that the fragmented and inconsistent nature of lived ideologies make them productive for social interaction, by providing a range of alternative discursive resources which are available to speakers. That is, ideological dilemmas function to facilitate and shape the ways in which we engage in conversation, argument and thought. Ideological dilemmas can therefore be seen, like interpretative repertoires, as culturally-situated resources available to speakers.

(3) *Subject positions*

Subject positions can be defined “quite simply as ‘locations’ within a conversation. They are identities made relevant by specific ways of talking” (Edley, 2001, p.210). As those ways of talking, such as interpretative repertoires and ideological dilemmas shift, so do the identities that are produced, or the subject positions that are made available.

The analyst then, needs to “stay aware of *who* is implied by a particular discourse or interpretative repertoire” (Edley, 2001, p.210), of the ways of being, or the kinds of identity that are made available by particular ways of talking. In a critical discursive approach to analysis, identities can be understood to emerge through social interaction, but not in a fixed way. Rather, identities are flexible, and constituted and reconstituted in discursive practices (Davies & Harré, 1990).

To summarise, in this section I have outlined a range of discursive approaches to analysis. Particularly, I have illustrated some of the key features of both post-structuralist approaches, and conversation analytic styles of analysis. Finally, I have discussed a synthetic approach that aims to combine features of both the above perspectives, allowing for a critical discursive psychology that focuses on the local context and detailed structure of language, as well as on the broader historical, cultural and political context in which such language is situated and for which it has implications. In the next section, I will turn to the application of critical discursive ideas in the field of health psychology.

2.3 Critical health psychology

The aim of this section is to examine how applying a synthetic discursive approach to analysis of accounts of breast cancer screening, risk and prevention can contribute to a critical health psychology. Critical health psychology, as a relatively new field that has emerged out of the growth of critical approaches in psychology as a whole, is concerned with examining assumptions and implications of health psychological research and practice, and dominant understandings of health and illness. As such, it has been engaged in questioning issues of methodology, epistemology and underlying values in health psychology and related health fields, such as public health (Murray, 2004c). For example, some critical health psychology has been involved with the application of theories and methods from critical and discursive psychology to notions and objects relevant to health behaviour. Critical health psychologists have also been involved with critiquing, deconstructing and highlighting the taken-for-granted and constructed nature of concepts relevant to health behaviour, such as 'health', 'illness' and the 'body'³, and with drawing attention to the political and social determinants of health (Marks, 2004; Murray, 2004a). The aim of such critical work in health psychology is not to be oppositional to other health research and practice but, rather, to contribute to the development of an ethical, reflexive and critical field as a whole (Murray, 2004a, 2004b).

Critical health psychology draws on a range of methodological and analytic approaches, and is certainly not limited to discursive approaches. In dealing with qualitative data, much critical health psychology has tended to draw on more traditional forms of qualitative analysis, such as content analysis and biographical

analysis (Wilkinson, 2000b). By applying both these approaches to the same set of data (transcripts of focus group interviews with breast cancer patients discussing causes of their disease), in addition to a discursive approach, Wilkinson (2000b) was able to provide a comparison of these three approaches to research. She found that each approach makes “fundamentally different epistemological assumptions about the data – assumptions that lead to entirely different understandings of the concept of ‘cause’” (Wilkinson, 2000b, p.452-453). Content analysis was thought to be attempting to elicit the participants’ attitudes and beliefs regarding causes of breast cancer, whereas biographical analysis could be understood to be deriving the ‘meanings’ of these beliefs for an individual’s construction of her life. In comparison, discursive analysis “examines the interactional work done by talk about causes (that is, talk as action)” (Wilkinson, 2000b, p.453).

The investigation specifically focused on three key epistemological issues of concern in qualitative research (‘context’, ‘footing’ and ‘multiple versions’). By assessing how well these issues were addressed by each approach, it was argued that a discursive approach “offers better solutions to these problems than do the other two approaches” (Wilkinson, 2000b, p.453), and should be used to advantage in the discipline of health psychology.

Similarly, Wilkinson has explored three of the key traditions of feminist research in health psychology, namely, positivist empiricism, experiential approaches and discursive research (Wilkinson, 2000a). She argues that although each of these traditions has grown out of a distinct theoretical position, they are all important in

³ I have placed these terms in inverted commas here to highlight their constructed, and contested,

advancing “understandings of women’s health and improving health care services” (Wilkinson, 2000a, p.359), but are suited to different types of research questions, and will generate different types of data.

From the synthetic discursive perspective taken in this thesis, talk and text are understood as the sites at which meanings around health, illness and the body are (re)produced and can be examined, to further the goals of a critical health psychology. Given the view of language as constructive and action-oriented in discursive approaches, “[t]alk about health behaviour is not, therefore, superfluous ostensible ‘noise’, which can be stripped away to reveal underlying internal intentions. Rather, talk itself, and what speakers are *doing* with their talk in particular local contexts is the focus of enquiry” (Peel, Parry, Douglas, & Lawton, 2005, p.781). Peel et al (2005, p.781) specifically refer to the application of discursive principles to health-related topics as a ‘Discursive health psychology’.

In Chapters 4-6, I analyse accounts of breast cancer screening, risk and prevention, taking into consideration the specific ways in which such accounts are put together, as well as the broader context in which they are produced and have implications. I consider assumptions and implications of language surrounding issues of risk and responsibility for health, examining the ways in which such language takes place in a social and political context, and has implications for the (gendered) subjectivities available for individuals, and ultimately for the kinds of health promotion strategies and health-care services that are available. I therefore locate my analysis within a

nature.

critical health psychology, and aim to contribute to the growing body of work that applies a discursive perspective in analysing health-related topics.

Before moving on to discuss the data that will be analysed in this thesis, I want briefly to discuss the issue of acknowledging the ‘reality’ of health and illness from a discursive perspective. Specifically, in taking a critical and discursive approach to analysing accounts of breast cancer screening, risk and prevention, I am certainly not aiming to deny the experience of illness, nor arguing that there may not be any identifiable or preventable health risks; I do not view these as ‘just social constructions’. Rather, the approach taken in this thesis argues that how we experience our bodies – healthy and ill – and what we take to be ‘risks’, or acceptable forms of prevention, are shaped by sociocultural processes (Lupton, 1999).

For example, as Petersen and Lupton (1996, p.47, italics in original) write of a social constructionist approach to health psychological research around HIV/AIDS,

[t]here is no doubt people die from the constellation of symptoms that currently bears the name ‘HIV/AIDS’. What *is* in doubt is the knowledge system operating around the causes of these symptoms, and the related issues of how best the syndrome can be treated and prevented.

Furthermore, the lived experience of health and illness can be understood as shaped and mediated by the discourses and dominant representations that exist culturally (Lyons, 2000; Yardley, 1997).

A critical and discursive analysis of discourses surrounding breast cancer screening, risk and prevention can examine the assumptions and implications of talk and text around these topics – the “knowledge system operating around” them (Petersen & Lupton, 1996, p.47, italics in original) - including the potential in language to challenge and negotiate dominant discourses. Furthermore, this approach allows for the location of understandings of health and illness within a social, historical and political context, separating them from a purely biological or psychological perspective and further opening up the potential for social change.

In the next section, I describe the data sources drawn on in this thesis, with reference to current debates around issues of data and context from within the discursive field.

2.4 Sources of data in this thesis

The data under analysis in this thesis come from three sources: media accounts of prophylactic mastectomy; health promotional campaign material relating to breast cancer screening; and women’s focus group talk about breast cancer screening, risk and prevention (as well as health and illness more broadly). These data include a mixture of talk-in-interaction and text. In this section I will briefly examine some of the debates surrounding sources of data for discursive research, before providing some discussion of each of my data sources.

The debates regarding appropriate data sources tend to divide discursive analysts in line with the theoretical divisions discussed earlier; between conversation analytic-style discursive research, and those approaches influenced by post-structuralism. CA

approaches generally take everyday talk-in-interaction as their focus for analysis, to see how talk is done and how meaning is produced in banal settings. For post-structuralist styles of analysis, talk-in-interaction is not required (although it can still be of interest) and, as such, analyses have often focused on a range of texts, including literary and philosophical texts (Potter, 1996b).

The key reason for this difference is the specific analytic focus of these approaches. As discussed, the analytic focus of CA is on the detailed organization, and systematic patterns, of talk as it is produced in everyday conversations. CA, as such, is interested in the fine-grained detail of *how* language is used, rather than (necessarily) what is constructed by language in a broader sense. Post-structuralist approaches are more interested in *what* truths are (re)produced in language, how those truths are historically and culturally contingent, and the ways of being or subject positions that are made possible by such truths.

There has also been a significant amount of debate and discussion surrounding the distinction between naturalistic and contrived data (see, for a useful summary, Lynch, 2002; Potter, 2002; Speer, 2002a, 2002b; Ten Have, 2002). ‘Naturalistic’ data can be thought of as data that would have existed regardless of the intervention of the researcher; “it has not been got up by the researcher” (Potter, 1996a, p.135). Another way of thinking of this, as suggested by Potter (1996a) is the ‘dead social scientist test’. That is, if the researcher had died on the way to work that morning, would the interaction still have taken place? If so, then the data can be understood to be naturalistic. Naturalistic data, then, includes things like everyday conversations (in person or on telephones) between family and friends, doctors and patients, work

colleagues, or even strangers. ‘Contrived’ or non-natural data, on the other hand, is generally thought of as language that is elicited specifically for the purposes of research, and is usually in the form of one-on-one interviews, or focus group discussions.

CA approaches tend to focus on naturalistic talk-in-interaction, as it is in everyday conversations that the organization of social interaction in language is displayed – the pauses, interruptions, all the details of interest in CA are found in everyday talk; it is interactionally rich. In contrast, interview data (including focus groups) can be thought of as ‘topic talk’, where participants speak on a topic they are asked about for the purposes of research. More interesting data is seen as everyday naturalistic talk-in-interaction, where the analyst is able to see how a concept or topic is worked up or *done* in talk. An analyst working from a CA perspective would prefer to collect naturalistic talk-in-interaction, rather than analyse interviews or textual data, allowing the analytic focus to be driven by the speakers’ talk.

However, in a synthetic discursive approach to analysis, as taken in this thesis, the distinction between naturalistic and contrived data is not as relevant. This is because both the interactive details and organization of talk-in-interaction, and the broader meanings being constructed and reproduced in, and by, talk and text, are seen as relevant and interesting in analysis. Furthermore, as discussed previously, the focus of this thesis is on investigating the social construction of risk, and of responsibility for health and illness. Taking three different sources of discourse around these topics allows for a more detailed examination of their construction in different social spheres, each with different functions and audiences.

2.4.1 Focus group data

The talk-in-interaction I will be analysing (in Chapter 6) occurred in the context of focus groups, conducted specifically for the purposes of the research. This data source does not pass the ‘dead social scientist test’ – the groups would not have taken place without my intervention as the researcher – and, in this sense, the data can be seen as ‘contrived’.

However, it has been suggested that how we determine if data is ‘natural’ depends on the focus of analysis. Lynch (2002) draws a distinction between naturalistic data and ‘naturally organised ordinary activities’. That is, interviews or focus groups may not classify as ‘naturalistic’, but may be able to be considered a naturally organised ordinary activity; research interviews in themselves could be considered an everyday setting for conversation (if we are interested at looking at how interview talk is organised). In analysing focus group data from a synthetic perspective, my analysis will consider both the organization of the interaction, acknowledging the context of a research focus group, and the broader constructions and subject positions drawn on and made available in the talk.

One of the primary advantages argued to be associated with ‘contrived’ data is that it allows the researcher to focus specifically on the chosen research topic: in this case, breast cancer screening and risk. Furthermore, while it could be thought that one-on-one interviews would be the best way to gather language on a specific topic, it has also been suggested that focus groups are an “ideal method for exploring people’s own meanings and understandings of health and illness” (Wilkinson, 1998b, p.329).

Wilkinson (1998b, p.334) has explored the “specific mechanisms through which focus groups elicit participants’ own meanings”. For example, focus groups have been shown to enhance the disclosure of participants, particularly when discussing sensitive issues. It is thought that it can be easier for a participant to discuss and disclose personal, even painful, experiences when they are in a group of people who have been in similar situations and are supportive, rather than in a one-on-one context with only an interviewer, who may not have shared experiences (Wilkinson, 1998b).

Focus groups are also thought to provide a researcher with access to participants’ own language and ways of discussing particular issues. As participants in a focus group tend to talk to one another more than they do to the researcher, it is their own language, rather than that of the researcher, which is primarily used. Particularly if the participants are of a different age, racial or cultural background to the researcher, the language they choose to use may be very different to the researcher’s. A focus group can therefore be seen as being closer to a naturalistic conversation than a one-on-one interview (Wilkinson, 1998b).

In the context of my own research, I was aware that, as a woman in my twenties, a one-on-one interview with a woman over 50 years of age regarding her breast screening behaviours (to many, a very personal issue), may not have elicited a relaxed flow of conversation, or a context in which the participant felt comfortable to speak freely. Although the point of my analysis was not to obtain the ‘true’ stories or feelings of my participants, focus groups with other women of a similar age allowed

my participants to feel more relaxed and to talk in a way that might be considered more 'naturalistic'.

Another function of the focus group is that the researcher's control over the topics of discussion is lessened. This can be seen as problematic, but it can also be advantageous if the researcher is interested in the participants' own meanings. By allowing the members of the focus group to direct the focus of the conversation, the themes that are particularly important to them will emerge. The researcher may not have considered these themes previously and, as such, their research may be more informed (Wilkinson, 1998b). In terms of the debate about naturalistic data, allowing the participants more freedom to talk can also be seen as advantageous. Although it must be considered that participants are talking in a specific context, constraining what they are able to say in the format of a question/answer one-on-one interview, I would argue, does not enable participants as much freedom to draw on some of the culturally 'normal' (and more 'naturalistic') patterns of talk-in-interaction. As Willott and Griffin (1997, p.110) write, focus groups enable the researcher "to maximize participants' contribution to the construction of meanings and to get as close as is possible, within the context of an interview, to 'everyday talk'". Thus, both the meaning-making, that is of interest in macro styles of discursive analysis, and the interactive nature of (something like) 'everyday talk', can be considered within analysis of focus group talk-in-interaction. Additionally, from a pragmatic point of view for this project, focus groups were, arguably, the best compromise between accessing naturalistic talk about breast cancer screening practices, and holding one-on-one interviews on the topic.

Finally, the focus group context can encourage participants to elaborate their accounts, as they are challenged or supported by fellow participants. As such, focus groups provide the researcher with “an opportunity to observe the co-construction of meaning in action” (Wilkinson, 1998b, p.338). Wilkinson thus concluded that “focus groups are an ideal method for eliciting people’s own meanings and understandings of illness” (Wilkinson, 1998b, p.341), and can be used within a range of analytic frameworks, and for a variety of research questions.

There is much scope for the development of focus group methodology. As yet, many researchers have tended to treat the data generated by focus groups as they would data from a one-on-one interview (Wilkinson, 1998a). As it is the interaction of focus groups that separates them from one-on-one interviews and enables the features discussed above to be present, the interaction should be included. Indeed, from a synthetic discursive psychological perspective, this interactive context is crucial, and interesting, in the analysis of focus group talk.

I will now talk about textual data as a focus for discursive analysis. By definition, the focus of CA is on conversation and, therefore, textual data, in which there is not interaction, is not appropriate for CA styles of discursive analysis. However, the ways in which I have approached my textual data from a synthetic style of discourse analysis will be discussed in the following section.

2.4.2 Textual data

In Chapters 4 and 5, I analyse data that is textual in nature. That is, it is not talk-in-interaction but, rather, printed text. Specifically, the data I will look at are in the form

of non-fictional media accounts (newspaper and magazine articles, and transcripts of television reports), as well as printed promotional material (pamphlets) for breast cancer screening. These sources of data provide further contexts, additional to the women's focus group talk, in which to examine the ways that ideas about breast cancer risk, and responsibility for risk, are constructed and deployed.

Furthermore, as Wetherell and Potter (1992) write, the theoretical interest, as discourse analysts, is in exploring "discourse as social practice". One of the consequences they describe as resulting from this focus is that it "has led us to analyze discourse in terms of its entry into the world of practical affairs: everyday conversation and texts" (Wetherell & Potter, 1992, p.90). I would argue that the textual data I have analysed constitute, in Wetherell and Potter's words, 'everyday texts', providing a site at which to "analyze discourse in terms of its entry into the world of practical affairs" (p.90). More specifically, the data provide access to culturally available ways of discursively constructing ideas around breast cancer screening - for example, health, illness, risk and responsibility – outside of a 'contrived' research interview. I will discuss each of my sources of textual data separately.

Media data

In Chapter 4, I discuss in detail the usefulness of analysing media data to investigate meanings of health and illness, so I will only briefly outline here some my reasons for taking this as a source of data.

Many researchers have argued that popular and news media constitute a crucial source of public information, and that the media exerts a powerful influence on public understandings of, and responses to, a range of contemporary issues, including health and illness (Chapman & Lupton, 1994; Chapman, McLeod, Wakefield, & Holding, 2005; Henderson & Kitzinger, 1999; Lyons, 2000; Miller, Kitzinger, Williams, & Beharrell, 1998; Petersen, 2001; Philo, 1999). It has been argued that print news media stories contribute to the shaping of agendas for public debate (Petersen, 2001), and that media stories are vividly recalled, and influence the understandings displayed by participants in other contexts (such as focus groups) (Henderson & Kitzinger, 1999; Lupton, 1994a). Furthermore, Lyons (2000, p.350) has argued that it is important for health psychologists consider media representations of health issues because:

First, they affect individuals' beliefs and understandings about health and illness, which in turn can affect a diverse range of issues such as risk perception and health behaviours. Second, representations create and reproduce meaning and thus can influence, for example, individuals' attitudes towards people with disease and how certain subgroups of the population are viewed. Third, representations of health can mediate individuals' lived experience of physical sensations and their subjectivities.

Similarly, it has been argued that detailed attention to specific forms of popular media is particularly important if we are to gain insight into how such representations might influence public understandings, particularly of health and illness issues such as breast cancer causes and prevention (Henderson & Kitzinger, 1999).

Health promotional material

In Chapter 5, I focus on an analysis of pamphlets promoting breast cancer screening. Like media accounts, these pamphlets also make up an everyday text and are, therefore, appropriate to be analysed to explore how discourse (at both micro and macro levels) is used as a social practice. Indeed, like media material, such health promotional material can be seen as a key source of public information about health and illness (Gigerenzer, 2002; Metsch et al., 1998), and a site at which contemporary discourses surrounding health and illness are constructed, maintained, and negotiated.

The synthetic discursive approach to analysis that I am taking in this thesis allows me to consider the local context of language, as well as the broader meanings, and ways of being or subject positions that are (re)produced in talk and text. As discussed, styles of analysis that focus on the local or micro features of language, typically, have analysed talk-in-interaction. I hope to show in my analysis in Chapters 4 and 5, however, that a synthetic approach can also adopt features of this fine-grained style of analysis, and focus on the specific rhetorical organization and function of accounts in textual data. Thus, I have analysed the talk and text in a range of printed media data and health promotional material, with a focus on investigating the action-orientation and constructive nature of specific discursive resources drawn on in accounts of breast cancer risk and prevention. In addition, in line with a synthetic discursive methodological approach, the broader constructions that emerge from the use of such discursive and rhetorical strategies are considered. Including these two different textual sources of data for analysis, as well as the women's focus

group talk, allowed for examination of the social construction of the key concepts of interest – health and illness, risk, and responsibility for risk – across contexts where they are used to achieve different functions and for different audiences.

2.5 Summary

In this chapter, I have introduced the methodological and analytic approach taken in this thesis: a synthetic discursive approach, which takes language as constructive and action-oriented, and is influenced by both post-structuralist theory and conversation analysis. Such an approach allows me to focus on the local context and detailed structure of language, as well as the broader historical, cultural and political context in which such language is situated. I also examined how applying a synthetic discursive approach to analysis of accounts of breast cancer screening, risk and prevention can contribute to a critical health psychology. Finally, I gave an outline of the sources of data that will be analysed in later chapters, with reference to some of the debates surrounding data sources for discursive analyses. Given the interest, in this thesis, on the broader historical, cultural and political context in which talk and text around breast cancer screening, risk and prevention are situated, a range of data sources were chosen to allow for a more in-depth analysis of the social construction of health, risk and responsibility.

In Chapter 3, I aim to provide a broader context for the research in this thesis, in terms of literature and previous research relating to breast cancer screening, risk and prevention, as well as public health, and sociological theorising about shifts in contemporary health-care.

Chapter 3

Contextualising the research

3.1 Introduction

In Chapter 1, I gave a brief introduction of the issues of concern in this thesis: contemporary preventative health practices and, particularly, breast cancer screening, risk and prevention. The aim of the current chapter is to provide a more extensive overview of relevant literature in order to contextualise the analysis that will follow in later chapters. I will therefore provide some background to the currently recommended breast cancer prevention and risk management techniques, as well as reviewing some of the controversies and debates that surround these practices. This background will be followed by a contextualising of current public health approaches and screening practices within a brief history of the development of public health as a field.

Finally, consideration will be given to ways in which current health practices and contemporary areas of focus in public health can be understood to be located within sociological theorising. This theorising is concerned with forms of governance in advanced liberal democratic societies and what they mean for the citizens of such societies. Such theorising also provides a context in which to understand the potential political implications of constructions of risk and preventative behaviours that are common in late 20th and early 21st Century Western cultures. Specifically of interest

here is what these forms of governance may mean for concepts of health, risk and responsibility.

3.2 Breast cancer screening, prevention and risk management

As discussed in Chapter 1, breast cancer is currently reported as affecting a significant number of women in Australia, and around the world. However, clear causes of breast cancer have yet to be identified. Subsequently, medical research and health promotion strategies have tended to focus on identifying ‘risk factors’ for the disease, and on developing means by which women might prevent or best detect the disease in its early stages. In particular, women (and especially those with any of the reported risk factors) are encouraged to participate in screening, in order to detect the early occurrence of breast cancer and, thus, potentially prevent death from the disease.

In the following sections of this chapter, I will briefly review the most commonly recommended forms of screening for breast cancer: mammography, and breast self-examination and/or clinical breast examination. I will examine some of the controversies and debates surrounding these practices, with the aim of showing that although these techniques are often recommended as unproblematic to women by way of various health promotion strategies, there are debates and disagreement surrounding them in the medical and psychological literature.

3.2.1 Mammography

A screening mammogram is basically a breast x-ray performed to detect any signs of disease in a woman who currently experiences no breast symptoms. The aim of screening mammography is to detect cancerous lumps at an early stage so that early treatment can reduce illness and death from breast cancer (Primary Care Division, 2003). It should be noted that mammograms are also used for diagnostic purposes. That is, if a woman presents with symptoms, such as a breast lump, she can be sent for a diagnostic mammogram – a breast x-ray to investigate further and diagnose her symptoms. My focus here, however, is on the use of mammograms for screening purposes.

History and critiques

Breast cancer screening was first established at a population level in the 1930s in Germany as part of the emphasis on cancer prevention and early detection that was a feature of the Nazi regime's approach to health (Proctor, 1999). Physicians and women were both urged, by way of mass campaigns, to be aware of the benefits of early detection, including breast x-rays and physical examinations (by doctors, and women themselves). Health promotion of these screening practices ceased during World War II, and campaigns promoting such screening in America did not emerge for another thirty years (Proctor, 1999).

After a Houston radiologist, Robert Egan, demonstrated in 1960 that mammography could detect early breast cancers, the technique was acknowledged in America as a diagnostic tool. In December 1963, a randomised control trial (which later became known as the HIP trial, due to the participation of women who were enrolled in the

Health Insurance Plan (HIP)) began to investigate the use of mammography as a screening method for asymptomatic women. The participants, 62, 000 women in greater New York, were allocated to either a control or an experimental group. Women in the experimental group were allocated to receive a clinical breast examination and a mammography each year for five years, whereas those in the control group were not encouraged to participate in screening. After 10 years, a significant reduction in the number of breast cancer deaths was noted in the experimental group compared to the control group. The results of the trial were interpreted as suggesting that mammography saves lives (Batt, 1996).

Since the HIP trial, mammography has continued to be a focus of research and debate, particularly in relation to the potential benefits of mammography, and the age at which women should begin having regular mammograms. To date, there have been 10 major randomised trials of mammography, the results of which have been interpreted as suggesting “there is yet no evidence that mammography screening reduces mortality from breast cancer for women in their 40s” (Gigerenzer, 2002, p.61). With regard to women who began screening at age 50 or over, three studies are reported as having found “a significant reduction in breast cancer mortality; four found reductions that were too small to be distinguishable from zero; and one found no reduction at all” (Gigerenzer, 2002, p.61). When the results of all the studies are combined, there appears to be some reduction in breast cancer mortality as a result of mammography screening in women aged 50 years and over. However, this conclusion has been disputed, particularly on the basis of criticisms that many of the trials have not been adequately randomised, and that variables other than the screening could explain the results. It should also be noted that although the

mortality from breast cancer appeared to be reduced, the overall mortality rates of the experimental and control groups across these trials were not significantly different (Gigerenzer, 2002).

In addition to the debates that surround the possible benefits of mammography, there are also reported detriments⁴. For example, it has been estimated that, over a series of 10 mammograms, one in every two women can expect at least one false positive result – that is, a positive mammogram, possibly leading to an ultrasound and biopsy, when a woman does not have breast cancer (Gigerenzer, 2002). There have even been cases of women who have mistakenly been given mastectomies (although these reports are primarily from the 1970s) (Zones, 2000).

Additionally, some breast cancers are non-progressive and, without detection as a result of a mammogram and the subsequent treatment, they would not necessarily affect the woman's health or length of life. Some breast cancers are slow-progressive – so slow that women who have them may die of other causes long before the cancer kills them. Women with non- or slow-progressive tumours go through potentially unnecessary and detrimental detection, diagnosis and treatment procedures as a result of mammograms.

It is also possible that some women may develop breast cancer as a result of exposure to radiation from mammograms. The number of women who develop radiation-induced breast cancer is hard to quantify for a number of reasons, and

⁴It should perhaps be noted that an American survey of a random sample of women (Schwartz et al, 2000 in Gigerenzer, 2002, p.73) found that a very small percentage of participants were aware of these detriments – or at least raised them in the context of the study.

estimates vary. The risk involved with exposure to radiation is, however, generally acknowledged as a potential cost of mammography (Gigerenzer, 2002; Zones, 2000).

There is also a group of women for whom mammograms do not perform the role intended: women who receive a false negative result (Zones, 2000). These women do have breast cancer, but it is not detected by their mammogram. However, it should be noted that these women are not necessarily worse-off from having a mammogram - it is possible that their cancers would not have been diagnosed without mammography either.

These issues of concern regarding the efficacy of mammography have been raised continuously over a period of years, since mammography was first recommended to women in broad-scale screening programmes in a number of countries. Notably, Maureen Roberts, the Clinical Director of the Edinburgh Breast Screening Project from 1979, issued a warning about breast screening, and particularly mammography, just before she died from breast cancer (Roberts, 1989). She raised many of the issues mentioned above, particularly that:

- randomised trials of mammography have shown a “non-significant reduction in mortality” (p.1153) and, as such, screening “may not reduce mortality in women of any age” (p.1153)
- mammography is “an unsuitable screening test: it is technologically difficult to perform, the pictures are difficult to interpret, it has a high false positive rate, and we don’t know how often to carry it out” (p.1153)
- “it is clear that the proportion of women with breast cancer who potentially may benefit [from screening] is small” (p.1154). Furthermore, Roberts

highlighted that the potential benefit of mammography is a “reduction in mortality. This is not offering any certainty of cure or normal life to the women who attend, merely a prolongation of years for a few. Not only that: we cannot predict who will have these extra years” (p.1154).

More recently, it has been suggested that by emphasising the importance of early diagnosis and treatment, and by suggesting (indeed, advertising) that “breast cancer (is) curable if properly treated” and diagnosed early enough, the medical profession is, arguably, “maintaining treatment expectations at unrealistically high levels” (Langlands, 1998, p.214). As Roberts wrote about women attending screening: “they were almost promised (if only by implication) a good outcome if they attended for screening” (1989, p.1154). High expectations of the diagnostic capabilities of mammograms, and of what treatment can achieve, are potentially leading to an increase in the number of malpractice suits against medical practitioners on the basis of delays in diagnosis (Langlands, 1998). It is widely thought that early diagnosis improves the chance of successful treatment and, although this may generally be true, it is not always the case. Consequently, it has been argued that to reduce “the risk of litigation” (Langlands, 1998, p.214), the medical profession needs to make it clearer to women, and the wider population, that diagnostic tests such as mammography are fallible and treatment will not always be successful (Langlands, 1998).

Furthermore, Roberts (1989, p.1154) highlighted the possibility, even likelihood, that the funding of breast cancer screening programs was “clearly a matter of politics”. She argued that the government (she was specifically referring to the UK

Government, but such screening programs emerged around the same time in many industrialised countries, including Australia) had poured a large number of limited resources into breast cancer screening when such funds could have been directed elsewhere - into more evidence-based preventive programmes for equally serious problems, for example, for smoking-related illnesses. She even questioned the personal political motivations for the implementation and funding of screening programs, commenting that it “cannot be coincidence that the age and social class of those men who are influential in decision making are similar to those of their wives who appear to be at greater risk of the disease and also have the best chance of benefiting from screening” (Roberts, 1989, p.1154).

Links are still being made between political motivations and breast cancer screening, as well as to a range of other aspects of breast cancer detection and treatment. For example, Zones (2000) argues that the promotion of mammographic screening (as well as other aspects of breast cancer detection and treatment) can be linked to specific economic and political benefits for particular sections of the medical profession, related medical organisations and governmental agencies, and companies involved in the manufacture of mammography equipment, rather than to mammography’s inherent benefit for women. She claims that, “[c]orporate influence distorts our understanding of breast cancer, which can lead to decisions that are not in the best interests of women” (Zones, 2000, p.145). Furthermore, Weisman (2000, p.235) has argued that,

the mammography screening debate is inherently political. It is not only about resolving differences in interpretations of scientific data on efficacy or

incorporating the findings from the latest studies; it is also about the implications of recommended guidelines for health insurance coverage of mammograms, for reimbursement to providers and facilities that provide mammograms, for breast cancer research funding, for the credibility of individuals and organizations on different sides of the debate, and for women's health.

Mammography is clearly not an easy issue about which to draw definite conclusions. There are potential costs and benefits of the technique, both of which are the focus of continuing research and discussion. It is not the aim here to deduce whether women should have mammograms or not. Rather, I hope to have shown that mammography is not a clear-cut issue, and that there is ongoing debate and controversy surrounding its practice. Despite these disputes, the recommended guidelines for women in Australia (and other Western nations) promote the practice of mammography in a generally uncomplicated manner. In Chapter 5, the communication and promotion of these guidelines will be examined in some detail, but for the present purposes it will be sufficient to outline the nature of such recommendations.

Current guidelines

Guidelines regarding breast cancer screening generally originate from a health organization, often a national, state-funded or charity organization, which is involved with research and dissemination of information regarding cancer. These organizations base their guidelines on current research, but given the inconclusive nature of much research concerning breast cancer screening practices, the recommendations vary from country to country, and from organization to

organization. For example, in the United States, the American Cancer Society and the National Cancer Institute recommend mammography screening annually, or every one to two years, respectively, for women over the age of 40. In contrast, the U.S. Preventive Services Task Force, and the Canadian Task Force on the Period Health Exam recommend that women have a mammogram every one to two years from the age of 50 (Gigerenzer, 2002). In the U.K., CancerHelp UK recommends that women over the age of 50 have a mammogram every three years (CancerHelp UK, 2002).

Following the forming of the National Better Health Program in Australia in 1989 (O'Connor-Fleming & Parker, 2001), the Health Ministers of each State and Territory, together with the Commonwealth Government, agreed, in 1990, to fund a national mammography screening program. Consequently, the National Program for the Early Detection of Breast Cancer (now known as BreastScreen Australia) was founded in 1991 (Primary Care Division, 2003).

BreastScreen Australia operates nationally, through units in each State and Territory, for example, BreastScreen SA in South Australia. The program specifically targets women with no breast symptoms who are between the ages of 50 and 69 years. Women aged 40-49, and 70 years and older, are also eligible to attend, but they are not actively targeted. The aim of the program is stated as being to “achieve significant reductions in the mortality and morbidity of women attributable to breast cancer”, by screening 70% of women in the target group every two years (BreastScreen SA, 2003; Primary Care Division, 2003).

In addition to mammograms, other currently available breast cancer screening techniques are breast self-examination and clinical breast examination. These techniques, and some of the debate that has surrounded their practice, will now be considered.

3.2.2 Breast self-examination and clinical breast examination

Breast self-examination (BSE) is a screening technique that aims to increase women's familiarity with their own breasts, thus potentially enabling them to detect changes or lumps that may be symptomatic of breast cancer. Women can be taught to do BSE by their doctors, or can get information from various health organizations, such as (in South Australia) The Cancer Council SA. Until recently, women have generally been encouraged to participate in BSE once a month (Baxter & The Canadian Task Force on Preventive Health Care, 2001; Imaginis: The Breast Health Resource, 2005; Nekhlyudov & Fletcher, 2001).

Recently, however, debate has emerged regarding the degree to which women should monitor their bodies, specifically, by way of BSE (Baxter & The Canadian Task Force on Preventive Health Care, 2001; Nekhlyudov & Fletcher, 2001). A review of studies of BSE suggested that there is "good evidence of harm" as a result of the practice, and "fair evidence of no benefit" (Baxter & The Canadian Task Force on Preventive Health Care, 2001, p.1837), leading to the recommendation that women aged 40-69 years should no longer be taught BSE. It was argued that there is not sufficient evidence to make a recommendation for women under 40 years, or 70 and over. 'Harm' in this context refers to an increased rate of benign breast biopsy results, a significant increase in the proportion of women who present for assessment

by a physician, and a higher benign needle biopsy rate. Negative psychological effects have also been discussed – “increased levels of worrying, anxiety and depression, and increased numbers of follow-up investigations because of false-positive findings” (Baxter & The Canadian Task Force on Preventive Health Care, 2001, p.1842). The ‘benefit’ of BSE is understood as a significant reduction in mortality as a result of the practice, however, it was claimed that this benefit has not been sufficiently demonstrated as resulting from BSE. As an alternative to teaching BSE then, it has been suggested that women should be encouraged to report any changes in their breasts immediately, as well as to participate in mammography and clinical breast examinations (Baxter & The Canadian Task Force on Preventive Health Care, 2001).

In response to these concerns surrounding the benefits and harms of BSE, it was suggested that the recommendation against teaching BSE is too hasty as there is insufficient evidence to support such a recommendation (Nekhlyudov & Fletcher, 2001). It was argued that ‘harms’, such as an increased number of false-positives, may be more common in countries where the breast cancer rates are lower and BSE may be carried out in isolation from other screening practices, such as in Russia and China, where the major randomised control trials are being carried out. This is in comparison with countries like Canada and the US, where the recommendations based on such data would take effect. Additionally, it has been reported that treatment differences between North America, and Russia and China might affect mortality rates more than BSE itself (Nekhlyudov & Fletcher, 2001).

Nekhlyudov and Fletcher (2001) also suggested that reversing medical advice on a practice which is now well-accepted and practised by women in North America, and one that gives women a “sense of control over their health care” (p.1852), may cause women to doubt medical advice with regard to other screening procedures. In essence, then, they argued that more evidence should be accrued before eliminating the teaching of BSE.

Despite this caution about ceasing to advise BSE, the American Cancer Society updated its guidelines for breast cancer screening in 2003 and, based on the findings of the Canadian Task Force on Preventive Health, included the following recommendation (Smith et al., 2003, p.143):

Beginning in their 20s, women should be told about the benefits and limitations of breast self-examination (BSE). The importance of prompt reporting of any new breast symptoms to a health professional should be emphasized. Women who choose to do BSE should receive instruction and have their technique reviewed on the occasion of a periodic health examination. It is acceptable for women to choose not to do BSE or to do BSE irregularly.

The shift to presenting BSE as an optional screening tool for women, rather than a recommended monthly practice, was accompanied by a call for further research and a suggestion that “women should be encouraged to be aware of how their breasts look and feel in order to be able to recognize any changes and promptly report them” (Smith et al., 2003, p.153). Similarly, The Cancer Council SA recommends that

women should be aware of the usual look and feel of their breasts, and see a doctor promptly if any changes are noted (The Cancer Council SA, 2004).

The change from a specific guideline (conducting BSE once a month) to something more general (awareness of breasts and reporting of changes) can be seen to fit with recognised shifts in the aims of public health in contemporary Western culture, as will be discussed in later sections of the current chapter. The focus of guidelines for BSE has shifted to become, arguably, more ambiguous, but increasingly the responsibility of the individual. Rather than using a specific procedure to be carried out periodically, women are now advised to be constantly vigilant regarding their breasts.

The main debate about clinical breast examination (CBE) is very similar to the discussion surrounding BSE. CBE has been included with mammography in many randomised control trials, but the U.S. Preventive Services Task Force has argued that “there is no evidence that the clinical exam increases the benefit of mammography” (Gigerenzer, 2002, p.56). There also appears to be “insufficient evidence to recommend for or against breast cancer screening with CBE alone” (Smith et al., 2003, p.150). In addition, research has suggested that CBE has similar costs to BSE, such as ‘psychological stress’, without providing sufficient benefits to warrant such costs (Gigerenzer, 2002).

It has, however, been suggested that CBE gives an opportunity for doctors to raise their patients’ awareness about breast cancer and discuss issues relating to the disease (Smith et al., 2003). There is also a push by some organizations, such as the

American group, The Breast Cancer Fund (TBCF), to favour screening by way of BSE and CBE, and to give women more information about the risks of mammography (particularly related to radiation-induced disease), which TBCF see as currently being minimised. TBCF regards the updated guidelines of the American Cancer Society to be “overstat[ing] the benefits and risks of mammography while discouraging BSE”, a tool they consider ‘important’ (The Breast Cancer Fund, 2003). They argue that a more effective screening technique (than those available) needs to be developed but, in the meantime, BSE and CBE “remain critical methods in breast cancer screening” (The Breast Cancer Fund, 2003).

In the recent update of the American Cancer Society’s guidelines, CBE was recommended as part of a general health examination, at least every three years, for women in their 20s and 30s. For women aged 40 and over, CBE was recommended annually (Smith et al., 2003). In South Australia where the present research was conducted, The Cancer Council SA suggests that “all women should have a breast examination by their doctor at least every year” (The Cancer Council SA, 2004).

Like mammography then, BSE and CBE are not techniques about which there is medical or public health consensus. Again, I want to emphasise that in providing this brief review of current discussions taking place about these screening methods, I am not trying to assess whether or not they are efficacious. Rather, the aim here was to show that the practices that women are being encouraged to take part in are not unequivocally ‘good’ or the ‘right thing’ to do.

There has also been considerable debate surrounding the preventative options for women who are at high risk of breast cancer, particularly as a result of their genetic make-up. Some of the discussions taking place concerning this group will be now be examined.

3.2.3 Women at increased risk of breast cancer

Of the women with a family history of breast cancer (one of the risk factors for the disease, as listed above), there is a smaller sub-group of women who have been a focus of interest in both the psychological and medical literatures, as well as in the popular media (Chapter 4 focuses on analysis of such media accounts). These women are categorized as being at 'high risk' due to their (potential) status as carriers of a genetic 'mutation' in one or both of the genes that have been linked with breast cancer, BRCA 1 and BRCA2. Such mutations are currently understood to increase a woman's risk of developing breast cancer considerably, and are reported to be associated with approximately 5-10% of breast cancer cases (Easton, Bishop, Ford, & Crockford, 1993). The mutations can only be confirmed by way of genetic testing; however, apart from genetic testing, there are several family history characteristics that are thought to indicate a possible increased genetic risk of breast cancer (Smith et al., 2003). These characteristics include two or more relatives with breast cancer; breast cancer occurring before age 50 in an affected relative; male relatives with breast cancer; and breast cancer occurring in a first-degree relative (such as a mother or sister).

On the basis of these characteristics or genetic testing, women can be assessed for their likelihood of being carriers of a gene mutation, and at increased risk of breast

cancer. It is important to note that current scholarly understanding around the identified 'breast cancer genes' is that 'testing positive' for these gene mutations associates a woman with an increased lifetime 'risk' of developing breast cancer, but does not mean that she will definitely develop the disease. Correspondingly, even if she tests 'negative' for these genes, the future occurrence of breast cancer cannot be ruled out.

There have been three main preventative and screening options featured in guidelines for the management of these women's 'increased risk' of breast cancer: (1) a strict regimen of surveillance (breast self-examinations, clinical examinations, and frequent mammography), possibly occurring more frequently and/or beginning at a younger age than normally recommended; (2) a preventative chemotherapeutic agent, for example, *Tamoxifen*; and (3) bilateral prophylactic mastectomy (removal of healthy, or non-symptomatic, breasts) (Imaginis: The Breast Health Resource, 2005; Stefanek, Enger, Benkendorf, FlammHonig, & Lerman, 1999; Stefanek et al., 1995; Zones, 2000).

The relative efficacy of these options, and the advantages and disadvantages of each, are continuing to be topics of investigation and debate. The first option of surveillance carries with it the benefits and detriments associated with screening discussed above. The second option, *Tamoxifen*, was reported to show considerable benefit as a preventative measure (see Zones, 2000 for a summary). However, some serious side-effects of the drug have been reported, including increased risk of uterine cancer, liver disease, blood-clotting disorders, eye damage, and menopausal symptoms (Fugh-Berman & Epstein, 1992, cited in Zones, 2000). The third option,

preventative surgery, has been the focus of considerable psychological research. Several recent studies have examined factors associated with women's decisions to undergo prophylactic mastectomy, and their reported satisfaction with the procedure after differing lengths of time (Frost et al., 2000; Meiser, Butow, Friedlander et al., 2000; Stefanek et al., 1999; Stefanek et al., 1995; Wagner et al., 2000). The following reported findings are of particular significance to the analysis of popular media accounts of prophylactic mastectomy, which appears in Chapter 4.

It has been suggested that preventative surgery is being considered a preferred option by increasing numbers of 'high risk' women (Hallowell, 1998; Meiser, Butow, Friedlander et al., 2000; Stefanek et al., 1995). Significant numbers of 'high risk' women in two samples (taken in the USA, and in Australia) were reported as expressing an interest in prophylactic mastectomy in questionnaires or checklists of possible risk-management options that were administered prior to visits to genetic counselling services (Meiser, Butow, Friedlander et al., 2000; Stefanek et al., 1995). Across a number of studies, variables that have been positively linked with an increased likelihood of a woman choosing prophylactic surgery have included: (i) her 'subjective risk perception' (usually measured by a woman's estimate of her percentage chance of developing breast cancer, in contrast to her 'objective breast cancer risk', as calculated by familial cancer clinic staff); and (ii) her breast-cancer-related 'worry' or 'anxiety' (generally assessed by responses to questionnaire items on a Likert scale) (Meiser, Butow, Friedlander et al., 2000; Stefanek et al., 1999; Stefanek et al., 1995).

It has also been argued that women who consider prophylactic mastectomy as a preventative option are often highly 'anxious' and that these women's decisions to undergo such surgery may be "associated positively with high levels of breast cancer anxiety and overestimating one's breast cancer risk" (Meiser, Butow, Friedlander et al., 2000, p.2255). This conclusion is typically based on the reporting of a correlation between breast-cancer-related 'anxiety' and an interest in prophylactic mastectomy (or the selection of prophylactic mastectomy as a preventative treatment option in a hypothetical situation). Subsequent recommendations have taken the form of suggestions that some women opting for prophylactic surgery may derive greater benefit from interventions aimed at reducing breast-cancer anxiety and correcting their 'exaggerated' breast-cancer risk perceptions, than from having the surgery itself (Meiser, Butow, Friedlander et al., 2000; Stefanek et al., 1999). However, despite these potentially cautionary findings about women choosing to have prophylactic mastectomies, Stefanek et al (1995) reported preliminary findings (based on a questionnaire study assessing women's satisfaction with the procedure a minimum of six months following surgery) that suggest a high level of satisfaction with the surgery, and the decision to undergo surgery.

Other investigations into the psycho-social implications of breast cancer risk management have concluded that women commonly report feelings of responsibility to others (in particular, their kin) that effectively constrain their choices to take action around determining and controlling their genetic risk of developing the disease (Finkler, 2000; Hallowell, 1998, 1999; Steinberg, 1996). In an interview study, Hallowell (1998, p.263) reported that women in the UK who had undergone genetic counselling described the benefits of prophylactic surgery as providing them with a

way to “(a) fulfil their obligations to other family members and (b) reduce risk and contain their fear of cancer”.

Despite the fact that prophylactic mastectomy is a controversial procedure and one that is the topic of continuing research and debate, it is increasingly being considered an option for women thought to be at ‘high risk’ of breast cancer. As Hallowell (1999, p.602) has pointed out, increasing interest in genetic explanations for breast cancer – what Lippman (1992) referred to as its ‘geneticisation’ – has meant that increasing numbers of women who would not have gone on to develop the disease are engaging in risk-management practices that may have “iatrogenic consequences”. Such consequences include the considerable risks that are associated with surgery, as well as possible psychological trauma, such as post-mastectomy feelings of compromised gender identity.

It should be noted that the carrying out of practices on the body that are arguably unnecessary, and potentially have some detrimental and possibly iatrogenic effects, is not restricted to the management of health risks. ‘Healthy’ women often have surgery, and carry out a range of (potentially harmful) practices on their bodies, often for cosmetic reasons. Similarities between accounts of surveillance and modification of women’s bodies for cosmetic and preventative health reasons are not the focus of analysis in the present research, but remain a fruitful topic for future research.

My aim here has been to give some background to the kinds of prevention and detection techniques that are available to women at risk of developing breast cancer (arguably, all women, to varying degrees), including consideration of the debates,

and points of continuing research, that surround such techniques. This background informs the analysis that follows – primarily, in terms of providing awareness of available techniques, but also in terms of providing awareness of the complex and contested nature of these techniques. Given the controversy surrounding these practices, the analytic focus of this research is on demonstrating how issues of responsibility, moral obligation and choice have been discursively worked up in a range of talk and text surrounding breast cancer screening and prevention; what implications might emerge from various constructions of these issues; and how such implications might relate to sociological theorising around the notion of governance in advanced liberal societies.

Although breast cancer can be understood as one of a number of current illnesses that affect significant numbers of people (and therefore, as a significant public health issue), breast cancer is particular in that it predominantly affects women. Further, the physical site of the disease is perhaps the most powerful symbol of femininity and womanhood. Discourses surrounding breast cancer are therefore inevitably shaped by, and themselves perpetuate, our cultural understandings of femininity and the female body. With this in mind, the symbolism of the breast and breast cancer, and its significance for cultural understandings of femininity will be briefly examined in the next section.

3.2.4 Cultural understandings of the breast and breast cancer

The breast, historically, has been associated with a range of meanings (Yalom, 1997). Although in contemporary Western culture the breast is predominantly viewed as a sexual symbol (although this is not true across all cultures), Yalom

(1997) has explored other meanings – sacred, maternal, political, psychological, commercial, liberated, and medical – that have been associated with the female breast. Arguably, no other part of the (male or female) body has been taken up and appropriated, culturally, for so many different purposes, or ‘owned’ by so many people or groups other than the individual of whose body it is a part. As Yalom writes, “[s]ince the beginning of the Judeo-Christian era, churchmen and secular males, not to mention babies, have considered the breast their property, to be disposed of with or without women’s consent” (Yalom, 1997, p.5).

The breast as a sexual or erotic symbol is argued to have emerged in Europe in the 15th to 17th Centuries, becoming more dominant than previous maternal and sacred meanings. Yalom highlights that these contrasting meanings of the breast – maternal and sexual – have consistently been in conflict with each other, and can be seen to represent the traditionally dominant understandings of femininity and woman – as mother, and as sexual object (Yalom, 1997). In art, literature and media, the female breast can repeatedly be seen as a powerful symbol of such meanings.

Contemporary representations of the breast still draw primarily on its currency as a sexual and maternal symbol. Accounts of breast cancer, a threat to this symbol, inevitably intersect with these meanings, and reveal something about current cultural understandings of femininity and the female body. For example, Saywell, Beattie and Henderson (2000, p.37) point out that

Breast cancer is unusual among illnesses, especially among other cancers, because of the specific ways that its bodily site – the female breast – is

sexualized in popular representations ... Cultural anxieties about breast cancer are determined by the intersection of popular discourses of femininity and illness at the icon of the breast, and complicated by its status as diseased. Taboos of illness and cancer are veiled by the erotic potential of the fetishized breast, and subjects are referenced according to gendered discourses which situate them according to discourses of sexual and maternal femininity.

Saywell, Beattie and Henderson (2000) reported that breast cancer accounts (and accounts of breast cancer risk and prevention) in a three year sample of UK newspapers (both tabloid and broadsheet) emphasised the gendered nature of the illness, and the horror of mastectomy as a “violation of femininity” (p.38). Narratives of (prophylactic) mastectomy tended to focus on young women and mothers as self-sacrificing and tragic, reproducing idealised notions about femininity, motherhood, and responsibility for others. As the authors point out, this is due to the status of the breast - the site of (possible) illness in these stories - as a symbol of both sexual and maternal femininity and the “currency through which feminine value is attributed” (Saywell et al., 2000, p.39). Breast cancer, by threatening this symbol of femininity, arguably threatens femininity itself, due to the “problematic ways in which femininity is located in and value attributed to the female body” (p.39).

Contemporary representations of breast cancer were also examined in Lupton’s (1994a) research concerning discourses surrounding breast cancer in the Australian press. Lupton investigated news articles referring to breast cancer, breast screening or mammography that appeared in newspapers and magazines around Australia in a period from August 1987 through February 1990. During this time, mammography

was debated extensively in both popular and medical literature and, at the beginning of 1990, the Federal Government announced the National Early Breast Cancer Detection Program. Lupton's analysis identified three dominant discourses or themes emerging from these articles, including one concerned with 'breast cancer and femininity'.

In this sample of Australian media coverage of breast cancer, the development of the disease was reported to be repeatedly linked to women's reproductive choices. That is, articles linked breast cancer with the 'failure' to have children, with taking the contraceptive pill, and with having a career. An example was a newspaper article published in 1988 which quoted the (then) Western Australian Health Commissioner as saying "that the incidence of breast cancer would fall by a third if all women had a baby before the age of 25 and maintained their ideal body weight" (Lupton, 1994a, p.75). Similarly, it was claimed in another newspaper report in November, 1987 that "Middle class housewives with six children were considered relatively safe". Thus, in these sorts of accounts, breast cancer was typically linked to a violation of, or resistance to, traditional stereotypes of femininity.

Representations of breast cancer have therefore been argued to draw on, and perpetuate, cultural notions of femininity and the symbolism of the breast. Furthermore, although breast cancer (as with other disease) is usually thought of in medical terms, cultural representations can be seen to have influenced understandings of the disease (Ferguson & Kasper, 2000). The idea that culture shapes our understandings of breast cancer links with Susan Sontag's (1978) work regarding the cultural metaphors that influence the ways in which we understand, and

potentially experience, illness. That is, what we take to be health and illness, how we understand and experience breast cancer as related to gendered notions of femininity, can be seen to be culturally shaped.

Our understandings of health and illness can also be seen to be historically shifting. The next section of the chapter continues to provide a context for the analysis that follows by locating the breast cancer prevention and risk management practices discussed above within an historical framework. The intention is to highlight the historically-located and socially-constructed (and therefore, shifting) nature of what is considered 'healthy' behaviour, and recommended 'public health' practice. Such an exploration draws attention to the ways in which political and economic factors (amongst others, like cultural symbolism surrounding the breast) contribute to our understandings of 'health' and 'illness'.

3.3 A brief history of public health

Given that a central feature of a synthetic discursive approach to analysis is a consideration of the broader context in which language takes place, the aim in this section is provide a background to the historical context of current public health approaches. Further, this form of discursive analysis draws attention to the ways in which particular truths, power structures and subjectivities are constructed and made 'real' in discourse. In drawing attention to the ways particular truths and realities regarding health and public health have shifted historically, there is increased potential to view current truths as flexible and able to be challenged.

There are a range of definitions of ‘public health’ and divergent ways in which this term is used but, generally, ‘public health’ refers to the health of groups – for example, communities or populations – rather than that of individuals (O’Connor-Fleming & Parker, 2001; Petersen & Lupton, 1996; Tulchinsky & Varavikova, 2000). The term also encompasses an “array of professionals and institutions who are responsible for measuring, monitoring, regulating and improving the public’s health ... as well as academics engaged in researching public health issues” (Petersen & Lupton, 1996, p.3). As will become evident in the following brief exploration of historical developments in the area of public health, ideas about what constitutes ‘health’ (and therefore ‘public health’) have shifted over time and cannot be simply defined.

A focus of the present exploration of historically-shifting definitions of ‘health’ will be on the ways in which such definitions have become increasingly broadened. Specifically, I will illustrate how this broadening has occurred to the point that the World Health Organization (WHO) charter defined health as “the complete state of physical, social and mental well-being, and not merely the absence of disease” (1946, cited in Tulchinsky & Varavikova, 2000, p.41-42) and that, currently, a central focus of public health and medicine is on asymptomatic but ‘at risk’ individuals - a category of which we are all, arguably, members.

It should be noted that the brief history provided here is primarily based around developments occurring in Western societies. The reason for this is two-fold. Firstly, with respect to public health (as with other fields), developments in Western culture have been more widely documented than those occurring in other societies. In

addition, it is current Western notions of public health that are under examination here and it therefore seems most appropriate to focus on the history of the field within this culture.

3.3.1 Early public health and environmental change

The earliest forms of public health focused on the prevention of communicable diseases by focusing strategies on environmental change, particularly by improving sanitation. Since ancient times, societies such as Chinese, Egyptian, Hebrew, Indian and Incan, “all provided sanitary amenities as part of the community religious belief system” (Tulchinsky & Varavikova, 2000, p.7). There are further examples of sanitation practices in ancient Greece and Rome, particularly with relation to water supply, bathing and toilet facilities, sewage systems and town planning (O'Connor-Fleming & Parker, 2001; Tulchinsky & Varavikova, 2000). Such techniques for the prevention of illness have continued to be carried out throughout history.

Growth in populations, as a result of increasing industrialisation and urbanisation, has repeatedly caused public health problems since medieval times. Problems related to “[c]rowding, poor nutrition and sanitation, lack of adequate water sources and drainage, unpaved streets, keeping of animals in towns, and lack of organized waste disposal” (Tulchinsky & Varavikova, 2000, p.12) have frequently led to increases in infectious diseases, from the late medieval period (11th to 15th Centuries) through to modern day. Particularly the communicable diseases of the Middle Ages (such as leprosy, the plague, pneumonia, syphilis, smallpox and measles) highlighted the need to prevent the spread of such diseases and led to preventative strategies centred on developing improved water management, and isolation or quarantine of the sick.

3.3.2 Scientific developments and State involvement

The next major stage in the development of public health has been linked to increasing scientific developments that tended to locate illness within individuals. From the 1850s to the 1870s, the ‘bacteriologic revolution’ occurred, with Louis Pasteur providing scientific evidence for the germ theory of disease causation. While this lent support to continuing developments in sanitation practices, it also led to implications for other areas of public health. This was particularly so in the area of vaccines, with Pasteur developing and demonstrating the process of immunisation, firstly, in animals and then in humans. Microbiology and immunology research (which developed as a result of the bacteriologic revolution) has continued up to the present time, resulting in the control of many infectious diseases by way of immunisation (e.g., measles, mumps, poliomyelitis, and rubella). The development of antibiotics has also been instrumental in controlling and treating infectious disease and, in addition to the increased use of vaccines, has been significant in the field of public health (Tulchinsky & Varavikova, 2000). In this second stage in the development of public health practices, then, health and illness were directly linked with medical processes. Public health strategies, in this period, were directed at a more individual level than had previously been the case (Ashton & Seymour, 1988; O'Connor-Fleming & Parker, 2001; Tulchinsky & Varavikova, 2000).

Simultaneously, there were social, intellectual and political developments taking place that led to increasing State involvement in medical and social welfare (Ashton & Seymour, 1988; O'Connor-Fleming & Parker, 2001). Particularly, in the 18th and 19th Centuries, ideas around the role of government in public health reform

developed, and governments in a number of countries, including France, Germany and Russia, promoted health initiatives. In many of the systems that were established, State regulations were taken to be a central force in modifying and promoting health practices. A complete authoritarian approach was resisted in most Western countries, but there was still a shift towards increasing legislation and regulation of public health by government bodies, such as mandatory vaccinations, and providing “municipal boards of health ... a public mandate to supervise and regulate community sanitation” (Tulchinsky & Varavikova, 2000, p.24).

There were also, however, intellectual developments in conceptualisations of the rights of citizens (white male citizens at least) in the 18th Century, often leading to movements aimed at promoting liberty from oppressive and dictatorial rule (Tulchinsky & Varavikova, 2000). These ideas were linked with an increasing emphasis on the individual, which is a key feature of current liberal humanist thought – a belief in the inherent worth of the individual and in the notion that individuals have rights, which are independent from those of the State. When applied to public health, this philosophy enabled all individuals to be understood as having a right to health. The development of movements and philosophical approaches that emphasised the rights of the individual to be healthy, in combination with the increasing role of the State in regulating health practices, led to changes in societal power relations and structures which have been the topic of some of Foucault’s writing around health and medicine (e.g. Foucault, 1984a; Foucault, 1984b).

It could be argued that the field of public health, as we understand it currently, has its origins in the 18th and 19th Centuries, when these intellectual, philosophical and

political shifts were taking place. With developing industrialisation in Western nations, it was increasingly in the interests of the State to ensure the health of the population to guarantee a productive work force and an able military – “health, as in education, is a contributor to economic growth, as healthy and educated individuals contribute to a creative and economically productive society” (Tulchinsky & Varavikova, 2000, p.48). Health, or disease, thus began to be understood as an economic problem, requiring a State solution.

It has been argued that the shifts that took place from the 18th Century have worked to produce a public health that can be seen to be concerned with the control of (potentially) problematic bodies, often with “coercive and discriminatory” outcomes for people’s lives (Lupton, 1994b, p.30). That is, as populations came to be understood as entities in themselves, whose health could be measured and improved, and whose progress in health was seen as an objective of government, individual bodies and lives were increasingly subject to forms of scrutiny and management that were not necessarily positive (Foucault, 1984a). From a Foucauldian perspective, then, “the body is the ultimate site of political and ideological control, surveillance and regulation” (Lupton, 1994b, p.23) and has, particularly since the 18th Century, been a site of disciplinary power. Arguably, contemporary public health approaches can therefore be traced back to shifts in power and the emergence of specific approaches to governance that occurred in the 18th Century: Foucault (1984a) considered the

modern state’s preoccupation with controlling bodies *en masse* as developing in Europe in the eighteenth century in concert with the birth of the medical

clinic, the growth of demand for individual medical care and a concern with the preservation and upkeep of the labour force (Lupton, 1994b, p.30).

Simultaneously, there was increased emphasis, as already mentioned, on the rights of individuals to have access to health services and to be healthy. We see then, the interests of the individual and of the State appearing to merge, with reform in the early 19th Century being influenced by economic and social philosophers such as Adam Smith and Jeremy Bentham, who argued for “liberalism, rationalism, free trade, political rights, and social reform, all contributing to ‘the greatest good for the greatest number’” (Tulchinsky & Varavikova, 2000, p.23). Coinciding with the publication of Marx’s *Communist Manifesto* in 1848, the mid- to late-19th Century also saw workers’ groups putting pressure on governments to improve the health and the living and working conditions of the labour force.

In Chapter 2, I introduced Foucault’s notions of power – that power is not conceptualised as something that one group or individual has and exerts over another. Rather, power is embedded in those truths and ways of being, of which we are all a part. Discourse can be understood as the site at which these truths, power structures and ways of being, are reproduced and challenged (Foucault, 1980), and is therefore a focus of analysis in post-structuralist and synthetic approaches. From this perspective on power and truths, the shifts that occurred in the 18th and 19th Centuries - with respect to citizens having rights to health, and governments increasingly regulating citizens - can be understood as building upon and shaping each other, and creating new truths and ways of being by which individuals came to live.

3.3.3 The new public health

Contemporary public health - often referred to as the 'new public health' (see, e.g., Ashton & Seymour, 1988; Petersen & Lupton, 1996; Tulchinsky & Varavikova, 2000) - encompasses a broad range of approaches to health and illness prevention. As such, definitions of the 'new public health', and ideas around what it is and does, may appear inconsistent or contradictory. Certainly, the summary presented here is brief and does not cover the breadth of writing on the topic and, consequently, also does not tease out all the nuances of the field. I hope to convey some idea of the new public health or, at least, its broad and encompassing nature, and the ways in which it has built on previous traditions of public health and come to incorporate all aspects of individual life as relevant to 'health', and 'public health'.

As covered so far, until the 20th Century there had been essentially two main phases of public health (in developed nations): the initial focus on environmental change (e.g., sanitation) to improve population health, followed by the added interventions made possible by developments in scientific knowledge, as well as the growing investment of the State in the health of the national population. By the first half of the 20th Century, infectious diseases were still the largest cause of death, even in developed nations. Particularly after World War II, however, there began to be a shift away from these illnesses as the causes of death, and an increase in death as a result of non-infectious disease (Ashton & Seymour, 1988; Petersen & Lupton, 1996). The average lifespan in privileged countries has since increased dramatically, and the non-infectious diseases that currently kill people (such as cancer and heart disease) affect mainly older people. Whereas epidemiological research had previously investigated risk factors for disease to some extent – research that associated scurvy

with sailors is one example (Tulchinsky & Varavikova, 2000) – contemporary epidemiological research has shifted its focus much more prominently onto risk factors associated with currently common non-infectious diseases. This focus on risk factors and non-infectious diseases can be traced to the 1950s, when studies that linked tobacco use and lung cancer became extremely influential (Tulchinsky & Varavikova, 2000). These were followed by studies on the links between diet and cardiovascular disease (Tulchinsky & Varavikova, 2000). Such research has led to the notion, significant in the second half of the 20th Century, of ‘lifestyle diseases’, explicitly linking lifestyle and behavioural factors with illness. As a result of the association between particular lifestyle factors and an increased risk of chronic diseases, public health shifted from its previous styles of intervention, to trying to prevent illness by focusing on lifestyle and behaviour. That is, the gaze of traditional public health strategies – which had been involved with changing physical aspects of the environment, or specific medical interventions, such as immunisation – was extended to include people’s lifestyles, and a focus on broader social aspects of life (Ashton & Seymour, 1988; Petersen & Lupton, 1996).

The period from the 1930s has been described as the third stage in public health and, more specifically, ‘the therapeutic era’ (Ashton & Seymour, 1988). As already mentioned, this period is characterised by a decline in infectious disease, as well as the “development of ideas in many developed countries about the welfare state” (Ashton & Seymour, 1988, p.18). At this point, there was a “weakening of departments of public health and a shift of power and resources to hospital-based services” (p.18). This created a much more individualistic focus for health-care, in addition to producing inequities, as it was primarily the more wealthy members of

society who could afford such care⁵. The increasing individual biomedical focus deflected attention away from the effect of social structures on health and illness, and enabled a focus on individuals to dominate understandings of health. With this as the central concern of public health, the behaviour of individuals became a point of (potential) modification.

By the 1970s, governments found themselves having to reduce expenditure on health. This was related to a number of factors, but particularly influential were the demographic shifts associated with increased lifespan and growing elderly populations, as well as increased health-care costs resulting from “technological innovation in treatment methods and an apparently limitless demand for medical care” (Ashton & Seymour, 1988, p.20). The economic crisis and ageing populations forced a reappraisal of health-care and public health, and led to a ‘new public health’ with a focus on prevention and the broader social factors influencing health and illness - “an approach which brings together environmental change and personal preventive measures with appropriate therapeutic interventions” (Ashton & Seymour, 1988, p.21).

The description of this approach as the ‘new public health’ suggests a contrast with the ‘old public health’. Within this dichotomy of ‘old’ and ‘new’ public health, ‘old public health’ refers to a paradigm that emerged in the 19th century, post-Industrial revolution. This paradigm has influenced the “intellectual and ideological framework

⁵ Ashton and Seymour (1988) suggest that this power differential favouring the wealthy particularly emerged as non-infectious diseases became more dominant. When infectious diseases were more prevalent, it was necessary to promote the health of the public as a whole to prevent the wealthy becoming sick. They suggest that the focus on population-level public health became less necessary when the most common illnesses were not contagious, and the wealthy could afford medical treatment.

for most epidemiological research and public health programs up to the present time” (O'Connor-Fleming & Parker, 2001, p.25). The ‘new public health’ is in essence expanding the view of previous public health notions – to include social and economical reforms, universality, ecology, environment, and prevention. As such, the ‘new public health’ “links traditional public health concerns (which tended to focus on physical aspects of the environment such as clean air and water, food, infection control, and occupational health and safety legislation) with broader social, environmental and economic factors” (O'Connor-Fleming & Parker, 2001, p.30). Further, the new public health “relates to or encompasses all community and individual activities directed toward reducing factors that contribute to the burden of disease and fosters those that relate directly to improved health” (Tulchinsky & Varavikova, 2000, p.56).

As Tulchinsky and Varavikova (2000, p.2) write, the new public health is “a synthesis of classical public health as experienced over the past several centuries, interacting with the biomedical, clinical and social sciences, economics and technology assessment, management, and experience of health systems as they have evolved and as they continue to develop”. As such, public health in the latter parts of the 20th Century, and into the 21st Century, has expanded its focus from environmental or situational factors affecting health (such as poor living and working conditions, sanitation, etc.), and from hospital- and medically-based interventions, to now additionally include factors about an individual’s lifestyle, for which they must take responsibility.

The 'new public health', then, can be seen as a rediscovery and expansion of the traditional public health endeavour (Petersen & Lupton, 1996; Tulchinsky & Varavikova, 2000). Ideally, this newer approach to public health continues the aims of reforms for health and improvement of general living conditions of the 'old' public health, however, the newer tradition aims to go beyond human biology to include social aspects of health. As such, there has been a development of public health initiatives into community projects and public policy. An examination of 'lifestyle' and behavioural factors, and an inclusion of these factors within contemporary public health practice is a key feature of the new public health (Petersen & Lupton, 1996). According to Petersen and Lupton (1996, p.ix) the new public health

takes as its foci the categories of 'population' and 'the environment', conceived of in their widest sense to include psychological, social and physical elements. With the development of this perspective, few areas of person and social life remain immune to scrutiny and regulation of some kind.

Many more areas of individuals' lives can now be seen as 'health-related', leading to increased 'scrutiny and regulation' in the name of health, and an expansion of the types of interventions considered acceptable within the aims of public health. For example, public health is increasingly taking an 'ecological' approach to health, acknowledging the effect of the environment on health (O'Connor-Fleming & Parker, 2001; Petersen & Lupton, 1996). Such an approach is concerned, both with how individuals interact with their immediate environment, including threats posed to

health by local surroundings, as well as how global environmental degradation is impacting on the health of populations. Environmental problems are thought to pose an increasing threat to global health.

A central aim of the new public health, then, is to move away from the individualist biomedical focus that had developed, allowing a return to interventions directed at the broader social level, and it should be noted that many strategies of the new public health have achieved, and continue to work towards achieving, this aim. However, given the lifestyle diseases affecting modern Western citizens, and the continuing dominance of the biomedical model of health and illness, critiques of the new public health have highlighted a range of potentially problematic implications of the endeavour. In particular, these critiques have often focused on the potential for the broadening gaze of public health - in conjunction with the emphasis on the prevention of lifestyle diseases - to place increasing responsibility for health on individuals.

For example, as part of the new public health, government policies developed that were designed to reduce spending on health and social services, while simultaneously there was an “enthusiastic promotion of an individualist ideology that urged self-responsibility” (Murray, 2004b, p.2). This push for individuals to take responsibility for their own health, in part, led to the rise of what has been termed a ‘healthist’ culture (Crawford, 1980), “in which an almost obsessive emphasis on health locates primary responsibility for health within the individual” (Crossley, 2003, p.502). It has been argued that by the late 20th Century, public health and health promotion were involved in informing individuals at mass levels about health

'risks' and "exhorting people to take responsibility" (Lupton, 1994b, p.31) for carrying out the appropriate self-discipline and self-regulation to ensure their health status.

With the expansion of public health, and of the number of issues relevant to health more generally, there has been a developing interest in the internationalisation of health-care, and the setting of global standards for health-care for which all nations should aim. The World Health Organization (WHO), founded in 1946 following World War II, marked the internationalisation of health-care, including public health, and is a key body in the monitoring and improvement of global health. Since the formation of the WHO, public technologies, such as immunisation, have spread to an increasing number of nations, with the aims of public health turning global. The WHO and UN accepted the notion of the right to health for all, adding "a universal element to the mission of public health" in the 20th Century (Tulchinsky & Varavikova, 2000, p.48).

In summary, public health began with a focus on reducing illness by changing aspects of the environment, for example, improved sanitation and housing. In the 19th Century, public health took on a more individualistic approach, as medical and scientific knowledge developed, for example, with respect to germ theory and the transmission of communicable disease. Interventions included immunisation and vaccination, and the State became increasingly involved in public health. In the first half of the 20th Century, a third stage of public health - which built on the strategies of the 19th Century and was more centred on individualistic biomedical and hospital-based interventions - emerged to deal with the decrease in the spread of infectious

diseases in developed nations. However, by the 1970s, the economic crisis facing governments and political systems - particularly with respect to health-care costs - led to a 'new public health' with a broadened focus on prevention, and on the lifestyle, behavioural and social factors affecting health. It has been argued that one of the potential implications of the new public health, and its broadened focus for health and health-care, is an emphasis on self-responsibility for health.

3.3.4 Screening, genetics, risk and 'patients without symptoms'

A major contemporary public health intervention, in line with the focus on prevention that is central to the new public health, is screening for disease. In Australia, a Health Targets and Implementation Committee produced a report in 1988 entitled "Health For All Australians". Within this report, five priority areas for action were identified, one of which was the prevention of cancer, particularly lung, skin, breast and cervical cancers. Following the release of this report, the National Better Health Program was established in 1989 to launch a range of projects and provide funding for health promotion, especially in the five priority areas (O'Connor-Fleming & Parker, 2001). Since that time there has been an increase in the number of public health and health promotion programs in Australia, often focusing on specific diseases or population groups. Most of these programs have aimed to promote screening or preventative behaviour, frequently centring on lifestyle factors, or on encouraging individuals to include increasing amounts of self-surveillance as part of their lifestyle. The focus on all aspects of lifestyle is part of the shift in understandings around notions of health that has occurred as part of the 'new public health'. Rather than focusing only on sanitation, or on vaccination for specific diseases, contemporary public health has widened its gaze to include lifestyle and

behaviour, environmental influences, and social and economic factors. Along with the inclusion of lifestyle as a factor influencing both individual and community health, and the emphasis on risk factors and prevention, the increasing promotion of screening practices can be seen as part of the expanding focus of public health. Breast cancer screening is a key example.

As with many other cancers, little is known about the causes of breast cancer. Consequently, medical research and health promotion strategies have tended to focus on 'risk factors', and on determining the best means by which women might prevent and detect the disease. As discussed earlier, a number of 'risk factors' for breast cancer – physiological and behavioural/social - are commonly discussed in the medical and public health literature. To detect the early occurrence of breast cancer and, thus, potentially prevent death from the disease, all women (especially those with any of the accepted risk factors) are encouraged to screen for the disease. Screening is therefore a secondary form of prevention, aiming to prevent the progression of disease (Ogden, 2004). Health promotion campaigns have aimed to inform women of the individual benefits of screening, and encourage them to adopt screening into their lifestyles as a preventative measure.

Although it is acknowledged that screening is a form of secondary prevention, the emphasis on detection and screening suggests that 'knowledge' of the presence of a disease is the solution to the health problem: early detection as prevention. The resulting implication is the medicalisation of healthy individuals' lives (all women are constructed as 'at risk'), and the expectation of self-regulation and self-management of potential illness (with responsibility placed on individuals to monitor

their own bodies to 'prevent' potential illness). Screening (mammography, breast self-examination and clinical examination) becomes a form of surveillance whose panoptic function forces women to become dependent on technology to reveal diseases occurring within their body of which they are unaware (medicalising healthy individuals' lives). Our understandings of health and illness are, as a result, redefined, with even apparently healthy bodies potentially carrying a hidden disease.

Furthermore, with the development of the Human Genome Project (and other genetic research), and the increasing focus on genetic understandings of disease, some women are understood to have a genetic predisposition to breast cancer. These women are categorized as being at 'high risk' due to their (potential) status as carriers of a genetic 'mutation' in one or both of the genes that have been linked with breast cancer, BRCA 1 and BRCA2. Such mutations are currently understood to increase a woman's risk of developing breast cancer considerably.

Genetic understandings of disease, and genetic technologies used to identify those individuals with genetic mutations predisposing them to disease, could thus be argued to blur the line between health and illness further, by allowing women to be identified, not only as being in an 'at risk' category, but as having a specific, apparently quantifiable chance of developing breast cancer⁶. 'Prevention', too, is taken to a different level, when we are no longer talking about lifestyle choices like diet and exercise, but potentially about surgery on healthy tissue, which may lead to iatrogenic dangers.

In examining current public health practices, and more general understandings of health and illness, and locating them within a historical context, it becomes apparent that illness has taken on meanings additional to simply the presence of physical symptoms. Indeed, it is worth noting here the distinction between ‘disease’ – a biomedical concept – and ‘illness’ which, in sociological terms, refers to the “innately human experience of symptoms and suffering” (Kleinman, 1988, p.3), or the experience of disease. Therefore, what we may think of as illness can be subject to change, as our experience of disease changes and we make sense of it differently. Particularly in contemporary Western societies, with the decline of contagious diseases and the increased mortality as a result of cancers and cardiovascular disease, illness is no longer as visible as it once was - we cannot necessarily tell if we, or others, are sick. Illnesses are much more silent and hidden, and often we don’t know they exist until it is ‘too late’ (Lupton, 1994b). There has, as a result, been much more emphasis placed on early detection than in previous approaches to public health. Early detection is now the “cornerstone of preventative medicine” (Lupton, 1994b, p.99) and, as Lupton writes, this focus has led to a redefinition of notions of health and illness:

Most screening programmes encourage well people to attend in the interests of detecting ‘hidden’ disease or the signs of impending disease: HIV antibodies, tiny breast lumps, high-lipid cholesterol levels, hypertension, pre-cancerous cervical cells. The process requires that anxiety levels be raised high enough in people who have experienced no symptoms so that they seek testing. In so doing, it requires that individuals question the veracity of their

⁶ The ways in which ‘risk’ is conceptualised, quantified and communicated in the context of genetic

own assessment of their health, and rely upon medical intervention (usually facilitated by high technology) to detect the invisible signs of disease (1994b, p.99).

Finkler (2000) has explored how what she referred to as the 'ideology of genetic inheritance' is "redrawing the boundaries between healthy and unhealthy people because, potentially, we are all unhealthy" (Finkler, 2000, p.50). That is, genetic explanations for diseases such as breast cancer have come to dominate other alternative causal explanations, forcing individuals to become dependent on technology to reveal potential diseases they may develop. The increasingly dominant genetic explanation of disease therefore constructs all bodies as being potentially ill. Healthy women, as a result, become "perpetual patients without symptoms" (Finkler, 2000, p.58). In Finkler's research, this was demonstrated through interviews with women in the US who had been identified as genetically susceptible to breast cancer, or who suspected they might be at risk due to a family history of the disease. For some of these women, prophylactic mastectomy was considered, while others understood their 'at risk' status (as determined by themselves or 'experts') as meaning they had a responsibility to engage in vigilant surveillance of their potentially ill bodies.

Given the high rate of breast cancer in Australia and the disease's status as the most common cause of death from cancer for Australian women (Australian Institute of Health and Welfare & Australasian Association of Cancer Registries, 2004), it could be argued that even women without a family history of breast cancer could suspect

counselling are topics of continuing research (see, e.g., O'Doherty, 2005, 2006).

that they may be 'at risk' and find themselves becoming 'perpetual patients' by virtue of the emphasis placed on the importance of screening behaviours. It has been argued that media campaigns such as "Early detection is your best protection" present the concept of prevention as being synonymous with early detection, placing the responsibility for prevention of the disease on individual women (Lupton, 1994a). However, it may be argued that once a lump is detected in a woman's breast, she potentially already has breast cancer and it has not been prevented. Again, it is acknowledged here that screening is recognised as a secondary form of prevention, however, the distinction between primary and secondary forms of prevention are, arguably, not clear to the general public.

Hallowell (1999) has argued that current practices of genetic counselling (labelling individuals as 'at-risk'; providing quantitative information about risk magnitude; representing risk as manageable in terms of specific actions) effectively place individuals under a moral obligation to determine and modify health risks. This is another example of the new ways in which responsibility for health is located with individuals in contemporary Western societies. Similarly, Finkler's (2000) research explored how the ideology of genetic inheritance is shifting our contemporary notions of family and kinship. In the interviews she conducted with women at risk of breast cancer due to a family history of the disease, Finkler reported that, as well as needing to be responsible for their own health, women often described a responsibility to members of their family to manage, and notify others of their at-risk status, even potentially to the extent of deciding not to have children to prevent passing genes on (Finkler, 2000).

The aim of discussing this history of public health has been to make visible some of the shifts in understandings of public health and of health more broadly. Particularly, I hope to have shown some of the ways in which those strategies thought to be appropriate for public health, and those aspects of individuals' lives which are thought to influence health, have over time been extended. This expansion has taken place to the point where individuals who previously might have been considered healthy and not in need of any medical or public health intervention are now, in the name of public health (for the good of themselves and the wider community), often encouraged, and even feel obliged, to take responsibility for their health, scrutinise their lives and make appropriate changes. Increasingly, such self-regulation and self-management involves not only dealing with already existing illness, but also applies to the regulation and management of risks, including genetic risks.

3.4 Theoretical context

A central aim of the new public health has been to move away from the individualist biomedical focus that had developed in the 20th Century, allowing a return to interventions directed at the broader social level, and many strategies of the new public health have worked towards this aim. However, given the lifestyle diseases affecting modern Western citizens and the continuing dominance of the biomedical model of health and illness, critiques of the new public health have highlighted a range of potentially problematic implications of this endeavour. In particular, these critiques have often focused on the potential for the broadening gaze of public health, in conjunction with the emphasis on the prevention of lifestyle diseases, to place increasing responsibility for health on individuals. Although this re-directing of responsibility onto individuals is not necessarily problematic *per se*, critical work

around public health has aimed to highlight ways in which such a focus may have negative implications, for example, increased regulation and control of individuals' lives and behaviours. The focus in this section is to situate current public health practices, and the notion of individuals' increasing responsibility to manage health risks, within a theoretical framework, with the aim of further contextualising the analysis to follow. Additionally, such theorising provides a starting point from which to approach an investigation of discourses surrounding breast cancer risk, screening and prevention, as well as a broader context in which to understand potential political implications of constructions of risk and preventative behaviours that are common in contemporary Western cultures.

As has been shown so far, the notions of risk and risk management are key issues in research and practice around breast cancer, as in current public health practice more generally. Sociological theorising would suggest that this focus on risk is typical of a more general shift in understandings of health and health-care in modern liberal democratic societies (Bunton, 1997; Nettleton, 1997; Petersen, 1997; Petersen & Lupton, 1996). These are typically Western societies (referred to by some sociological writers as 'neo-liberal' or 'advanced liberal') like those of present-day Europe, the United States, and Australia and are "characterised by a form of political rationality that reactivates liberal principles: an emphasis on markets as regulators of economic activity; scepticism over the capacities of governments to properly govern; and the replacement of 'welfare dependency' by active entrepreneurship" (Petersen, 1997, p.193; see also Rose, 1993). As such, neo-liberalism is "a form of rule which involves creating a sphere of freedom for subjects so that they are able to exercise a regulated autonomy" (Petersen, 1997, p.194). In advanced liberal societies, then, an

emphasis on the existence of rational, autonomous individuals has emerged (Rose, 1989, 1993).

Governance in such societies operates “not through imposing constraints upon citizens but rather through the ‘making up’ of citizens capable of exercising regulated freedom” (Rose & Miller, 1992, p.174, in Petersen & Lupton, 1996, p.10-11). That is, governance tends not to be “domineering, repressive or authoritarian” (Petersen & Lupton, 1996, p.12) but, instead, involves the production of subject positions for citizens as active, ‘informed’ societal members who self-regulate and self-govern in line with the aims of the State - such as achieving a “healthy, happy, and productive population” (Nettleton, 1997, p.211). In advanced liberal (or neo-liberal) societies, then, it has been argued that matters of health and health-care become the responsibility of individual citizens, who have a “right and a duty to maintain, contribute to and ensure ... their health status” (Nettleton, 1997, p.208). Petersen and Lupton (1996) have argued that the discourses and practices of the new public health focus on the regulation and transformation of citizens. In their words, these discourses

transform the awareness of individuals in such a way that they become more self-regulating and productive both in serving their own interests and those of society at large. By providing norms by which individuals are monitored and classified, and against which individuals may be measured, the emphasis of the new public health is upon persuading people to conform voluntarily to the goals of the state and other agencies (1996, p.12).

The concept of risk is central in producing citizens who are “more self-regulating and productive”. In order to take responsibility for their health, individuals are increasingly encouraged to monitor and manage risks. The assessment and management of risks have therefore become an important part of the modern citizen’s management of self (Bunton, 1997). Consequently, risk factors themselves come to be understood as “diseases to be cured” (Nettleton, 1997, p.215); they become something that individuals, as active, responsible citizens, must do something about in order to ensure their future health.

As discussed above, the dominance of genetic explanations for disease has increased the sense at which all bodies can be understood as ‘at risk’, thus further medicalising ‘healthy’ individuals lives and positioning them as “perpetual patients without symptoms” (Finkler, 2000, p.58). Furthermore, with the extended focus of new public health, all aspects of an individual’s life can now be seen as related to issues of health, and there are arguably an increasing number of risk factors that individuals can be expected to take responsibility for monitoring and managing, as rational autonomous citizens.

Once again it should be noted that public health interventions that emphasise self-management and self-regulation of health risks (including genetic risks) are not (necessarily) oppressive or controlling. A contradiction of public health lies between the notions of individuals having the (apparent) freedom to choose how they wish to behave, and society having the right “to control individuals’ bodies in the name of health” (Lupton, 1994b, p.32). Disciplinary power, however, is produced and maintained through a number of current public health and health promotion

strategies, enabling the control of bodies, while still giving individuals the ‘freedom’ expected within advanced liberal societies. This negotiation of the contradiction between these aims is made possible by the invisibility of the disciplinary power in public health policies, in the sense that health is seen as a “universal right, a fundamental good”. Therefore, approaches that aim to improve the health of the population, including those that encourage self-management and self-regulation, are seen as benevolent, rendering those socially controlling or disciplinary aspects of such strategies invisible (Lupton, 1994b). Furthermore, in health promotional strategies that emphasise self-surveillance, “power relations are rendered invisible, and are dispersed, being voluntarily perpetuated by subjects upon themselves as well as upon others” (Lupton, 1994b, p.32).

This understanding of disciplinary power as being embedded within practices that are ‘voluntarily perpetuated’ by individuals draws on Foucault’s (Foucault, 1980, 1984b) approach to power, in which power is not seen as an oppressive force, possessed by some (the powerful) to control others. Instead, power is implicit in social relations, and produced by knowledge. Medicine, for example, produces knowledges which are taken up as truths, and which produce particular power relations in the world. Power “needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression” (Foucault, 1984b, p.61). In this formulation of power relations, individuals “unconsciously ... exert disciplinary power, both over others and over the self through self-regulation” (Lupton, 1994b, p.32).

The public health enterprise is an example of the ways in which power can be understood as produced by knowledge and as shaping the surveillance in which individuals (voluntarily) engage. As Petersen and Lupton write (1996, p.3), the new public health, in particular, can be seen as

but the most recent of a series of regimes of power and knowledge that are oriented to the regulation and surveillance of individual bodies and the social body as a whole. This is not to say that it is simply a controlling or oppressive influence, and that there is no scope for individual autonomous action ... rather it is to caution against the dominant view that the new public health is unproblematically a liberating project or 'movement'.

The style of governance in advanced liberal societies has, in part, been related to the emergence of the "so-called new social movements, such as the green movement, the peace movement, the gay and lesbian rights movement and the women's movement" (Petersen & Lupton, 1996, p.11), which emphasise the democratic and humanitarian rights of citizens. As suggested in the above quote, the new public health is one such movement that has emerged and is in line with the values emphasised by neo-liberalism. These social movements, including public health, argue for, and place emphasis upon, the rights of citizens. However, with this 'rights' discourse comes a 'duties' discourse that draws focus to the responsibilities of individuals to improve both themselves and their community. This reinforces the self-regulatory emphasis of governance of a liberal democratic state. For example, it could be argued that in winning the right to free mammography (as is the case in Australia), women correspondingly have a duty to participate in screening for their own benefit and for

the benefit and health of the wider community. This discourse of responsibility and duty contributes to the ‘making up’ of citizens who, apparently by their own choice, (should) participate in screening programs.

These theoretical notions about the forms of governance in advanced liberal democratic societies, and the disciplinary power embedded in contemporary public health interventions, provide a context in which the analysis of this dissertation can be read. In particular, such theorising provides a starting point from which to approach an investigation of discourses surrounding breast cancer risk, screening and prevention, as well as a broader context in which to understand potential political implications of constructions of risk and preventative behaviours that are common in contemporary Western cultures.

3.5 Conclusions

The aim of this dissertation, as discussed in Chapter 1, is to examine accounts of breast cancer screening, risk and prevention, and to consider implications of the language drawn on in such accounts. For example, the subject positions made available for citizens (and, in particular, women) in contemporary advanced liberal societies will be considered. The analysis that will be presented in the following chapters, therefore, draws on empirical data (media texts, health promotion campaign material and women’s talk) to investigate the ways in which language is flexibly deployed to negotiate issues of risk and responsibility for health – issues of interest in sociological theorising around health-care in modern Western societies.

In this chapter, I have provided an overview of literature in order to contextualise the analysis of talk and text about breast cancer prevention and risk management that follows. It should be noted that this is not the only background that could be seen as relevant to issues surrounding breast cancer risk and screening, but was deemed a significant and appropriate context, given the kinds of research questions of interest in this dissertation.

In summary, the currently available breast cancer detection and prevention strategies (e.g., mammography, breast self-examination, clinical breast examination, prophylactic mastectomy) are still subject to debate and continuing research, despite being often recommended to women as unproblematic by way of various health promotion strategies. Furthermore, when locating current public health strategies and techniques within a history of public health, the shifting nature of truths about public health, and health more broadly, becomes apparent. Particularly, I hope to have shown some of the ways in which those strategies thought to be appropriate (and required) to improve population health, and those aspects of individual's lives which are thought to influence health, have been extended over time. This expansion has taken place to the extent that individuals who previously might have been considered healthy and not in need of any medical or public health intervention, are now often encouraged, and even feel obliged, to take responsibility for their health, scrutinise their lives and make appropriate changes. Increasingly, such self-regulation and self-management involves not only dealing with already existing illness, but also applies to the regulation and management of risks, including genetic risks.

Critiques of the new public health have focused on this individualising of health-care, and of the strategies which aim to improve population health, and have located such individualising within the context of a general pattern of governance typical to advanced liberal democratic societies. Drawing on Foucauldian theorising, disciplinary power can be seen as embedded within the strategies of the new public health, including the self-regulation and self-management of risks (including genetic risk). Theorising around the power relations inherent within contemporary social movements, including the new public health, provides a starting point from which to approach an investigation of discourses surrounding breast cancer risk, screening and prevention. Such theorising also provides a broader context in which to understand potential political implications of constructions of risk and preventative behaviours that are common in contemporary Western cultures.

This background informs the analysis to come in terms of providing awareness of the complex and contested nature of breast cancer screening and preventative techniques, as well as the shifting, and inherently political, nature of the public health enterprise. In the next chapter, I turn to popular media accounts of prophylactic mastectomy as a site at which to begin analysis of accounts of breast cancer screening, risk and prevention. Subsequently, Chapters 5 and 6 focus, respectively, on health promotional campaign material, and women's talk about breast cancer risk.

Chapter 4

Media accounts of prophylactic mastectomy

4.1 Introduction

The aim of this dissertation, as discussed in Chapter 1, is to explore accounts of breast cancer screening, risk and prevention, and to consider implications of the language in such accounts. From this point on, the thesis will focus on an analysis of empirical data (media texts, health promotion campaign material and women's talk) investigating the ways in which language is flexibly used to negotiate issues of risk and responsibility for health.

As discussed in Chapter 3, there is debate surrounding the various techniques that are currently used to detect and manage risk of breast cancer (see, e.g., Baxter & The Canadian Task Force on Preventive Health Care, 2001; Langlands, 1998; Meiser, Butow, Barratt et al., 2000; Meiser, Butow, Friedlander et al., 2000; Nekhlyudov & Fletcher, 2001). In particular, women with a family history of breast cancer, and those who are categorized as being at 'high risk' due to the results of genetic testing, have been a focus of interest in both the psychological and medical literatures, as well as in the popular media. One option for the management of these women's 'increased risk' of breast cancer is bilateral prophylactic mastectomy, or the removal of their healthy breasts. Psychological research concerned with this procedure is continuing, with findings so far indicating that (a) increasing numbers of women would consider such surgery (Hallowell, 1998; Meiser, Butow, Friedlander et al.,

2000; Stefanek et al., 1995), and (b) women who consider surgery as a preventative option are often highly 'anxious' and overestimate their risk of developing breast cancer (Meiser, Butow, Friedlander et al., 2000). It has also been reported that women commonly report feelings of responsibility to others (in particular, their kin) that effectively constrain their choices to take action around determining and controlling their genetic risk of developing the disease (Finkler, 2000; Hallowell, 1998, 1999; Steinberg, 1996).

Additionally, in Chapter 3, I discussed how current risk management and preventative strategies for breast cancer can be understood as located within a history of public health, and a broader theoretical framework. It was argued that individuals are increasingly engaging in self-regulation and self-management with respect to health risks, and that such risk management is a feature of the new public health, and of approaches to health-care in modern liberal democratic societies. It should be noted that individual risk management is not the sole focus of the new public health; indeed, the new public health aimed to shift focus away from the individualising of health-care to an incorporation of broader social and environmental factors. However, with the rise of a 'healthist' culture, an increase in 'lifestyle' diseases, and a broader cultural shift towards individualism, critiques of contemporary approaches to public health have highlighted the potential for interventions to target all areas of individuals' lives, and to place the responsibility for the management of health with individuals.

Furthermore, the increase in the focus on health risks has been argued to be linked to the increasing medicalisation of individuals, such that individuals who previously

might have been considered healthy and not in need of any medical or public health intervention are now often engaging in the scrutinising and changing of their lives in order to manage risks. The number of risks that are being managed have also increased, with genetic risks now also being considered in the management of health. Breast cancer risk, and particularly genetically-indicated risk, is an example of the kinds of risks that are now a focus in contemporary public health, and in conceptualisations of health and health-care in modern liberal democratic societies (Bunton, 1997; Nettleton, 1997; Petersen, 1997; Petersen & Lupton, 1996).

The background presented in Chapter 3 has informed the analysis in terms of providing awareness of the complex and contested nature of breast cancer screening and preventative techniques, as well as the shifting, and inherently political nature of the public health enterprise. For example, as part of the focus on risk that is central to the new public health (and particularly risk factors for lifestyle diseases), health-care can be seen as relevant in a range of sites, in addition to, and even replacing, older institutional practices of health-care. In the 19th and 20th Centuries, and particularly following World War II, health-care and public health interventions were primarily hospital-based and drew on an individualistic biomedical model of health and illness. In comparison, health concerns can now be seen as central to all aspects of life, rather than being constrained to specific situations, such as times of illness. Particularly since the emergence of the new public health in the 1970s, many more areas of life can now be seen as health-related, and as potential sites for intervention. One contemporary site in which health-care can be seen as located is the popular media and, in this chapter, I will focus on examining popular media accounts of one

specific type of risk management associated with (typically genetically-indicated) breast cancer: prophylactic mastectomy.

4.2 Media representations of health

Popular and news media have been argued to constitute a crucial source of public information about health and illness, and to exert powerful influences on public understandings of, and responses to, contemporary health problems (Chapman & Lupton, 1994; Henderson & Kitzinger, 1999; Lyons, 2000; Miller et al., 1998; Petersen, 2001; Philo, 1999). Indeed, Bunton (1997) uses the term, ‘magazine medicine’, to refer to what has become a key source of contemporary popular health knowledge. In this regard, the media represent a site at which shifts in advanced liberal conceptualisations of health and health-care – for example, the focus on risk management as a mode of medical intervention (rather than intervention being concerned, more specifically, with the care of the ill), and the specification of a subject who is active and enterprising in her/his own health maintenance – are both displayed and (re)produced, influencing the understandings available to citizens about health behaviours that are considered normal and expected.

For example, Petersen’s (2001) analysis of the way print news media frame stories on genetics and medicine led him to conclude that such stories contribute to the shaping of agendas for public debate. Likewise, Henderson and Kitzinger’s (1999) research with focus groups indicated that media stories about breast cancer that focused on inherited/genetic risk were the types of coverage that women most vividly recalled, and that also made a considerable impression on their understanding of genetic risk. Interestingly, Henderson and Kitzinger’s (1999) content analysis of

UK media representations of breast cancer in the late 1990s indicated that higher levels of attention were devoted to genetic risk, relative to other types of risks associated with breast cancer (such as use of the contraceptive pill, HRT, age, smoking, or diet). In particular, media stories about genetic risk typically focused on issues surrounding prophylactic mastectomy, and the experiences of women from 'high-risk' families. Their findings chime with Lupton's (1994a) claim that the popular media influence people's understandings of illness and potential treatments by virtue of their representations of 'typical' victims and suggested causes. Lupton's (1994a) research was concerned with the discourses surrounding breast cancer in the Australian press in the late 1980s, when mammography was debated extensively in both popular and medical literature, and just before the Australian Federal Government announced the National Early Breast Cancer Detection Program. Lupton reported that the media accounts she analysed focused on particular kinds of victims of breast cancer and causes of the disease. For example, breast cancer was typically linked to a violation of, or resistance to, traditional stereotypes of femininity, often with respect to women's reproductive choices. That is, articles linked breast cancer with the 'failure' to have children, with taking the contraceptive pill and with having a career.

Furthermore, Lupton argued that "the press sought to locate the responsibility upon individual women for changing their lifestyles in order to avoid developing breast cancer" (1994a, p.85). As well as risk factors such as childlessness and entering the workforce, many articles linked breast cancer with other lifestyle factors such as diet, exercise and stress. If women 'failed' to perform the necessary lifestyle changes, the implication was that they were neglecting their health. The most significant risk

factor for breast cancer - age - was rarely discussed. These accounts provide examples of ways in which the media, by representing 'typical' victims and possible causes, arguably shape understandings of illness.

A content-analytic study of US popular magazine representations of breast cancer similarly demonstrated a particular focus on young white women who were in the prime of their lives as victims of the disease (Lantz & Booth, 1998). The authors pointed out that the demographics of breast cancer in the US (and elsewhere) suggest that less than 20 per cent of newly diagnosed cases occur in women under the age of 50, with the average age at diagnosis being 65 years. They concluded that typical media portrayals worked to convey strong messages about ideal roles for women in the culture and that, in particular, younger, professional women who were engaging in fertility control were depicted as suffering pathological bodily reactions as a consequence.

Likewise, Saywell, Beattie and Henderson (2000) found that a significant 'sub-genre' of breast cancer accounts in UK newspaper articles related to prophylactic mastectomy and that these accounts, like others in the wider genre of breast cancer stories, emphasised the gendered nature of the illness, and the horror of mastectomy as a "violation of femininity" (p.38). Narratives of prophylactic mastectomy tended to focus on young women and mothers as self-sacrificing and tragic, reproducing idealised notions about femininity, motherhood, and responsibility for others. As the authors point out, this is because the site of (possible) illness in these stories - the breast - is symbolic of both sexual and maternal femininity. Accounts of breast

cancer, a threat to this symbol, reveal much about cultural understandings of femininity, as well as health and illness, as discussed in Chapter 3.

It has, therefore, been argued that detailed attention to specific forms of popular media is particularly important if we are to gain insight into how such representations might influence public understandings of breast cancer causes and prevention (Henderson & Kitzinger, 1999). In this chapter, the analysis will focus on popular media reporting about prophylactic mastectomy. The aim of the analysis is to explore the ways in which prophylactic mastectomy was constructed and women undergoing the procedure were positioned in popular media accounts, given the controversy surrounding both this and other prevention and risk management techniques.

4.3 Data and analysis

The data under analysis in this chapter come from a collection of five media accounts of prophylactic mastectomy that appeared in the Australian print and broadcast media in 2002. This collection was coded for repeated discursive patterns, including the subject positions made available to women, and the ways in which prophylactic surgery was constructed. In particular, two contrasting accounts of prophylactic mastectomy form the basis of the data to be subjected to detailed analysis in this chapter - one from print and one from broadcast media. These two accounts both focus on individual women with a family history of breast cancer who had recently undergone a bilateral prophylactic mastectomy. They are of interest in that they provide relatively contrasting accounts of the procedure, and best represent the variations in depictions of prophylactic surgery in the sample examined.

The first account is an article published in the popular Australian women's magazine, *New Idea* (March 30, 2002), entitled 'Fiona farewells her breasts'. The article was selected for analysis due to its publication in one of the major, widely read women's magazines in Australia, and its depiction of prophylactic mastectomy as a reasonable and necessary action. *New Idea* is published weekly, has an estimated circulation of around 400, 000 (average weekly sales), and is read by an estimated 1.9 million people per week (Pacific Publications, 2003). For the purposes of analysis, the text of the two-page article was transferred into a Word document, with paragraph breaks and formatting features (such as bold print) from the article kept intact. Line numbers were added for ease of reference (lines 1-82). Extracts from this document are provided below to support the analysis (a full version can be found in Appendix 1).

The second account is a report called 'Stieve's story' that appeared on *60 Minutes* (March 3, 2002), described on its owner's company website as "Australia's groundbreaking, ratings-leading and opinion-forming current affairs show" (ninemsn, 2005). *60 Minutes* is aired weekly, and is consistently rated amongst the most watched television programs in Australia (OzTAM, 2005). The account analysed here was in contrast to the one presented in *New Idea* and drew on conflicting opinions of medical experts in order to depict a young woman's decision to undergo prophylactic mastectomy as ill-informed and unnecessary. The specific focus of analysis here is on the talk in this program and, as such, the text under analysis is the transcript of this program as published on the *60 Minutes* online website (<http://sixtyminutes.ninemsn.com.au/sixtyminutes/>). This transcript was also transferred into a Word document, with paragraph breaks and formatting features

kept intact, and line numbers added (lines 1-308) (see Appendix 2). Again, extracts from the transcript are provided in the analysis below.

In the analysis of these accounts, specific features were explored with a focus on investigating their “orientation to action and the resources ... out of which they are constructed” (Hepburn, 2000, p.607). That is, the analysis takes as a starting point the constructive and action-oriented nature of language, and focuses on what the text is doing, accomplishing and constructing, rather than treating the text merely as a report or description of real events (see Edwards, 1997; Edwards & Potter, 1992; Hepburn, 2000; Potter, 1996b; Potter & Wetherell, 1987 for extended discussion of discursive approaches to analysis). More specifically, the analysis is concerned with examining the particular discursive practices and rhetorical devices used to work up a construction of this surgical procedure as either a good, responsible and rational action, or as an action that was unwarranted, and based on an ill-formed decision. The aim is not draw conclusions about whether these particular women *should* have had the surgery, nor about the truth of their categorisation as responsible or otherwise. Instead, I am interested in how the two prophylactic mastectomies are discursively constructed within the accounts, and with exploring the possible implications of such constructions.

4.4 ‘Fiona farewells her breasts’: An account of prophylactic mastectomy in *New Idea*

Given the controversy surrounding both prophylactic mastectomy and other prevention and risk management techniques, the aim of this section of analysis is to

explore the ways in which one woman's prophylactic mastectomy was accounted for in a popular women's magazine. I will demonstrate how this magazine article works up a construction of the removal of healthy breasts, in this instance, as a reasonable and necessary health behaviour. As such, it can be seen to normalise what might otherwise be considered extreme preventative behaviour. The account also serves to perpetuate the notion of healthy people as 'patients without symptoms' that is increasingly salient in contemporary public health (see Chapter 3). It can be seen as functioning to extend the kinds of preventative health behaviours that are expected, and whose absence is morally and socially accountable. In line with the values of advanced liberalism, then, the magazine article reproduces the idea that concern about illness is not limited to people who are sick or to the medical profession. It constructs individuals as needing to be responsible for pro-actively managing their own health and (potential) illness, particularly if they are members of the category 'mother' and therefore have an added responsibility to remain healthy for their children.

The analysis is concerned with the particular discursive practices and rhetorical devices used to work up a construction of the removal of a woman's 'healthy' breasts as 'reasonable' and 'necessary'. This construction can be considered within the broader context of current debate and controversy surrounding preventative mastectomy (see Chapter 3). It is possible to imagine, for instance, that such a decision might alternatively have been presented as extreme or dangerous, if not unwarranted. Such an alternative construction will be examined below, in the analysis of 'Stieve's story' in section 4.5. The construction of Fiona's surgery as reasonable, which will be examined here, can also be also contrasted with recent

psychological research suggesting that women's decision to undergo such surgery may be "associated positively with high levels of breast cancer anxiety and overestimating one's breast cancer risk" (Meiser, Butow, Friedlander et al., 2000, p.2255). In particular, in analysing this text, I will focus on two regularities or repeated patterns of textual construction that contribute to the normalisation of preventative surgery: (i) the positioning of Fiona in terms of the key membership category, and dominant construction of femininity, 'mother'; and (ii) her construction as almost certain to develop breast cancer in the absence of the surgery.

Before proceeding to the analysis, I will give a brief description of the layout of the magazine article. The first page of the story contains the title, 'Fiona farewells her breasts', in bold red writing above the main body of text (presented as three columns). Two small photographs appear in the bottom left-hand corner of the page; one showing Fiona and her mother (captioned 'Fiona lost her mum Dawn'), and the other showing Fiona with her daughter ('She wants to live for her children, including Lauren') who is pictured as a toddler, despite being described in the text as six years old. The second page contains an almost full-page photograph of Fiona by herself, with the caption, 'Fiona no longer has her breasts, but she has her life'. On the far right of this page is a column entitled 'The facts', containing three short questions regarding hereditary breast cancer ('What is hereditary breast cancer?', 'What can I do if I have a strong history of breast cancer?', and 'Can they test for the gene now?') and longer answers, along with details of a telephone hotline for women who have concerns about breast cancer.

4.4.1 Positioning as a ‘mother’

Fiona is described in a number of ways in the article: as a ‘woman’, ‘from Bundaberg, Qld’, as having ‘a clean bill of health’, a ‘35-year-old’, ‘a size 18DD’, as potentially ‘brave’ but ‘actually a coward’, and as a ‘Christian’. She is also defined as a wife, daughter, sister, and cousin by mention of her relationship with various family members, although these terms are not explicitly used to describe her. However, throughout the article, her identity is most consistently constructed in terms of the membership category ‘mother’. This form of representation is in line with Saywell et al’s (2000, p.48) finding that, in a sample of UK newspapers accounts, the “most conspicuous figure in breast cancer narratives was that of the mother”.

The positioning of Fiona as a mother is discursively accomplished both by explicit references, and by describing her relationship with her children as central in her life and in her decision to have surgery. Instances of the ways in which Fiona’s children are constructed as crucial to her decision, as well as Fiona’s explicit positioning as a ‘mum’, are illustrated in Extract 1, which occurs approximately halfway through the article.

Extract 1

28 ‘Unfortunately, like so many women in my family, I too
29 carry the gene mutant for breast cancer. While I may be fine at
30 the moment I’m doing this as a life insurance policy. I want to
31 be around to be a mother to my children.’

32 Fiona - mum to Ben, 12, Hayden, 10, and Lauren, 6 - says
33 she’s been a size 18DD ‘forever’, but call her brave and she
34 quickly corrects you.

35 'It's nothing to do with being brave. I'm actually a coward,
36 but I didn't see that I had a choice in it,' she says.

37 'When Mum was diagnosed she was told she had three weeks to
38 live. Instead she survived for three agonising years, and that
39 was a hell and a suffering I don't ever want my own children to
40 see their mother go through.

41 'It has taken me six months to make up my mind to go ahead
42 with this. Recently I was helping my best friend get her
43 daughter ready for prom night, and Lauren looked up at me and
44 said: "Mummy, will you help me look like a fairy princess on my
45 prom night?"

46 'She's only six, and that's along way off, so I'm going to
47 do everything I can to make sure I'm here to make that dream
48 come true for her.'

In this extract, Fiona is positioned as a mother in several ways. She is reported as describing herself as “a mother to my children” (line 31) when giving a reason for having the mastectomy, and she is then described explicitly as a ‘mum’ in the next line, where her children are given names and ages (line 32). Being a mother is not just an abstract category to which she belongs; her children are made ‘real’ for readers by their identification. A little further on (lines 39-40), she is reported as giving another version of her reason for having the surgery. Drawing on a discourse of motherhood as self-sacrifice, she is presented as describing that she did it to protect her children from suffering: “a suffering I don't ever want my own children to see their mother go through” (lines 39-40). We can consider here how Fiona might alternatively have presented her rationale for wanting to avoid the fate of her own mother. She might reasonably have said “that was a hell and a suffering I don't ever want to go through myself”. Instead, the focus in the article is on a category-bound

activity (Sacks, 1992) – self-sacrifice and prioritising of one’s children - that is culturally appropriate to the key identity category, ‘mother’.

The depiction of Fiona’s motivation for the surgery as being primarily to protect her children from suffering contributes to a reading of her as an authentic, appropriate member of the identity category ‘mother’, thus normalising her decision by drawing on traditional discourses of femininity and motherhood. This notion of the self-sacrificing mother mirrors Hallowell’s (1999) finding that women undergoing genetic counselling for breast/ovarian cancer, like Fiona, “did not just regard themselves as having a responsibility to remain healthy so that they could care for their family; they also regarded themselves as having a duty to prevent their children ... from seeing a loved one die” (Hallowell, 1999, p.612).

At lines 44-45 in Extract 1, the magazine account utilises the technique of active-voicing: Fiona’s young daughter’s request to her ‘Mummy’ is presented as if it is a direct report of the child’s talk. Such a discursive strategy, again, works to emphasize the authenticity of Fiona’s positioning as first and foremost (in relation to the decision to have a mastectomy, at least), a mother. As at lines 46-48, the extended justification for the surgery given here very strongly invokes a category-bound activity that is incumbent upon good mothers: facilitating or helping to make their children’s desires/dreams come true. As Hallowell (Hallowell, 1999, p.611) found in interview data, women “described themselves as having a responsibility to remain healthy so that they were able to engage in the practice of ‘mothering work’”. Again, this prioritising of others, and particularly children, frames Fiona’s decision and

experience in terms of traditional discourses of femininity thus justifying and normalising the action of preventative surgery.

Depicting Fiona as a mother who wants ‘to do everything I can to make sure I’m here’ (line 47) for her children is a prominent feature of this story’s construction that enables readers to view her decision to undergo a prophylactic mastectomy as reasonable, correct and morally responsible. As a mother, it can be seen to be her responsibility to take care of herself, and to prevent illness, so that she can ‘be around’ (line 31) for her children. If having preventative surgery is presented as what she has to do to ‘live for her children’ (from the caption attached to one of the accompanying photographs), then it is understandable that ‘even though she has a clean bill of health – she has opted to have a double mastectomy’ (lines 14-16).

This account of a decision to undergo prophylactic mastectomy, then, repeatedly positions Fiona as a mother, and as responsible and self-sacrificing for her children, thus drawing on traditional discourses of femininity and motherhood. This positioning is typical of the ways in which breast cancer narratives have been previously reported, with women being constructed as martyrs and heroes by virtue of their fulfilling their ‘motherly’ responsibilities to protect their children (Saywell et al., 2000).

4.4.2 Positioning as a ‘patient without symptoms’

As well as presenting the decision to undergo this surgical procedure as a matter of what Fiona *should* do as a responsible mother - doing whatever she can to remain alive and healthy for the sake of her children - the article also constructs prophylactic

mastectomy as being something that she *needs* to do in this instance. This latter function is accomplished by the working up of Fiona as almost certain to get cancer (and, subsequently, to die) if she does not have the surgery. Extract 2, below, demonstrates an instance of the way in which Fiona's future health status was typically constructed if she had not chosen to have the surgery. This extract begins three paragraphs into the article (and immediately precedes Extract 1). It commences with the first instance in which a justification for Fiona's 'decision' is presented in the article.

Extract 2

17 'The reason I've decided to do this is simple - I just
18 want to live,' says 35-year-old Fiona, who admits her tragic
19 family history led her to her painful decision.
20 'I lost my mum Dawn to ovarian cancer, and she lost not
21 only her mother to breast cancer but also one sister at 32 and
22 another at 40 to the disease.
23 'My own sister, who is only 43, has had one breast
24 removed due to cancer and has had her other breast taken off as
25 a preventative measure.'
26 Fiona sadly reveals that she has also lost four cousins
27 on her mother's side of the family to the disease.
28 'Unfortunately, like so many women in my family, I too
29 carry the gene mutant for breast cancer. While I may be fine at
30 the moment I'm doing this as a life insurance policy. I want to
31 be around to be a mother to my children.'

By presenting Fiona's 'reason' for having surgery in terms of her statement, 'I just want to live' (lines 17-18), a particular assumption, or framing, is being introduced into the account at the outset. If Fiona has her breasts removed, the implication is that

she will live and, correspondingly, if she does not have the surgery, it is implied that she will not. This framing is further developed by the working up of Fiona's 'tragic family history' that occurs across lines 18-29. In describing how Fiona has 'lost' multiple female family members, a construction of her family as tragic, and even as destined to die young, is reinforced. Having detailed her fated family tree, the article confirms, at lines 28-29, that Fiona is also affected by her family's legacy and thus a sense of inevitability that she will develop breast cancer is conveyed. Although she is described here as 'fine at the moment' (lines 29-30), Fiona is constructed as not entirely healthy. She 'too carr[ies] the gene mutant for breast cancer' (line 29) and, as such, her positioning can be seen as an example of the form of subjecthood that Finkler (2000, p.58) argued is made available by the emergence of genetic explanations for disease: she is a 'patient without symptoms'. It is important to note here that current scholarly understanding around the identified 'breast cancer genes' (BRCA 1 & BRCA2) is that 'testing positive' for these genes associates an individual with an increased lifetime 'risk' of developing breast cancer, but does not mean that this individual will definitely develop the disease. Correspondingly, even if a person tests 'negative' for these genes, the future occurrence of breast cancer cannot be ruled out.

At various points throughout the article, references are made to Fiona's acts of choice or decision-making in relation to undergoing prophylactic mastectomy. Depictions of this choice to have a mastectomy (indicated by underlining in the examples that follow) were repeatedly presented in the broader context of her construction as the 'carrier' of an inevitably life-threatening disease. Her choice can be read as rational and reasonable here, on the basis of her status as a 'patient without

symptoms'. In the introduction to the article, for instance, an apparent paradox is set up which, following the conventions of narrative structure, readers can expect to be resolved by the story that follows:

13 . . . she has
14 chosen to speak exclusively to New Idea to tell why - even
15 though she has a clean bill of health - she has opted to have a
16 double mastectomy.
17 'The reason I've decided to do this is simple - I just
18 want to live,' . . .

This statement is followed by the detailing of her family history of breast cancer (as presented in Extract 2). Another reference to 'choice' then follows in which Fiona modestly heads off potential attributions of bravery for taking such preventative action. She does this by drawing on an idiomatic expression that conveys a sense of a decision that is so clear-cut that 'choice' does not enter into consideration. The consequence of this justification is that her situation is constructed as being such that she had no alternative but to engage in prophylactic mastectomy:

35 'It's nothing to do with being brave. I'm actually a
36 coward, but I didn't see that I had a choice in it,' she says.

Then, two sentences later, we are told that her decision is not one that has been reached lightly:

41 'It has taken me six months to make up my mind to go
42 ahead with this.

Finally, towards the end of the article, Fiona makes two further references to her active choice in the matter:

61 'The only thing I know for sure at the moment is that
62 while some people may question what I'm doing, a lot of women
63 have never had a choice. I count myself as one of the lucky
64 ones.'

. . .

77 . . . 'If I ever have any doubts I just tell myself that
78 because of my decision, the reward is that I get to live.

In these various depictions of choice, we are presented with a portrayal of a woman who has acted on the basis of a reasoned decision. She has taken considerable time ('six months') to consider her options in a rational and reasonable way, and has eventually been led to an inescapable conclusion ('I didn't see I had a choice in it'). These repeated constructions of Fiona's active choice work up a strong case for mastectomy as rational and reasonable in the circumstances (the inevitability of her developing cancer), thus normalising what might otherwise be seen as unnecessary or risky behaviour.

Additionally in the excerpt above, Fiona is quoted as saying that 'a lot of women have never had a choice. I count myself as one of the lucky ones' (lines 62-64). This first-hand portrayal can be understood in terms of its function as a membership category device (Sacks, 1992). We are being enjoined to read Fiona as a member of the 'lucky' subgroup (she has the choice to take action to prevent the disease's occurrence) of the more general category of 'women with breast cancer'. Given her membership in this category of 'women with breast cancer', Fiona's decision to

undergo prophylactic mastectomy can easily be seen as warranted; as what any rational, responsible woman would do.

In the last full extract to be considered, Extract 3, we see how people who do not share Fiona's opinion concerning prophylactic mastectomy as responsible and reasonable preventative behaviour are depicted in this article. A contrast structure is deployed here: Fiona's 'negative', hurtful friends are contrasted against her loving, supportive husband.

Extract 3

49 Fiona says her decision was made much harder because of
50 negative attitudes from her friends.

51 'I'm a Christian, and one woman told me I had no right to
52 play God by doing this. That really hurt and I don't understand
53 that attitude.'

54 But Raymond, her husband of 17 years, is supportive of
55 her decision.

56 'He just wants me alive and has basically left the
57 decision in my hands. But he reassured me that even if I didn't
58 have reconstruction surgery he'd still love me.

59 'Basically he said he'd rather have me with him than a
60 pair of boobs in a coffin.

A clear contrast is set up in this extract, the details of which make for an obvious implication: Fiona has made the right 'decision'. On the one hand, at lines 49-53, we are presented with a depiction of Fiona's 'friends' who hold opposing 'negative' attitudes about mastectomy that Fiona cannot 'understand'. The example implies a knowing, and therefore hurtful, insensitivity to Fiona's fundamental religious beliefs (a member of the category 'friend' can be expected to be aware of one's religious

affiliations). On the other hand, at lines 54-60, we have her long-term partner ('of 17 years'), who has not tried to influence her decision ('he ... basically left the decision in my hands'), but who has selflessly reassured her that he will 'still' love her even in the absence of surgery to reconstruct her breasts. The attitudes of her friends have made her decision 'much harder'; her husband, in contrast, has been 'supportive' of it, and 'reassuring'. The last sentence of this extract also does work to reinforce the notion that Fiona's death is inevitable in the absence of surgery to remove her breasts. Her husband is reported as seeing the situation in terms of a life or death option: he will either have Fiona 'with him' or he will be left with 'a pair of boobs in a coffin' (lines 59-60).

It is interesting to note that, in this magazine article, Fiona is never described as being at 'high risk' of developing breast cancer due to her family history and genetic status. It is also worth noting that the words 'risk' and 'chance', that one might expect to see in an account of prophylactic mastectomy, do not appear in this account. Their absence can be seen as contributing to the construction of Fiona as someone who is almost certain to develop breast cancer. She is not described as being 'at risk' of developing cancer and, therefore, the article does not focus on her 'options' as an 'at-risk' individual. Instead, it is easy to read her as *destined* to develop breast cancer unless she has preventative surgery.

In summary, then, the magazine article manages to account for, and normalise, Fiona's mastectomy in two broad ways. Firstly, she is positioned, predominantly and repeatedly throughout the account, as a mother and, as such, it is her responsibility to her children to do whatever she can to remain healthy and alive. Secondly, she is

constructed as almost certain to develop breast cancer (and, possibly, to die like many of her female relatives) unless she has a prophylactic mastectomy. As a result of these two positionings, her ‘decision’ to undergo the surgery is presented as a reasonable, and even morally ‘right’, thing to do.

The next section of this chapter focuses on the analysis of another, contrasting media account of prophylactic mastectomy to examine further ways in which key concepts in theorising around health in modern liberal societies are reproduced in the popular media.

4.5 ‘Stieve’s story’: Prophylactic mastectomy on *60 Minutes*

The aim of this section of analysis is to explore the ways in which a different prophylactic mastectomy was depicted on a popular current affairs television program, *60 Minutes*. As previously discussed, prophylactic mastectomy is a relatively controversial risk management technique. Despite this, the analysis above demonstrated how a popular media account normalised this procedure, representing it as reasonable and necessary. In contrast, the next account to be analysed drew on the conflicting opinions of medical experts in order to depict a young woman’s decision to undergo such a procedure as uninformed and unnecessary. This television report of prophylactic surgery represents a young woman - Stieve - as undergoing a procedure that went badly, was potentially unnecessary, and was ultimately constructed as regrettable. Further, I demonstrate how the young woman in this report is positioned as not taking personal responsibility for the rational assessment and management of health risks. In line with theorising around health-care in contemporary Western societies (discussed in Chapter 3), this positioning of the

woman, Stieve, as not rational and responsible can also be argued to perpetuate the notion that individuals *should* be responsible and make rational, informed decisions to manage their own health and (potential) illness.

The analysis that follows is concerned with the particular discursive practices and rhetorical devices used to construct the decision to have a prophylactic mastectomy as uninformed, unnecessary and even irrational. It is interesting to note, however, that the procedure itself is not constructed negatively here. Rather, I will show how it is the decision, and the woman undergoing the surgery, that are positioned as falling short of ideal and, consequently, whose negative depiction functions to construct individuals as needing to take responsibility for their own health and risk management. In particular, in analysing this text, I will focus on three features of textual construction: (i) the positioning of Stieve as a ‘patient without symptoms’; (ii) the positioning of experts in the account; and (iii) the construction of the choice to have surgery. Finally, I will draw some comparisons between this television report and the popular women’s magazine article analysed above, and argue that, despite the differences between the two accounts, both function to perpetuate the notion that individuals are increasingly expected to be active in, and responsible for, the management of their own health and (potential) illness.

The *60 Minutes* report is presented in two parts. The first introduces Stieve, and her situation, before the mastectomy was carried out; the second takes the form of a follow-up story months later, focusing on the negative results of the surgery and the discovery that Stieve, perhaps, did not require the surgery after all.

4.5.1 Positioning as a ‘patient without symptoms’

In the first part of the *60 Minutes* report, the reasons for Stieve’s prophylactic mastectomy are repeatedly worked up. These typically centre around her role as what Finkler (2000) has termed a ‘perpetual patient without symptoms’ – a contemporary form of subjecthood made available by the increasing dominance of genetic explanations for disease. The extract below illustrates some of the ways in which this subject position is constructed for Stieve in the television account. It is taken from the beginning of the interview between Stieve and the reporter, Tara Brown, and immediately follows the introduction of the report.

Extract 1

30 TARA BROWN: "Cancer" must have been a word that you were
31 familiar with from a very young age.
32 STIEVE DUKE: I grew up with it. I don't remember ever not
33 knowing it. It's similar to knowing you're adopted
34 and never questioning it. I've always known that
35 there was cancer in the family. I've never not
36 known it. It's like living with a shadow behind you
37 the whole time, waiting for the day. It's like it's
38 the day that I – I go to bed and I feel for lumps
39 and I think, is this the day I find one? Was that
40 there yesterday? Am I imagining it? It plays on you
41 every day.

In this extract, Stieve is described as having ‘grown up’ with cancer, despite her not having ever had cancer. ‘Cancer’ is constructed as a disease affecting her family as a whole: it is ‘in the family’ (line 35). Such a construction exemplifies ways in which the ideology of genetic inheritance can be seen to impact on families, rather than

individuals. Stieve's family is described as cancer-affected and, as a member of that family, Stieve is represented as constantly living in fear – 'It's like living with a shadow behind you the whole time ... It plays on you every day' (lines 36-37, 40-41). Consequently, she describes engaging in constant surveillance of her body – 'I go to bed and I feel for lumps and I think, is this the day I find one?' (lines 38-39). In this sense, she is positioned as monitoring her body for medical reasons, and as affected by cancer, but as simply not have any symptoms yet: she can be read as a 'patient without symptoms'.

The ideology of genetic inheritance is further illustrated in Extract 2 below, which follows almost directly from Extract 1, and focuses on the introduction of Stieve's mother, Margaret.

Extract 2

44 TARA BROWN: Margaret is Stieve's mum. Margaret's mother, sister
45 and, she believes, her grandmother all had breast
46 cancer. In 1981, concerned by her family history,
47 Margaret had a double mastectomy. She understands
48 why Stieve is about to go through the same
49 operation. Stieve talks about breast cancer being a
50 shadow that's followed her since about the age of
51 four.

In describing multiple female family members as 'having' breast cancer at lines 44-46, the construction of the family, and consequently of Margaret and Stieve, as affected by cancer, and therefore appropriately concerned, is strengthened. At line 47, we learn that Margaret has also had a double mastectomy, which, given her

motivation as ‘concerned by her family history’ (line 46) (rather than, for example, due to a diagnosis of breast cancer), can be read as preventative and as further working up the severity of the family’s affliction.

Preventative mastectomy is, therefore, arguably normalised at this point in the account. Stieve’s family history of cancer is worked up as real and severe enough to have previously justified her mother’s prophylactic mastectomy. Furthermore, her mother’s surgery is implicitly represented as having been successful in preventing cancer by virtue of the absence of any mention of Margaret having had breast cancer, especially given the length of time since the procedure was carried out (line 46 – ‘In 1981’). The representation of Stieve’s family history, therefore, further works to position her as a ‘patient without symptoms’, justifying her need to engage in risk management, such as daily breast self-examination (as described in Extract 1).

Stieve’s position as a ‘patient without symptoms’ is in line with notions central to theorising about the new public health, and about health-care in modern Western nations, where health-care has been argued to be increasingly differentiated from its earlier focus in specific locations and interactions, such as in hospitals or clinics with physicians. Stieve’s description of her daily bodily monitoring is an example of the shifting of concerns about health and illness into individuals’ everyday lives. This subject position also mirrors one of the dominant constructions in the *New Idea* article about Fiona’s mastectomy. Fiona was also depicted as a ‘patient without symptoms’; a construction that was argued to function as warranting and normalising her prophylactic mastectomy.

With contemporary public health in Western nations being concerned primarily with so-called ‘lifestyle’ diseases, and the increasing dominance of genetic explanations for disease, the forms of risk management and public health intervention that are currently available are shifting from more traditional means. As discussed already, prophylactic mastectomy is one specific type of risk management associated with breast cancer (and particularly, genetically-indicated breast cancer), and in Extract 3 below, this procedure can be seen to be constructed as a means of dealing with Stieve’s ‘at risk’ diagnosis.

Extract 3

57 TARA BROWN: Two years ago, Stieve, a part-time model and
58 painter, found a lump in one breast. Although
59 benign, it scared her into thinking seriously about
60 having her breasts removed.
61 STIEVE DUKE: I have the looming idea of more lumps coming, more
62 operations, more tests, more scans, and I'm sick of
63 it. I don't want it any more.

By virtue of Stieve’s description of herself as having ‘more lumps coming’ and as requiring more medical procedures and interventions (lines 61-62), her life and body can be read as being medicalised, functioning to position her further as a ‘patient without symptoms’. She therefore can be seen to require some ‘cure’ or final successful intervention to end her current ongoing risk management. Despite not having had cancer, she draws on the narrative of someone who is dealing with a chronic illness – in this case, her illness is her ‘at risk’ status. The repeated use of the term ‘more’, and particularly her statement, ‘I don’t want it any more’ (line 63), depicts her experience as ongoing. She can therefore be read as justified in wanting a

way to treat and remove her risk – in ‘thinking seriously about having her breasts removed’ (lines 59-60). As in the account concerning Fiona, the procedure is arguably normalised as an available risk management strategy for breast cancer risk.

In Extract 4, the television report continues to legitimise and normalise Stieve’s prophylactic surgery, by drawing on a discourse of genetic inheritance, and a representation of risk as a diagnosis requiring management. This extract illustrates the beginning of a discussion between Stieve and the surgeon who is to perform her operation, Nigel Sax, with an introductory ‘voice-over’ comment by Tara Brown, the interviewer.

Extract 4

- 66 TARA BROWN: Stieve's fear is real, and for a small number of
67 high-risk women, a double mastectomy will save
68 their lives. In most cases, those women have
69 inherited a defective breast cancer gene, located
70 by genetic test. In other cases, so strong is the
71 family history, doctors are convinced there are
72 other defective breast cancer genes science has not
73 yet identified. Although the genetic test for
74 Stieve's family was negative, she still feels she
75 can only achieve peace of mind through a double
76 mastectomy and a breast reconstruction. So, last
77 April, Stieve went to Nigel Sax, an Australian
78 surgeon practising in London. Stieve provided him
79 with information about her family history.
- 80 NIGEL SAX: As we discussed, there is a very strong family
81 history which means there's almost certainly a
82 breast cancer predisposing gene in your family, as
83 you know.

84 STIEVE DUKE: Yep, yep.
85 NIGEL SAX: They haven't been able to identify which gene it is
86 as yet.
87 STIEVE DUKE: Yes.

Throughout this extract, genetic links to breast cancer (e.g., 'a defective breast cancer gene, located by a genetic test' at lines 69-70) are explicitly mentioned. By constructing a 'very strong family history' (lines 80-81) as a symptom of a 'breast cancer predisposing gene' (line 82), and by presenting a doctor as validating Stieve's own description of her family as cancer-affected, she is represented as one of the 'high-risk women' for whom a 'double mastectomy will save their lives' (lines 67-68). A prophylactic mastectomy is therefore constructed as reasonable. Furthermore, by moving from this specific case – 'Stieve's fear is real' (line 66) – to the more general case of 'high-risk women', the report positions Stieve within a broader context of a category of women, thus normalising her experience somewhat, and further legitimising the decision to undergo the procedure.

I have examined how Stieve, in this television report about her prophylactic mastectomy, can be seen as positioned as a 'patient without symptoms'. Her 'at risk' status, at least in the first half of the account (pre-mastectomy), was repeatedly worked up by drawing on what has been termed the 'ideology of genetic inheritance' (Finkler, 2000), and by positioning her as one member of an inevitably cancer-affected family. Given this premise, her surgery can be seen as justified and, as such, the validity of prophylactic mastectomy as a form of risk management is worked up. However, as the report continued, Stieve's risk status was questioned, and her decision to have preventative surgery was constructed as emotional and misled and,

therefore, as flawed and irresponsible. In the next two sections, I will explore aspects of the report that contribute to such a construction: the positioning of experts in the account, and the construction of the choice to have surgery.

4.5.2 Positioning of experts

In contrast to the other popular media account of prophylactic mastectomy analysed earlier in this chapter, representations of doctors and the medical profession are repeatedly drawn upon in this television account. Both sections of the report centre on interactions between Stieve and two different doctors – one in each section.

In the first part of the *60 Minutes* story, a ‘consultation’ is shown between Stieve and Dr Nigel Sax (Dr Sax was introduced towards the end of Extract 4 above). Sax is introduced as ‘an Australian surgeon practising in London’ (lines 77-78) and, as such, he is already explicitly constructed as an ‘expert’ by virtue of his membership of the category ‘surgeon’. In the consultation that follows (some of which can be seen at lines 80-87 in Extract 4), Sax can be seen to be directing the conversation, while Stieve is relatively passive in the interaction, giving only short responses to Sax’s statements. He is represented as being knowledgeable with respect to breast cancer risk and prophylactic surgery, and as taking an active role in the assessment of Stieve’s risk. Furthermore, in Extract 5 below, which shows the interviewer, Tara Brown, questioning Sax, he can also be seen as active in the decision regarding the management of risk – i.e., the preventative surgery.

Extract 5

101 TARA BROWN: Did her age worry you at all?

102 NIGEL SAX: No, because if the whole reason for doing an
103 operation at that age is you get a greater
104 percentage benefit. If you operate on somebody at
105 the age of 50, a lot of their risk has already
106 passed by then, so the potential benefit is less.
107 TARA BROWN: Who would you not do this operation on?
108 NIGEL SAX: I wouldn't do it on someone I didn't think was
109 properly understanding as to what their real risks
110 were and what the potential benefit was.

By asking Sax these questions, there is a sense that it is he (rather than Stieve, for example) who will make the final decision about whether or not to carry out the surgery. For example, both Brown and Sax represent the prophylactic mastectomy as something 'done' by Sax 'on' a patient (lines 107-108: 'Who would *you* not *do* this operation *on*?', 'I wouldn't *do* it *on* someone ...'; emphasis added). The construction of 'choice' and 'decision-making' in this account of Stieve's prophylactic mastectomy will be further examined in the next section, but it should be noted, here, that Dr Sax is positioned as active in choosing to 'do' the operation, rather than, for instance, carrying out the procedure as a result of a patient's decision.

Extract 6 provides a further example of an instance in the text where Sax was represented as active. It shows the continuation of the discussion between Stieve and Dr Sax (again with an introduction from the reporter).

Extract 6

125 TARA BROWN: Before the surgery, Stieve seeks reassurance.
126 STIEVE DUKE: You're happy – in your mind, you're happy with
127 that?
128 NIGEL SAX: Yes.

129 STIEVE DUKE: So just – I want to hear it from you.

130 NIGEL SAX: I'm very happy, yes. I'm happy.

It is not clear exactly what Stieve is referring to by 'that' at line 127 – the surgery itself, or details of the reconstruction, which was a topic of discussion between lines 90-97, prior to this extract. However, it can be argued that by virtue of being the provider of reassurance here, Sax is again positioned as the assessor of risk and of the suitability of preventative surgery. Stieve is simultaneously represented as somewhat hesitant and in need of guidance. This depiction can be seen in the description of her as 'seeking reassurance' (line 125), and her repeated request for confirmation that Sax is 'happy' about the surgery. She is therefore represented as deferring to his judgement ('you're happy with that?' - lines 126-127), rather than independently deciding to go ahead with the mastectomy. It should perhaps be reiterated here that it is not the aim of this analysis to assess whether Stieve did or did not make an independent decision regarding her surgery; rather, the analytic focus is on the portrayal of her decision that is worked up in this media report.

The account then describes how 'Nine days after her first consultation, Stieve goes under the surgeon's knife' (lines 140-141). Note again, in this description, that Stieve is constructed as passive in relation to 'the surgeon's knife'. This construction of Stieve works discursively to locate agency with the surgeon. Alternatively, Stieve could have been positioned in a way similar to that in which Fiona was depicted in the *New Idea* account - "Fiona has now endured the 11-hour marathon surgery" (lines 65-66) – as heroic, strong and as actively participating in her surgery. Instead, constructing Stieve as passively worked upon contributes to the construction of her actions as not being those of a rational, autonomous individual.

The second part of the *60 Minutes* report takes place post-surgery, and focuses on Stieve's description of her 'many months of pain' (lines 157-158) following the operation, as well as her interaction with another surgeon, Professor Robert Mansell, who is described as 'one of the top breast cancer surgeons in Britain' (lines 189-190). The report describes Stieve as 'seeking help' (line 181) from Professor Mansell. In Extract 7, Stieve and Professor Mansell discuss 'side-effects she didn't expect' (line 171), and her 'bloody awful' reconstructed breasts (line 168). The extract is taken from part-way through Stieve and Professor Mansell's interaction, when Mansell had just watched film of Stieve's discussion with Dr Sax.

Extract 7

204 PROFESSOR ROBERT MANSELL:

205 In that interview, you focused on a lot of areas of
206 the shape, the height, which means to me, if I was
207 talking to you about this operation, I would want
208 you to think long and hard about it because I would
209 be telling you that maybe these things wouldn't
210 turn out as well as you would hope.

211 STIEVE DUKE: See, I was under the impression that this was
212 standard fare, easy ...

213 PROFESSOR ROBERT MANSELL:

214 Yes. It's not. One of the things we do here is make
215 sure that people are counselled in great depth,
216 that they see photographs of the scars, that they
217 ideally talk to somebody who has had it done so
218 they can actually talk woman to woman to someone to
219 say, "This is what it's like," and they talk at
220 length to the breast care nurses and counsellors.

Without explicitly criticising Dr Sax, Professor Mansell can be argued to be positioned here as a more authentic member of the category ‘expert’. This is achieved by representing what Mansell would have done in managing Stieve’s situation, as implicitly in contrast with what Sax did: ‘if I was ... I would want ...’, ‘I would be telling you ...’ (lines 206-209), and ‘One of the things we do here ...’ (line 214). This contrast follows the description of how Stieve’s surgery went badly, functioning to associate what Mansell would have offered with a more positive outcome. In addition, Professor Mansell has already been described as a ‘top breast cancer surgeon’ and the doctor to whom Stieve has gone to for help. Mansell is therefore positioned as able to assess, and help resolve, the negative results of Stieve’s prophylactic mastectomy, in contrast to Sax, who can now be read as the doctor who led to her problematic situation.

Mansell is constructed, not only as an expert, but as a ‘good’ doctor who, in contrast to Sax, would have dealt with Stieve’s situation in such a way that she would have had a different, and better, outcome. Having been positioned in this way, he is then depicted as revealing to Stieve that she, allegedly, has a much smaller ‘lifetime risk’ of developing breast cancer than she believes, and that on this basis he would not have advised surgery. Extract 8 illustrates part of this interaction between Stieve and Mansell, with ‘voice-over’ comments from the reporter Tara Brown.

Extract 8

221 TARA BROWN: But Stieve is in for a bigger shock yet. All her
222 life, she's believed she's a high-risk candidate
223 for breast cancer. Professor Mansell believes
224 otherwise.
225 PROFESSOR ROBERT MANSELL:

226 I'm going to ask you some simple questions, and
227 then it will tell you what your risk is. So, for
228 instance, your age when your periods started?
229 STIEVE DUKE: 15.
230 TARA BROWN: Using a recently developed test, databanks many
231 geneticists in Britain now rely on, Professor
232 Mansell does some calculations.
233 PROFESSOR ROBERT MANSELL:
234 Okay. Just by pressing a simple button like that,
235 you get a risk. I know it's going to shock you –
236 your lifetime risk is 8.5 percent.
237 STIEVE DUKE: Right. That doesn't take into account my aunt or
238 the fact that my mother had a mastectomy to prevent
239 breast cancer.
240 PROFESSOR ROBERT MANSELL:
241 No, it doesn't matter. It doesn't increase your
242 risk at all. If you haven't got a first-degree
243 relative – a mother or sister – with breast cancer,
244 you're unlikely to be in a very high-risk group.
245 They've not found a gene when they tested the
246 family, so on that simple calculation, I would not
247 have advised you to have this operation.

Professor Mansell is depicted, in this extract, as using the most modern technology ('a recently developed test', line 230), and techniques shared by other experts ('databanks many geneticists in Britain now rely on', lines 230-231), constructing him as up-to-date and informed. Furthermore, Mansell is depicted as providing much more detail in explaining Stieve's 'risk' than did Sax, arguably contributing to the sense that he is giving Stieve (more) accurate information.

‘Risk’ is, therefore, a central concern in this extract, as it has been argued to be in the new public health more generally. By describing Professor Mansell’s ‘calculations’, which involve ‘some simple questions’ (line 226) and ‘just pressing a simple button’ (line 234), risk is constructed as being an objective, measurable entity. This can be further seen in the description of Stieve’s ‘lifetime risk’ as ‘8.5 percent’ (line 236); her risk is constructed as real by virtue of its ability to be quantified. Such a representation can be seen as similar to the kinds of quantification examined by Potter, Wetherell and Chitty (1991) with respect to ‘cures’ for cancer. They argue that a ‘cure’ (like a ‘risk’ in the current data), rather than existing outside of discourse and able to be simply described by a quantification or measurement, is instead constructed flexibly in language, often through the use of quantification⁷. That is, “some objects or concepts may be *constituted* through linking them to numbers” (Potter et al., 1991, p.337, italics in original). Stieve’s risk of breast cancer, in the *60 Minutes* account, can similarly be argued to be worked up as real and measurable by its association with a percentage figure. Stieve, however, is not able to measure, or know, her risk herself and must rely on an (accurate) expert calculation - one that takes into consideration the appropriate risk factors.

‘Risk’ is therefore also constructed as something that can be measured inaccurately and as something that doctors themselves may not agree upon. Such differences in medical opinion can be seen in the debates surrounding breast cancer screening and prevention techniques discussed in Chapter 3, as well as in Extract 9 below. In this excerpt from the report, Tara Brown questions Professor Mansell about Dr Sax’s

⁷ ‘Quantification rhetoric’ will be further discussed in Chapter 5, and examined with respect to health promotional pamphlets for breast cancer screening.

decision-making and conduct, thus continuing to work up a contrast between the two doctors.

Extract 9

275 TARA BROWN: The doctor has said to me that he was driven by her
276 anxiety, that Stieve was so anxious about one day
277 developing cancer, that he was motivated to help
278 relieve that fear. Is that justification for what
279 he has done?

280 PROFESSOR ROBERT MANSELL:
281 We do that every day of the week. That's part of
282 our job. It doesn't mean you have to do surgery to
283 do that. You need explanations, you need to say
284 what the real risk is and you need to give
285 counselling – that's what it should be.

286 TARA BROWN: Dr Nigel Sax declined to take part in another
287 interview with *60 Minutes*. Through his lawyer, he
288 said he had followed best practice guidelines and
289 had recommended Stieve undergo counselling before
290 her operation.

At lines 280-285, in response to a question about Sax's actions, Mansell is, again, positioned in contrast to the first doctor. Initially, Mansell draws on a membership category device to position both his and Sax's identities as part of the broader category 'doctor' - 'We do that every day of the week. That's part of *our* job' (lines 281-282, emphasis added). He then however, at lines 282-285, works to differentiate himself from Sax, by drawing a contrast between carrying out surgery and providing other services. Given that the former led to Stieve's problematic situation, the latter can be clearly read as preferable in this instance. This is particularly so given the description of the alternative to surgery: 'You need explanations, you need to say

what the real risk is and you need to give counselling' (lines 283-285). This three-part list includes elements that would all be expected in a medical consultation regarding preventative (and other) surgery. Further, surgery and other options are constructed as being, in this instance at least, mutually exclusive: the implication arguably being that Sax performed the surgery *without* explanations, identification of the 'real risk' or counselling. Sax's actions are, therefore, constructed as flawed and as leading to unnecessary surgery, whereas Mansell can be read as good doctor who carries out what 'should be' done.

The reporter's final comment in Extract 9 (at lines 286-290) is further evidence of the construction of Sax as not performing his role as Stieve's doctor adequately. It could be argued that describing Sax as 'declin[ing] to take part in another interview' (lines 286-287) rhetorically positions him as acknowledging some criticism or wrongdoing, and undermines his claim that he had followed 'best practice guidelines' (line 288).

The contrast drawn between the doctors in the *60 Minutes* account highlights a dilemma that exists for consumers of health-care systems in advanced liberal societies. Individuals, like Stieve, must rely on experts to discover and quantify their risk and, yet, the experts may miscalculate risk, or disagree on how best to calculate it. Doctors are therefore not simply 'experts' who can be relied upon to provide accurate information and to make medical and health decisions on behalf of individuals. The responsibility for making such decisions lies with individual citizens. This television report constructs complexity and controversy in the doctor-patient relationship, and in the level of consensus between doctors. Specifically, it

represents disagreement between experts regarding prophylactic mastectomy and understandings of ‘risk’. Sax and Mansell are both positioned as ‘experts’ in their interactions with Stieve and, yet, they do not give her the same information or advise the same course of action. Doctors, as a category, are therefore represented as not necessarily in agreement and as potentially giving the wrong advice. In this account, Sax is depicted as appearing to have misadvised Stieve. Stieve, however, as the recipient of the medical procedure, has to live with the effects of the surgery and, ultimately, seems to regret the procedure, as will be examined in the next section that explores constructions of her choice.

4.5.3 Construction of the choice to have surgery

This section of the analysis focuses on how, given the disagreement amongst the experts in this account and the negative results of Stieve’s operation, the choice to have the surgery was portrayed. Specifically, several ways in which choice was constructed in this television account will be examined: as motivated by Stieve’s ‘patient without symptoms’ status; as not autonomous; and as emotional, rather than rational. By examining these features of the report, in conjunction with the analysis in the preceding sections of the chapter, I argue that, ultimately, Stieve’s decision to undergo prophylactic mastectomy was represented as the wrong choice, as emotional and misled.

Choice as motivated by ‘patient without symptoms’ status

In the first section of the report, which was recorded prior to Stieve’s mastectomy, the choice to undergo the procedure was largely constructed as motivated by Stieve’s status as a ‘patient without symptoms’ (details of some of the ways in which this

subject position was constructed in the account are examined above). Like the depiction of Fiona in the *New Idea* account analysed above, representing Stieve as part of a cancer-affected family and, therefore, as potentially carrying a breast cancer gene, positioned her as 'at risk' and consequently as requiring some management of her condition. As such, the choice to undergo a prophylactic mastectomy, although extreme, can (to some extent) be read as warranted at this point in the report. Extract 10 below illustrates some of the ways in which Stieve can be read as making the decision to have surgery on the basis of her cancer-affected life. The extract comes from the first part of the report, immediately following Extract 5 which depicted Tara Brown questioning Nigel Sax, and preceding Extract 6, which showed Stieve 'seeking reassurance' from Sax.

Extract 10

- 111 TARA BROWN: Are you frightened at all?
- 112 STIEVE DUKE: A little and then I'm a little excited as well. I'm
113 excited that I'm going to get on with the rest of
114 my life and I'm not going to have ultra sounds
115 every six months. I'm not going to have to watch
116 for lumps, I'm not going to worry people around me
117 who love me. I'm just going to live normally, like
118 normal people do, and I've never lived like that.
- 119 TARA BROWN: So, you're quite prepared to lose your breasts so
120 you can live like that?
- 121 STIEVE DUKE: Yep. I think given the same choice, a lot of people
122 would. A lot of people wouldn't and I respect that,
123 I really do, but for my peace of mind, I need to do
124 it for my peace of mind.

In this extract, by describing having surgery as meaning that she is ‘not going to have ultra sounds every six months’, ‘not going to have to watch for lumps’ and ‘not going to worry people around [her]’ (lines 114-116), it could be argued that Stieve is implicitly constructed as currently engaging in these actions. These behaviours can be read as indicative of someone who is unwell and, as such, Stieve is positioned as a patient, even though she does not have evident symptoms. A prophylactic mastectomy, by reducing the need for these behaviours, is thus constructed as a means to better manage her risk ‘condition’. This construction of Stieve, and of prophylactic surgery, therefore functions to warrant her choice to undergo surgery.

Furthermore, prophylactic surgery is constructed as a way in which Stieve can begin to ‘live normally, like normal people’ (lines 117-118) and ‘to get on with the rest of my life’ (lines 113-114). This contrast between ‘normal people’ and Stieve positions her as ‘abnormal’ as a result of her health status, further working up the construction of her as sick or unwell, and as requiring intervention. Prophylactic surgery is thus constructed as allowing her to be other than a ‘patient’. Although it is acknowledged that surgery is an intervention that involves sacrifice (‘you’re quite prepared to lose your breasts so you can live like that?’, lines 119-120), Stieve is positioned as both willing to make this sacrifice, and as not unusual for her willingness: ‘I think ... a lot of people would’ (line 121-122). Finally, at lines 123-124, Stieve employs the bottom-line argument that she is ‘do[ing] it for my peace of mind’. This construction sets up a dichotomy where if she has surgery, she will have peace of mind, but if she does not have surgery, she will remain unhappy and be unable to live ‘normally’. Such a construction is rhetorically persuasive, as it works up one side of the dichotomy as clearly preferable. Therefore, by being an action that other people

would also choose in such an abnormal, problematic position, as well as being motivated by her desire for 'peace of mind', her choice can be read as not unreasonable, and as motivated by valid reasons.

The next extract comes from the end of the first section of the report, before Stieve underwent the surgery. Here, the decision to have surgery is again constructed as 'reasonable', given her family history (line 144). Furthermore, Stieve is positioned as 'self-determined', 'very well informed' and as someone who has 'thought about it carefully'.

Extract 11

- 137 TARA BROWN: Are you sure this is what you want to do?
- 138 STIEVE DUKE: No, it is actually the self-determination of what
139 I've done that makes me not nervous.
- 140 TARA BROWN: Nine days after her first consultation, Stieve goes
141 under the surgeon's knife.
- 142 NIGEL SAX: She's young, she's very well informed, I think
143 she's thought about it carefully. I think it's
144 reasonable. Given her family history, I think if it
145 was my sister, I'd strongly consider it.

Stieve's decision is constructed here in a similar way to Fiona's in the popular magazine account analysed earlier. Fiona's choice was also represented as reasonable and warranted given her 'tragic family history'; she was also positioned as a 'patient without symptoms' who required medical intervention. Despite this similarity, though, there are some notable differences in the ways in which the women's stories were portrayed. For example, by drawing on a discourse of motherhood, Fiona's decision to have surgery was depicted as heroic and as rationally managing her

responsibility for her children. In contrast, the account of Stieve's choice as based on of her 'patient without symptoms' status was undermined by the constructions of her choice as not autonomous, and as emotional. These features will be examined now.

Choice as not autonomous

Despite the depiction of Stieve's choice to undergo prophylactic mastectomy as, to some extent, reasonable and warranted (as discussed above), it could be argued that, overall, the choice to have surgery is constructed as flawed in this report. This construction is worked up in several ways, one of which is that the decision was, arguably, not autonomously made. Rather, Stieve is positioned as influenced and possibly misled by her first doctor, Dr Nigel Sax.

The construction of Stieve's choice as not autonomous can be seen as closely related to the positioning of Nigel Sax, examined in section 4.5.2 above. Sax is constructed in this report as active in the assessment of Stieve's risk of breast cancer, and in encouraging her to undergo a mastectomy to manage her risk. In examining Extracts 4, 5 and 6, I illustrated how he was represented as directing the interaction with Stieve, answering the reporter's questions regarding the appropriateness of the procedure, and offering Stieve reassurance before the surgery. Sax can therefore be read as, not only active in the choice to have surgery, but as *more* active than Stieve herself. As such, the choice to have surgery is not constructed as undertaken by Stieve herself, autonomously and independently of Sax.

After the surgery is revealed to have gone badly, Sax is constructed as potentially misleading Stieve. Sax can now be read as the doctor who led to Stieve's problematic

situation, with Stieve is positioned as being misled by Sax, rather than as a patient who made an independent decision.

The construction of Stieve's choice to undergo surgery as not fully autonomous is in contrast with the representation of Fiona's choice in the women's magazine account of prophylactic surgery examined previously. In the *New Idea* account, no medical experts were represented at all, and the 'choice' for the surgery was constructed as solely Fiona's. She was positioned as rational, informed and autonomous, and her prophylactic mastectomy was constructed as warranted. It is reasonable to assume that medical professionals could have been described in the *New Idea* article, given the medical nature of prophylactic mastectomy. However, the absence of any representation of medical professionals in the *New Idea* account can be seen as functioning to contribute to the positioning of Fiona as independent and autonomous, and as taking sole responsibility for her risk management. In contrast, the *60 Minutes* account drew on the conflicting opinions of medical experts, and this can be seen as functioning to depict Stieve's decision to undergo prophylactic mastectomy as not autonomous.

Choice as emotional, rather than rational

One final, and dominant, construction of the decision to have surgery in this account is as emotionally-motivated, rather than being carried out on the basis of a rational assessment of risk. For example, throughout the first half of the report, Stieve is described as 'frightened' (lines 3 & 55), as 'fear[ing] she's a prime candidate' (line 27), 'afraid' (line 42), as having a 'lot of fears' (line 52), and as being 'scared ... into thinking seriously about having her breasts removed' (lines 59-60). These

descriptions position Stieve as motivated by her fear - an emotion that dominated and shaped her thinking - rather than a rational assessment of her 'risk'. Extract 12, from the very beginning of the report, further illustrates Stieve's choice as motivated by fear and emotion, rather than by rationality.

Extract 12

1 It was a year ago that Tara Brown met a young woman called
2 Stieve. With a family history of breast cancer, Stieve was
3 frightened.

4 She'd become convinced that she had the breast cancer gene
5 and that gene could lead her to contract the cancer that kills
6 more women in Australia than any other.

7 Her story was so compelling that Tara followed her for many
8 months as Stieve wrestled with an awful decision – should she, at
9 just 29, surgically remove both her breasts?

10 This is a story to make every woman stop and think – with a
11 most dramatic outcome.

At line 3, as discussed above, Stieve is described as 'frightened'. Furthermore, she is described, at line 4, as having 'become convinced' that she would develop breast cancer. By describing Stieve in this way, it could be argued that doubt is cast over her status as genuinely 'at risk' – her 'at risk' condition is not represented as real and non-problematic, but as something about which she had 'convinced' herself. Consequently, Stieve can be read as the central, and possibly sole, party in her risk assessment, rather than, for example, as being informed (or 'convinced') by others that she was at increased risk. Given the positioning of Nigel Sax in the report as actively informing Stieve of her risk, she could have potentially been represented at line 4 as having 'been informed that she may have the breast cancer gene'. Instead,

describing her as having ‘become convinced’ arguably functions to place the onus on her as an autonomous individual, and to position her as irrational, and as motivated by emotion and potentially inaccurate information.

This introduction arguably frames the possible ways in which the subsequent report can be read. That is, although the decision to have the surgery seems, to some extent, reasonable in the first half of the report (due to Stieve’s positioning as a ‘patient without symptoms’ as discussed in section 4.5.1), the report is set up in the introduction as a ‘compelling’ and ‘dramatic’ ‘story’ (lines 7 & 11); a ‘story to make every woman stop and think’ (line 10). Such framing at the outset arguably provides a context in which the report is to be read, even including the initial depiction of surgery as reasonable.

The introduction to the *New Idea* account of Fiona’s mastectomy is provided below to illustrate an alternative depiction of a prophylactic mastectomy ‘story’.

1 In order to safeguard her family’s future – and her own
2 life – one woman has taken the boldest step yet against
3 breast cancer

Fiona can be seen as positioned here as heroic (‘to safeguard her family’s future’), and a pioneer (‘the boldest step yet’). The reason given for her preventative behaviour (‘to safeguard her family’s future – and her own life’) points to the dominant discourse of motherhood drawn on in the account, particularly given the foregrounding of her ‘family’s future’ over ‘her own life’. Arguably, this portrayal represents the story and her actions as positive and warranted, if unusual and

extreme. This is in contrast to the portrayal of Stieve, in the introduction to the *60 Minutes* account, as ‘frightened’ and ‘convinced that she had the breast cancer gene’, and the construction of the report as ‘compelling’, ‘dramatic’ and ‘a story to make every woman stop and think’. Such discursive work can be seen to construct Stieve’s choice to have a prophylactic mastectomy as problematic, and as a warning to other women.

Extract 13 provides a further example of the representation of Stieve’s motivation to have surgery as being emotionally-motivated, rather than the outcome of a rational decision-making process. In this extract (which replicates part of Extract 9), the reporter is providing an account to the second surgeon, Professor Mansell, of the initial doctor’s justification for carrying out the surgery.

Extract 13

275 TARA BROWN: The doctor has said to me that he was driven by her
276 anxiety, that Stieve was so anxious about one day
277 developing cancer, that he was motivated to help
278 relieve that fear. Is that justification for what
279 he has done?

Describing Stieve as ‘so anxious’ (line 276) that she required surgery to ‘relieve that fear’ (line 278) can be argued to construct her as having the procedure for emotional reasons, rather than rational and justified medical reasons. Providing this representation in the context of the second part of the report, where the surgery is described as unnecessary and ultimately regrettable, could be argued to construct an association between the emotional motivations for the surgery and the resultant negative outcome. Also note again here, the construction of the doctor as being

‘driven’ and ‘motivated’ (lines 275 & 277) to do the operation, positioning him as making the final decision, rather than it being autonomously reached by Stieve. It is Sax’s actions (‘is that justification for what *he has done?*’ – lines 278-279, emphasis added), rather than Stieve’s, that are called into question here. The focus on the doctor’s actions arguably functions to imply that he made the (wrong) decision to go ahead with the prophylactic mastectomy. Stieve can be understood as having been influenced by his decision, as a result of her ‘anxiety’ and ‘fear’, rather than making her own rational, informed choice.

This portrayal of Stieve as needing to undergo surgery to relieve her ‘anxiety’ and ‘fear’ is reflective of the findings of Meiser et al’s (2000) research. They argued that women who consider surgery as a preventative option often have “high levels of breast cancer anxiety” (p.2255) and overestimate their breast cancer risk. Consequently, they argue that rather than undergoing prophylactic mastectomy, some women “are likely to benefit from interventions aimed at reducing breast cancer anxiety and corrective exaggerated breast cancer risk perceptions” (p.2250). Such a position can be seen to be represented in Mansell’s response to Tara Brown’s question above (see Extract 9 for the full exchange): ‘It doesn’t mean you have to do surgery ... You need explanations, you need to say what the real risk is and you need to give counselling’ (lines 282-285). Interestingly, this depiction of Stieve, and the findings of Meiser et al’s research, is in contrast to the representation of Fiona in the *New Idea* account. Arguably, this difference in the accounts is linked to the construction of Fiona as being a mother and, thus, as having an indisputable reason to warrant any risk-reducing strategy: she is doing it to ‘safeguard her family’s

future'. Unlike Stieve, Fiona is also not depicted as having an 'exaggerated breast cancer risk perception', but as destined to develop cancer without surgery.

The construction of Stieve as not making a rational, responsible decision to have a mastectomy is further worked up in the next extract, which appeared at the very end of the report.

Extract 14

293 TARA BROWN: If a 29-year-old woman came to you today and said,
294 "I think I've got a pretty good chance of getting
295 cancer some day in my life?" what would you advise
296 her to do?
297 STIEVE DUKE: I'd advise her to research it properly, which is
298 really, really tough to do if you're not a doctor,
299 but I'd tell her what happened to me and go and
300 find out for herself and then make it with a clear
301 conscience in her mind.

Here, in response to the reporter's hypothetical question at lines 293-296 about the advice she would give another woman, Stieve's recommendations, at lines 297-301, work up a contrast between what she did and what she should have done. That is, in representing this as her advice to others, there is a corresponding implication that this is what Stieve did not do; she did not 'research it properly' (line 297), 'go and find out for herself' (lines 299-300), or 'make it [the decision] with a clear conscience in her mind' (lines 300-301). Such a representation further positions Stieve as not making a rational, informed, autonomous decision regarding prophylactic mastectomy – a decision which resulted in her possibly unnecessary surgery, and the subsequent negative outcomes.

This conclusion to the *60 Minutes* report can be contrasted with the corresponding section of 'Fiona farewells her breasts'. The conclusion to that account, while acknowledging negative aspects of the mastectomy ('huge financial drain', line 67; 'some problems with my husband', line 68; 'no ... sensation in my breasts', line 72; 'a further operation to reattach my nipples', line 73), finishes positively. Fiona reaffirms at the very end that she does *not* regret her decision: 'If I ever have any doubts I just tell myself that because of my decision, the reward is that I get to live' (lines 77-78). This account functions to represent her surgery as a success by virtue of its allowing her 'to live', and 'to be a mother to my children' (line 31). Furthermore, she is positioned as owning her choice – 'my decision'.

It should be noted that Stieve's choice was not exclusively constructed as emotional; for example, in Extract 10 examined above, Stieve is represented as talking about undergoing a prophylactic mastectomy for her 'peace of mind' (lines 123-124). Such a formulation could be argued to draw on a notion of her cognitive state (rather than emotion) as informing and motivating her decision. She is also described at various points as 'very well informed' and as having 'thought about it carefully' (lines 142 & 143, Extract 11). Additionally, emotional and rational language should not necessarily be viewed as two mutually exclusive ways of accounting, with different functions and implications (Edwards, 1997). Instead, discursive approaches understand language as flexibly deployed, and as containing multiple contradictions and variations. However, in line with the framing of Stieve in the introduction as wrongly convinced that she needed surgery, and with the general construction of her surgery as unnecessary and poorly carried out, the construction of the choice as

motivated by emotion can be seen to undermine the alternative that it was rational and justified.

In the *60 Minutes* report of prophylactic mastectomy, then, Stieve is positioned as being motivated by emotion, rather than a rational assessment of her 'real risk' of developing breast cancer. She is also influenced by someone else's potentially misguided, even inaccurate, information. The doctors in the account are represented as not necessarily knowing, or agreeing upon, the 'facts' and the right course of action. Ultimately, though, it is represented as Stieve's responsibility to 'research it properly' and not unquestioningly follow expert advice; she should determine the 'facts' and make her own informed decision. In this report, however, Stieve is positioned as emotional and as simply following what an expert had told her, not researching and making her own decision as she *should* have.

4.6 Similarities and differences between the accounts

In the *60 Minutes* account examined here, Stieve's prophylactic mastectomy was represented as going badly, as potentially unnecessary, and as ultimately regrettable. Furthermore, I have argued that this television report of prophylactic surgery positions Stieve as not taking responsibility for the rational assessment and management of her own health risks. This depiction of prophylactic mastectomy is in contrast with that in a popular women's magazine article, 'Fiona farewells her breasts', which was shown above to have constructed another woman's prophylactic surgery as rational and reasonable. There are some notable differences between these two accounts of prophylactic mastectomy; however, I would argue that both accounts

function to perpetuate similar ideals of individual responsibility for health that are dominant in contemporary Western society.

One of the key differences between the media reports analysed here is the way in which discourses of femininity were repeatedly drawn on in the *New Idea* account, but not so dominantly in the *60 Minutes* report. I argued above that the magazine article drew on traditional gendered discourses of femininity and motherhood to position Fiona almost exclusively as a mother and, as such, as engaging in risk management to carry out both her personal responsibility for her own health, and her responsibility to protect and care for her children. In contrast to the depiction of Fiona's children and husband in the *New Idea* account, Stieve's mother is interviewed in the television report, placing Stieve in the familial role of 'daughter' and even 'child' (despite being an adult). She is also depicted as 'young', bolstering her positioning as emotional and misled. Furthermore, the reasons presented in favour of her surgery are not as strongly worked up as those in favour of Fiona's surgery.

Another way in which the reasons for surgery are worked up differently in the respective media accounts of prophylactic mastectomy analysed here is the contrasting representation of 'risk'. As noted in the analysis of the *New Idea* account, the words 'risk' and 'chance' never appear in that magazine article. This absence arguably functions to position Fiona as certain (rather than probable) to develop, and die from, breast cancer without surgery. Such a positioning contributed to the construction of her mastectomy as reasonable and warranted. The *60 Minutes* report of Stieve's mastectomy repeatedly draws on the notion of 'risk'. Stieve, in contrast to

Fiona, is positioned as *possibly* developing cancer in the future, rather than having a disease with an inevitable diagnosis. Furthermore, 'risk' in this television account is constructed as something about which there are differing medical understandings and means of assessment. The probability of Stieve developing cancer in the future is represented as debatable and arguably not extreme enough to warrant surgery.

The depiction of experts in the respective accounts constitutes another significant difference. In the women's magazine report in which Fiona's surgery is constructed as justified and rational, no experts are represented. In contrast, representations of doctors and the medical profession are repeatedly drawn upon throughout the *60 Minutes* account. Indeed, the television report largely focuses on interactions between Stieve and two different doctors. It is reasonable to assume that medical professionals could have been described as involved in the assessment of Fiona's risk and in the decision regarding (and carrying out of) her prophylactic mastectomy, given the medical nature of the procedure. Discursive analyses typically focus on the talk and text that are present in an account, however, absences can be notable and still able to be analysed for their action-orientation (Edwards, 1998). I would argue that the absence of any representation of medical professionals in the *New Idea* account functions to construct the 'choice' for surgery as solely Fiona's, and to contribute to the positioning of Fiona as independent and autonomous, and her prophylactic mastectomy as reasonable and warranted. She is not represented as having someone else make the decision for her, nor even as reliant on expert opinion or guidance.

The dominance of experts in the account of Stieve's mastectomy (particularly when considered against an alternative depiction in the *New Idea* article) functions to deflect attention away from Stieve's potential positioning as the primary decision-maker regarding her surgery. Rather, she is constructed as reliant and dependent on the medical experts and, therefore, as not taking individual responsibility for making a rational decision regarding her risk management. It could be argued that had her surgery been described as 'successful', Stieve may have been constructed as following relevant advice to manage her risk. However, given her final comments regarding the advice she would give another woman, Stieve can be read as not having engaged in a rational independent decision-making process. Despite the representation of doctors as divided and potentially recommending the 'wrong' course of action, ultimately, this account constructs Stieve as being responsible for her own risk management.

The differences between the media accounts examined here highlight the ways in which the *60 Minutes* account represents risk assessment and management as complicated and dilemmatic, arguably functioning further to construct the decision to undergo prophylactic mastectomy, in this instance, as the wrong choice. Interestingly, however, I would argue that it is not the procedure – the mode of risk management – that is called into question, but rather the means of assessing risk, and the role of the individual and experts in the making decisions regarding risk. Both popular accounts of prophylactic mastectomy examined here can be seen as functioning to perpetuate notions of modern citizens as needing to be responsible for the rational and autonomous management of their own health and (potential) illness.

Similarly, both accounts work to extend the kinds of risk management techniques that are available to be, and arguably should be, considered.

4.7 Summary and conclusion

This chapter has examined ways in which prophylactic mastectomy was depicted in two popular media accounts of the procedure, with a focus on how the procedure was constructed and accounted for, and the women undergoing the surgery were positioned. This analytic focus was of interest for three reasons: (i) the controversy surrounding both this and other breast cancer prevention and risk management techniques, (ii) the sociological theorising regarding contemporary shifts in the sites of responsibility for health-care (including risk management), and (iii) the powerful influence the media has been argued to have on public understandings of health and illness.

The two media accounts of prophylactic mastectomy that were the focus of detailed analysis in this chapter were particularly of interest as they provided relatively contrasting accounts of the procedure. Both accounts focused on individual women with a family history of breast cancer. However, one presented prophylactic mastectomy as reasonable and warranted, and positioned the woman in the account as rational, informed and responsible. In contrast, the other represented the decision to have surgery as emotionally-motivated, potentially misled, and, ultimately, flawed and leading to unsuccessful surgery.

Firstly, I examined here how a popular women's magazine article, 'Fiona farewells her breasts', worked up a construction of the removal of a woman's non-

symptomatic breasts as rational and reasonable. It has been argued that this magazine account drew on traditional gendered discourses of femininity and motherhood to position the woman in the account, Fiona, almost exclusively as a mother. Additionally, the account constructed her as almost certain to develop breast cancer and die without preventative surgery. Consequently, the decision to undergo prophylactic mastectomy, despite involving an implicit personal sacrifice, was presented as a way in which she could manage both her personal responsibility for her own health, and her responsibility to protect and care for her children.

Interestingly, the two dominant constructions in the magazine article explored here correspond with the two benefits of prophylactic surgery described in interviews with women who had undergone genetic counselling (Hallowell, 1998): that surgery is a means to fulfil familial obligations, while also reducing risk of breast cancer. However, the potential *costs* of surgery that these women identified (such as “upsetting the natural balance of the body”, “not offering protection from cancer”, and involving “operative and post-operative complications” (Hallowell, 1998, p.263)) were not focal points of this popular media account. This absence of discussion of the potential negative consequences of prophylactic mastectomy further demonstrates how this popular account works to represent the decision to have surgery as being appropriate and, indeed, morally preferable for Fiona.

The analysis of ‘Fiona farewells her breasts’ has demonstrated the reproduction, in the popular media, of particular constructions of women, and their roles and responsibilities, which have previously been identified in studies examining women’s interview talk about breast cancer risk and management. The repeated

reproduction of these ways of understanding women and health makes them readily available as commonsense accounting practices in relation to risk management and preventative behaviour. This process of reproduction perpetuates notions of individual responsibility for, and self-regulation of, health risks that are central to government in contemporary advanced liberal societies. Given the powerful influence the media have been argued to have on public understandings of health and social issues, it could be argued that women's risk management and broader health decisions are potentially shaped by the kinds of gendered discourses examined here. It has hopefully been demonstrated that the positioning of women, and specifically mothers, as self-sacrificing and responsible for others can serve to justify extreme preventative surgery, and to extend and redefine those preventative behaviours that women are expected to engage in, and for whose absence they might be held accountable.

In the second section of analysis in this chapter, I explored ways in which a second woman's prophylactic mastectomy was accounted for on a popular current affairs television program, *60 Minutes*. Potentially, this young woman could have been constructed as having achieved her aims: she had her breasts removed and therefore diminished her risk of developing breast cancer. However, the operation was constructed in this account as a failure. The woman in the account, Stieve, was represented as unhappy with her reconstructed breasts, as enduring more pain and negative consequences than she expected. In addition, after surgery, she was given an alternative version of her risk status. Based on this second risk calculation, the report represents another doctor as questioning the recommendation of surgery. This account thus drew on the conflicting opinions of medical experts in order to depict a

young woman's decision to undergo prophylactic mastectomy as uninformed and potentially unnecessary.

The analysis here has examined how this television report initially drew on discourses of family history and genetic risk to construct Stieve's mastectomy as warranted and reasonable. This construction, however, was argued to be undermined by the dominant positionings of experts as in conflict and as potentially giving misleading information. Furthermore, the choice regarding surgery was constructed as not carried out by Stieve, rationally and autonomously. The decision to undergo prophylactic mastectomy - which led to negative outcomes, and was later revealed to be potentially unnecessary - was therefore represented as flawed.

This *60 Minutes* television account of prophylactic mastectomy then, like the magazine article 'Fiona farewells her breasts', drew on and perpetuated a construction of individuals as 'patients without symptoms' – a notion salient in theorising about contemporary public health. Furthermore, both accounts can also be argued to reproduce the notion of individuals in contemporary Western cultures as needing to take responsibility for the rational, objective and independent management of their health risks. Stieve is positioned as not taking this responsibility but, rather, as emotional and misled in her risk assessment and management. Her surgery is depicted as unsuccessful, and her story 'compelling', 'dramatic' and a warning to other women. Fiona, on the other hand, is positioned as taking rational responsibility, not only for her own health, but also regarding her obligations as a mother. Her surgery is represented as successful and allowing her 'to live'.

In line with theorising around health-care in contemporary Western societies (discussed in Chapter 3) and, specifically, around the concept of autonomous rational responsible citizens in such societies, the respective positionings of Fiona and Stieve can be seen to (re)produce the notion that individuals should be responsible for making rational informed decisions to manage their own health and (potential) illness successfully. Additionally, the accounts normalise extreme preventative behaviour as an option that can be considered by ‘at risk’ individuals by perpetuating the notion of healthy people as ‘patients without symptoms’. They work to reinforce the idea that concern about illness is not limited to people who are sick nor to the medical profession.

An interesting contrast between the accounts relates to the depiction of experts in each report. Arguably, Fiona’s decision was able to be constructed as rational, in part, due to the absence of any representation of experts or ‘risk’. Additionally, in the account of Fiona’s mastectomy, reasons in favour of surgery (e.g., her role as a mother) were dominant and presented unproblematically. Stieve’s decision, on the other hand, was constructed as fraught with dilemmas and contradictions. In this television account, there was a prevailing problematising of risk, and of the decision-making process regarding risk management. Such problematising highlights a contemporary dilemma surrounding preventative (and other) health-care: individuals are constructed as ultimately responsible for informed decisions regarding their health, while also being dependent on others, such as medical professionals, to provide information on which to make decisions. This dilemma is particularly concerning when considered within a broader political context that has been argued to locate the site of intervention and modification for improved health outcomes

increasingly at the individual level. As Lyons and Griffin (2003, p.1638) point out, the “late 20th century ‘management’ discourse is associated with consumer society, and notions of responsibility and control. It implies a ‘problem’ that needs to be controlled and dealt with, by someone with ‘expertise’ (a medical professional), but also strongly implies that the ‘consumer’ is responsible for their own well-being”.

In terms of locating this analysis within a broader context, I would argue that examining the ways in which prophylactic mastectomy is discursively worked up in these media accounts allows some light to be shed on current ideological dilemmas (Billig et al., 1988) that surround preventative health, such as the implicit contradiction noted above. Discursive analysis of these accounts has also aimed to highlight available ways in which preventative health behaviours can be accounted for and constructed, for example, in terms of discourses of femininity and motherhood. The repeated reproduction, in the popular media, of these constructions of individuals’ responsibilities regarding health, arguably, extends their availability as commonsense accounting practices in relation to risk management and preventative behaviour. For example, this analysis has aimed to call attention to the potential for popular media accounts of prophylactic mastectomy to perpetuate notions of individual responsibility for, and self-regulation of, health risks that are central to government in contemporary advanced liberal societies.

It should finally be noted that in attempting to highlight some of the ways in which preventative behaviour is discursively constructed, my aim was not to comment on whether or not either of these women *should* have had prophylactic surgery. Rather, the aim here was to highlight some of the means by which accounting for, and

construction of, extreme preventative behaviour takes place, and to contribute to the opening up of a space in which the implications of such constructions might be further explored and debated.

In the next chapter, I will examine another important site at which meanings around health and illness (and, more specifically, risk management) are worked up: health promotional campaign material publicising breast cancer screening.

Chapter 5

Discursive and rhetorical strategies employed in pamphlets promoting breast cancer screening

5.1 Introduction

The aim of this dissertation, as discussed in Chapter 1, is to explore discourses surrounding breast cancer screening, risk and prevention, and to consider implications of such discourses. In this chapter, I examine some discursive and rhetorical strategies employed in pamphlets promoting breast cancer screening. These materials are of interest for two reasons. They are a key source of public information about health and illness (Gigerenzer, 2002; Metsch et al., 1998), and they also represent a site at which contemporary discourses surrounding health and illness are constructed.

As discussed in Chapter 3, the various treatments and techniques that are currently used to detect and manage risk of breast cancer are continuing to be the subject of debate and controversy in public, academic, and professional medical forums (see, e.g., Baxter & The Canadian Task Force on Preventive Health Care, 2001; Langlands, 1998; Meiser, Butow, Barratt et al., 2000; Meiser, Butow, Friedlander et al., 2000; Nekhlyudov & Fletcher, 2001). For example, despite often being recommended as unproblematic to women by way of various health promotion strategies, there is no consistent 'expert' medical or public health opinion regarding either the efficacy of mammography, or the age at which age women should be

targeted for screening using this technique. As such, recommendations for women vary across nations and between organizations. Similarly, there is ongoing debate about the possible benefits and detriments of breast self-examination.

Additionally, in Chapter 3, I discussed how current risk management and preventative strategies for breast cancer can be located within a history of public health, and also within a broader theoretical context. This theoretical background would suggest that the increased societal emphasis on risk is typical of a general shift in conceptualising health and health-care in modern liberal democratic societies (Bunton, 1997; Nettleton, 1997; Petersen, 1997; Petersen & Lupton, 1996). Specifically, there has been an extension of the number and type of public health strategies that are thought to be required to improve population health, as well as the aspects of individual's lives which are thought to influence health. This extension has taken place to the point where individuals who previously might have been considered healthy and not in need of any medical or public health intervention, are now often encouraged, and even feel obliged, to take responsibility for their health, scrutinise their lives and make appropriate changes. Currently, such self-regulation and self-management involves not only dealing with existing illness, but also applies to the regulation and management of risks, including genetic risks. In particular, a focus on breast cancer risk can be seen as a contemporary public health issue that exemplifies the shifts in conceptualisations of health and health-care in modern liberal democratic societies and the issues of concern in the new public health (Bunton, 1997; Nettleton, 1997; Petersen, 1997; Petersen & Lupton, 1996).

As part of the increased focus on risk and risk factors, health-care can be seen as relevant in a range of sites in addition to, and even replacing, older institutional practices of health-care. Particularly since the emergence of the new public health in the 1970s, many more areas of life can now be seen as health-related, and as potential sites for intervention. Health promotion has been central in this infiltration of health-related concerns into increased aspects of everyday life, and in this chapter, I focus on examining a sample of health promotional pamphlets concerned with breast cancer screening practices.

5.2 Health promotion and health education

It has been suggested that the study of health behaviours is based upon two key assumptions; “that in industrialized countries a substantial proportion of the mortality from the leading causes of death is due to particular behaviour patterns, and that these behaviour patterns are modifiable” (Conner & Norman, 1995, p.1). Health promotion and public health, as fields aiming to improve the public’s health, have drawn on various psychological theories and models in attempting to account for, and modify, health behaviours. The models that have generally been drawn on have tended to be influenced by attitude and social cognition theories, and have included the health belief model (Becker, 1974), the theories of reasoned action and planned behaviour (Ajzen, 1985; Ajzen & Fishbein, 1980), and the stages of change model (Prochaska & DiClemente, 1984).

It is not the aim here to provide a review of the various models and theories that have influenced public health and health promotion strategies, but rather to highlight that many of them draw on the principles of health education. That is, the models tend to

take educating and informing individuals, and providing 'cues' to health behaviours, as a key factor in influencing the take-up of those behaviours. According to Naidoo and Wills (1994), the

rationale of health education has been to inform people about the prevention of disease and to motivate them to change their behaviour, through persuasion and mass communication techniques, and to equip them through education with the skills for a healthy lifestyle (p.68).

The degree to which the aim of health education is overt behavioural change, as opposed to informing people and empowering them to make their own decisions, has been a point of debate, and health promoters do not all agree about the aims of health education and promotion (Bennett & Murphy, 1997; Naidoo & Wills, 1994; O'Connor-Fleming & Parker, 2001). For the present purposes, however, it is sufficient to note that, generally, health education aims to provide people with the knowledge and skills to make informed choices about their health behaviours, although it tends to be assumed that increased knowledge will lead to changed (and 'healthier') behaviour. Furthermore, health education is seen as an integral part of health promotion and improving the health of populations.

As one example, the health belief model (Becker, 1974) stresses the importance of facilitating behavioural change through (i) cues to action and minimising the costs of engaging in health-promoting behaviours, and (ii) increasing barriers and reducing cues to unhealthy behaviours. Applied to public health and health promotion, reducing barriers and increasing cues to 'healthy' behaviour can include

interventions such as: increasing the number and quality of cycling and pedestrian trails to promote exercise; increased advertising promoting 'healthy' behaviours; and printing nutritional information on food packaging. Creating barriers and reducing cues to 'unhealthy' behaviour can include: taxation on tobacco and alcohol; restricting the advertising of cigarettes; restricting the media portrayal of unhealthy behaviours in television programmes and movies; and restricting the availability of cigarettes/alcohol to people less than 18 years of age. The model also takes into account the influence of an individual's level of perceived susceptibility of a disease, and the perceived severity of the disease. Informed by this model (and others), it has been argued that an individual is

most likely to change their behaviour in response to a fear-arousing health message if they believe they are susceptible to disease, ... the disease will have severe consequences, they perceive a link between protective behaviours and reduced risk for disease, and consider themselves capable of engaging in them (Bennett & Murphy, 1997, p.100).

Viewed in the light of models such as this, pamphlets promoting breast cancer screening can be understood to be aiming to inform women of the benefits of screening, and to persuade them to participate. Pamphlets can be seen as a form of health education – they inform women of the availability of screening, and potentially act as a 'cue' to modifying behaviour to include screening.

5.3 Critiques of the promotion of breast cancer screening

Given the continued debate that surrounds breast cancer screening practices, and particularly mammography, one criticism of the promotion of such techniques has been based around the simplification of the benefits and detriments of the techniques that typically occurs in health promotional pamphlet presentations (Gigerenzer, 2002; Slaytor & Ward, 1998). For example, Gigerenzer (2002) has argued that pamphlets published by health organisations are one source of the “mammography illusion”, in which “[m]any women ascribe almost magical powers to mammography, and virtually none see harm in it” (Gigerenzer, 2002, p.74).

It should be noted that Gigerenzer is concerned with illustrating that the information (and, specifically, the statistics) presented in health promotional material is often manipulated and could be presented more ‘accurately’. That is, he takes a realist perspective regarding issues of risk and screening. From this point of view, risks are seen as able to be accurately measured, and the advantages and disadvantages of screening as able to be accurately calculated and communicated. In contrast, my aim is not to argue that the pamphlets under analysis present correct or incorrect information, but rather, to consider the functions of presenting risk, screening and prevention in particular ways. It is, however, worth noting that critiques of the promotion of breast screening exist from realist perspectives.

Other research that has examined the promotion of breast cancer screening has also considered the presentation of statistics. Slaytor and Ward (1998), for example, conducted a content analysis of 58 Australian pamphlets, looking specifically at how risks of breast cancer, and benefits and potential costs of screening, were

communicated to women. As part of their findings they reported on the types of quantification that were used (and not used) in the pamphlets they analysed. They reported the following results:

- Lifetime risk of developing breast cancer was the most commonly stated risk. Only one pamphlet of the 58 examined mentioned the risk of dying from the disease, and only three mentioned survival rates.
- The benefit of mammography was exclusively represented in terms of relative risk reduction. Benefits were never presented in terms of an absolute risk reduction or the number of women needed to be screened to save one life.
- Information about the accuracy of mammography was provided only occasionally.
- The statistics presented varied across pamphlets, for example, estimates of the lifetime risk of developing breast cancer ranged from one in eleven to one in sixteen.
- Consideration of the possible costs of screening was notably absent. For example, none of the pamphlets mentioned the issue of false positive tests, or that some cancers discovered by mammography may be slow or non-progressive and lead to potentially unnecessary treatment.

On the basis of their examination of the ways in which risks of breast cancer, and benefits and potential costs of screening, were communicated in the pamphlets, Slaytor and Ward (1998) questioned the degree to which we can presume that

women participating in mammography screening have made an ‘informed choice’ to participate.

Keeping in mind these critiques of ways in which screening techniques are promoted, and the debates that surround such methods (see Chapter 3 for a discussion), the analysis here is concerned with examining the discursive resources employed in a series of breast cancer screening pamphlets.

5.4 Data and analytic approach

The data under analysis in this chapter come from a collection of eight health promotional pamphlets for breast cancer screening published by BreastScreen Australia, BreastScreen SA, The Cancer Council SA and the National Breast Cancer Centre (see Appendix 3). The pamphlets analysed were the principal health promotion materials relating to breast cancer screening published by these organisations at the time of data collection. The pamphlets were available to the public at BreastScreen clinics, The Cancer Council offices, doctors’ surgeries, and women’s health centres. They were also available by contacting BreastScreen or The Cancer Council and the information was, for the most part, available on these organisations’ websites. For ease of reference, I have numbered the pamphlets 1–8. A detailed description of each pamphlet is available in the text boxes below, including some background about the organisations that produced the material.

In this chapter, I examine ways in which these pamphlets promoting breast cancer screening were discursively constructed to inform their female readers about screening, and to persuade them to participate. That is, I am interested in the detail of

the language used to accomplish the goals of health education and promotion, and in the potential implications of such language.

In analysing this health promotional material, I focus on the text that appears in the eight pamphlets. In particular, the analysis adopts a discursive approach, as outlined in Chapter 2. Specific features of the pamphlets were therefore explored with a focus on what they construct and accomplish. More specifically, the analysis is concerned with the particular discursive practices and rhetorical devices that were used in the promotion of breast cancer screening, particularly given the debates that surround the techniques of mammography and breast self-examination (see Chapter 3 for a discussion of these debates), and the critiques of ways in which these techniques are promoted (discussed above).

I argue that the pamphlets work to position female readers as both 'at risk' of breast cancer, and as responsible for the management of their risk status. These positionings can be seen to reproduce the notion of individuals as 'patients without symptoms' (Finkler, 2000). That is, individuals can increasingly be seen as having their lives medicalised when they previously might have been considered 'healthy'. The construction of females as sufficiently at risk of breast cancer to warrant action is dominant throughout the pamphlets analysed here. Furthermore, women are positioned as, ultimately, needing to be responsible for their own health and risk management. Such an emphasis on self-regulation and self-management has been argued to be a feature of health-care in modern democratic forms of government.

To illustrate the discursive strategies employed in the pamphlets, I will draw on extracts to illustrate repeated patterns that appear in the text. These extracts are, on the most part, short and may seem to be presented with little context. However, the text, as it appears in the pamphlets themselves, is often made up of separate and stand-alone statements and, as such, it seems appropriate to present them in this way for analysis. The following text boxes (5.1–5.4) provide some description and background of the pamphlets.

Box 5.1 *BreastScreen Australia pamphlets*

Pamphlets 1 and 2 are promotional material for the National Program for the Early Detection of Breast Cancer, or BreastScreen Australia. This is the national mammographic screening program and is a joint program of the Commonwealth and the States and Territories of Australia (Primary Care Division, 2003). The specific national campaign of which pamphlets 1 and 2 were a part featured a well-known Australian woman, Sara Henderson, who died in 2005 (after the collection and analysis of these pamphlets was carried out). Henderson figured in television and printed promotional material for BreastScreen for approximately ten years prior to her death. Henderson owned and worked on her late husband's cattle station in the outback of the Northern Territory, struggling through severe debt to bring the station into financial solvency, which resulted in her winning Australian Businesswoman of the Year in 1991. Henderson was later diagnosed with breast cancer and also wrote several autobiographical books.

Pamphlet 1 is in the form of a bookmark, with a smiling Sara Henderson on the front, pictured at her station in the Northern Territory, *Bullo River*, with a horse leaning over her shoulder, with its nose in her book. The caption reads, "Before you read this book, read this bookmark". The back of the bookmark contains four short paragraphs encouraging women to have a screening mammogram and not to "wait till you've finished this book to do it!"

Pamphlet 2 is a ten-page pamphlet, with Sara Henderson on the cover, leaning on what looks like a fence post, wearing work gloves and an akubra hat, and looking seriously at the camera. The caption here reads, "Early detection, the best protection". On the second page is a note, beginning "Hi, I'm Sara Henderson", and the following pages contain information under the headings: "Some facts about breast cancer", "Why screen for breast cancer?", "How the Program works", "National policies", "Who should be screened?", "High standards", "General Practitioners – A vital role", and "Where can you find the Program?"

Box 5.2 *BreastScreen SA pamphlets*

Pamphlets 3, 4 and 5 were produced by BreastScreen SA, the South Australian division of BreastScreen Australia. Pamphlet 3 is an A4 sheet, folded into thirds, with writing on each side. It is entitled, “Do you know about free screening for breast cancer?” and contains information under the headings, “What is BreastScreen SA?”, “What is a screening mammogram?”, “How does the mammogram feel?”, “Who benefits from having a screening mammogram?”, “What about family history?”, “What about the results?”, “Do some women need a second check?”, “How to make an appointment...”, “Practical hints to make your visit easier and more comfortable...”, and “In addition to your regular screening mammogram, we recommend you...”. There are no pictures in the pamphlet.

Pamphlet 4 is very similar to pamphlet 3 but is entitled, “At what age should a woman be screened for breast cancer?” The headings under which information is grouped are: “Age and breast cancer screening”, “Screening for women younger than 40 years”, “Screening for women aged 40 to 49”, “Screening for women aged 50 to 69”, “Screening for women aged 70 and over”, “Screening for women with a strong family history of breast cancer”, “Summary of recommended practices” and “Recommended action for a woman of any age who has a breast symptom”. Again, there are no pictures.

Pamphlet 5 has a similar look to pamphlets 3 and 4, having also been produced by BreastScreen SA, but is in the format of a 16-page booklet entitled, “Breast Cancer and Screening Mammography”. Nearly all the information contained in pamphlets 3 and 4 also appears in this booklet, as well as additional details, including information about the biology of the breast, risks and myths regarding breast cancer, and the process for a woman following an abnormal mammogram.

Box 5.3 *The Cancer Council SA pamphlets*

Pamphlets 6 and 7 are produced by The Cancer Council South Australia - a “non-government, charitable organisation . . . with the objectives of increasing scientific understanding and public awareness of cancer” (The Cancer Council SA, 2003). The organisation began as independent from any national body, but is now a member of The Cancer Council Australia, a national non-governmental organization that aims “to lead the development and promotion of national cancer control policy in Australia, in order to prevent cancer and reduce the illness, disability and death caused by cancer” (The Cancer Council Australia, 2003).

Pamphlet 6 is partly coloured bright pink with white writing, and partly white with pink writing. It is entitled, “Breasts: what should I know?” and includes headings such as “What should I know?”, “What should I look for?”, “What should I be doing?”, and “All women should have a breast care plan that includes:” It is much smaller, and contains much less information, than the pamphlets produced by BreastScreen. It should also be noted that, in contrast to BreastScreen, who offer a mammography service, pamphlets produced by The Cancer Council are not solely aiming to promote mammography. As such, the information included on this pamphlet includes lifestyle influences on breast cancer risk and what to look for in breast self-examination.

Pamphlet 7 is also produced by The Cancer Council SA, but is focused solely on breast self-examination. It is titled, “Breast Self Examination (BSE) – Getting to know your breasts”, and has a sketched picture of a woman’s body from the waist up. She is naked, with arms stretched above her head. The pamphlet begins by outlining the three ways ‘you can care for your breasts’ (checking them regularly yourself, having your doctor check them, and having a mammogram), but the majority of the rest of the pamphlet gives a detailed guide to BSE, including steps and sketched illustrations.

Box 5.4 *National Breast Cancer Centre pamphlet*

Pamphlet 8 was published by the National Breast Cancer Centre (NBCC). The NBCC is funded by the Australian Department of Health and Ageing and was established to “improve breast cancer control by: analysing research and making it readily available to women and health professionals; developing, disseminating and encouraging the adoption of clinical guidelines to improve the diagnosis, treatment and support of women with breast cancer; providing accurate and accessible information to well women, women with breast cancer, primary care providers and breast cancer specialists; developing a national monitoring system to provide information about all aspects of breast cancer” (National Breast Cancer Centre, 2001).

The pamphlet produced by the NBCC has a navy blue cover, with no pictures, just white writing stating, “What you do after you find a change in your breast could change your life.” When the pamphlet is opened, two pages are displayed. On the left is written, “You will probably never develop breast cancer”, with a picture of a middle-aged and an elderly woman embracing, and on the right is printed, “But if you do, finding breast cancer early will increase your chances of effective treatment.”, followed by “What you do after you find a change in your breast could change your life.”, in smaller print. When the pamphlet is opened out again, it can be seen to contain information under headings like, “What should I look for?”, “What causes breast changes?”, “Why find breast cancer early?”, “Things to remember”, “How do I find changes in my breast?” and “See your GP”. The pamphlet is not currently a resource being distributed by the NBCC.

5.5 Positioning women as ‘at risk’

The aim of this section is to examine ways in which the sampled pamphlets work to position women as ‘at risk’ of breast cancer and as, therefore, needing to screen. In particular, I focus on two regularities or repeated patterns of textual construction that

contribute to this positioning of women: (i) the use of quantification rhetoric; and (ii) the use of two-part rhetorical structures.

5.5.1 Quantification rhetoric

The pamphlets I examined, as is the case with other health promotional material, included a great deal of quantification, both numerical and non-numerical. It could be thought that the numbers and calculations represented in the pamphlets simply reflect facts about breast cancer and about statistical risk of breast cancer. However, even from a realist perspective, it is widely acknowledged that statistics can be misunderstood and manipulated to further particular ends. For instance, both Gigerenzer (2002), and Slaytor and Ward (1998) focused on the ‘false’ or ‘misleading’ presentation of numbers and statistics in health promotional material for breast cancer screening.

An alternative, discursive approach would instead consider the function of including and presenting specific forms of quantification in particular ways. For example, Potter, Wetherell and Chitty (1991) have shown how quantification can be understood as a form of rhetoric that is used for particular purposes. They argue that “instead of thinking of quantification accounts as more or less accurate renditions of some putative reality, we should view them as designed for their robustness in an argumentative arena” (Potter et al., 1991, p.337). Rather than viewing the statistics and numbers that are represented in the pamphlets as simply reflecting an objective truth, then, the focus here is on questioning the function of particular forms of quantification in the specific context of this promotional material. My aim is not to determine whether or not women are being informed of the ‘right’ statistics with

respect to breast cancer risk and screening. Instead, it is to examine “the way quantification is deployed to accomplish this rhetorical goal” (Potter et al., 1991, p.339) – in this case, the goal of persuading women to screen.

I will examine three different uses of quantification in the pamphlets examined: the quantification of lifetime risk, of risk factors, and of the benefit of screening.

Quantification of lifetime risk

One of the frequently reported statistics in the pamphlets examined here was the lifetime risk of developing breast cancer (also termed the incidence of the disease, see Slaytor & Ward, 1998). The most common way of depicting this statistic in these pamphlets is illustrated in the following short extracts:

Pamphlet 1

It's a fact that one in fifteen Australian women develop breast cancer.

Pamphlet 2

One in fourteen women will develop breast cancer in her lifetime.

Pamphlet 5

In South Australia:

- One in 11 women will develop breast cancer in her lifetime

What is perhaps initially striking about these statements is that estimates of the lifetime risk of developing breast cancer differ. However, it is not my aim to discern which of these is accurate but, rather, to explore possible rhetorical functions of such

quantifications. It is interesting to note though, that even among the relatively small sample of pamphlets examined here, there was not always consistency in the information presented (even between pamphlets published by the same organisation⁸). This inconsistency may reflect an updating of information, or broader uncertainty and disagreement in current understandings.

I would argue that, in the context of pamphlets produced to encourage women to engage in breast screening, quantifications like ‘one in fifteen Australian women develop breast cancer’ function rhetorically to position all women as ‘at risk’. This formulation of the number of women who develop breast cancer arguably places emphasis on the one woman amongst a (relatively small) group that will develop the disease. A potential implication is that any woman could be that one who develops breast cancer, thus positioning all women as ‘at risk’. Given the relatively small number of women from which the ‘one’ will be drawn, any individual woman’s ‘odds’ of developing the disease are presented as being high. This kind of quantification functions to construct breast cancer as sufficiently serious a problem (one in 11 is quite a lot of women), and position women as sufficiently at risk (anyone could be the one woman), that some sort of action is justified, even needed. This framing of the problem of breast cancer as affecting a large portion of Australian women therefore contributes to the construction of screening as a required practice.

Slaytor and Ward (1998) also reported that in pamphlets promoting screening, and particularly mammography, statistics relating to the incidence of breast cancer are

⁸ This discrepancy could be accounted for if individual pamphlets were published at different times,

frequently presented. They suggest that this is particularly interesting when one considers that mammography, and other screening techniques, do not reduce the incidence of the disease. If anything, early and improved detection of the disease leads to an increase in the number of the women thought to be developing breast cancer. As Slaytor and Ward (1998, p.263) write, “it is a circular argument to encourage participation in mammographic screening only because of an increasing number of cases”.

Arguably, presenting incidence rates in the form illustrated above positions women as more at risk than presenting other statistics, such as mortality rates – because more women develop breast cancer than die from it. Furthermore, it has been argued that the different definitions and implications of incidence and mortality rates of a disease are not necessarily understood by the general population. For example, Gigerenzer (2002) reports the findings of a trial breast cancer screening program in Switzerland, in which women were informed about screening and asked to participate. The apparently ‘informed’ women who did participate turned out to be more likely than women in the general population to believe that screening would prevent them developing breast cancer. However, once cancer is detected by a mammogram, or other form of screening, it has already developed and has not been primarily prevented.

In these pamphlets, then, representing ‘one in fifteen/fourteen/11’ women as developing breast cancer could be understood as functioning to emphasise individual

with more or less up-to-date information. However, they were all in circulation simultaneously.

women's risk of developing the disease, potentially increasing their subsequent likelihood of screening.

A further quantification that could be argued to position women as 'at risk' was that relating to the lifetime risk of dying from the disease (the mortality rate). As with Slaytor and Ward's (1998) study, this statistic was presented less frequently in my data than the quantification of developing cancer. The following examples illustrate the instances in which this information was represented in the pamphlets examined:

Pamphlets 3 and 5 (the same text appeared in both pamphlets)

. . . Breast cancer is one of the most common causes of cancer deaths in women.

Pamphlet 5

. . . In South Australia:

- One in 11 women will develop breast cancer in her lifetime
- In 1999, 928 new cases of breast cancer were recorded, and 195 women died from this disease.

Here we see two ways of representing the number of women who die as a result of breast cancer – non-numerical and numerical. The first example illustrates a non-numerical quantification – 'one of the most common' – which can be contrasted with the 'one in 11' quantification of the incidence of breast cancer, given that a specific probability is not represented. Quantifying the mortality rate numerically in the same 'one in ...' form, would arguably not have been as persuasive in positioning women as 'at risk' as is the equivalent incidence statistic. The number of women from which

the 'one' is drawn would have been significantly higher and, thus, the 'odds' depicted would not have been as high.

Instead, I would argue that quantifying the mortality rate non-numerically allows the severity of the disease to be rhetorically maximised. 'One of the most common' functions as an extreme case formulation here, again constructing breast cancer as a serious threat to women. It is also interesting that breast cancer is 'one of the most common causes of *cancer* deaths' (emphasis added). Thus, it is not one of the most common causes of deaths overall, but nevertheless the description of breast cancer as 'one of the most common' arguably involves women being positioned as quite likely to die from breast cancer.

The second example provided above involves a numerical quantification of the lifetime risk of dying from breast cancer. In this example, exact numbers of women who were diagnosed and who died from the disease were presented. Although a very different form of quantification than the previous non-numerical example ('one of the most common'), this description arguably has a similar function: to construct breast cancer as a problem for all women, thus maximising women's positioning as 'at risk'. This quantification - '195 women died from this disease' - draws attention to the number of women who died, without providing any additional information, such as how many women there are in South Australia, or how many women died from other causes. Alternatively, a percentage, a non-numerical quantification, or a figure presenting the number of breast cancer deaths relative to those from other causes could have been presented, all of which would, potentially, not have been as rhetorically persuasive as giving an absolute number.

In the pamphlets examined, then, different forms of quantification of women's lifetime risk of breast cancer were represented. These representations - of both incidence and mortality rates of breast cancer - can be seen to function, in this context, to position women as 'at risk' of breast cancer.

Quantification of risk factors

The pamphlets analysed were aimed at women in the general population; they were not targeted at women in any specific 'risk' group, such as those with an inherited genetic predisposition for breast cancer. Despite this, many of the pamphlets did address some 'risk factors' for the disease, particularly those of age and heredity. The ways in which these 'risk factors' were represented in the pamphlets can be seen to function rhetorically, once again, to maximise the construction of risk, positioning all women as 'at risk' of the disease. The following extracts illustrate typical ways in which the quantification of risk factors was presented.

Pamphlet 1

It's a fact that one in fifteen Australian women develop breast cancer. And the biggest risk factor is age.

Pamphlet 2

. . . One in fourteen women will develop breast cancer in her lifetime. Over 70% of breast cancers occur in women over 50. Nine out of ten women who get breast cancer do not have a significant family history of the disease.

Pamphlet 5

. . . Breast cancer is mainly a disease of women over 50 years of age, although it does occur in younger women. As increasing age is

the major risk factor, all women are at risk of developing breast cancer.

The discussion of age and heredity in these extracts can be seen to function in a similar way to the quantification of the incidence and mortality of breast cancer – to position all women as ‘at risk’ of the disease. The most common risk factor mentioned was age. The extracts above illustrate ways in which age as a risk factor was portrayed. In particular, extreme case formulations were drawn on – ‘*biggest* risk factor’, ‘*major* risk factor’, ‘*all* women are at risk’ (emphasis added) – to maximise the construction of breast cancer risk. By highlighting age over other risk factors, all women can be seen as increasingly at risk of developing breast cancer, as explicitly stated in the extract from pamphlet 5.

The other risk factor repeatedly mentioned was heredity. There were sections in the pamphlets specifically for women with a strong family history of breast cancer. However, in the general discussions of risk, as in the extracts above, family history was also mentioned; for example, ‘Nine out of ten women who get breast cancer do not have a significant family history of the disease’. Rather than being maximised as a risk factor as was age, however, family history is minimised here. That is, in this claim, quantifying ‘nine out of ten women’ with breast cancer as *not* having a family history of the disease, arguably works to minimise heredity as a risk factor. By emphasising that age is the ‘biggest risk factor’ and that most ‘women who get breast cancer do not have a significant family history of the disease’, all women can be portrayed as at risk of breast cancer. Such a minimisation of heredity as a risk factor arguably functions to manage a potential justification available to women who do not screen: that they do not need to screen because they don’t have a family history of

breast cancer. By emphasising that age is the ‘biggest risk factor’ and that most ‘women who get breast cancer do not have a significant family history of the disease’, all women can be thought of as ‘at risk’ of breast cancer, regardless of family history.

By discursively constructing an ‘at risk’ subject position for all women, the health promotional materials examined here can be argued to be working to maximise women’s perceived susceptibility to the disease - one of the factors understood to contribute to the up-take of particular health behaviours. Perceived severity of the disease is argued to be another factor that influences behaviour, and this notion was also discursively maximised in these pamphlets by maximising the quantification of mortality rates for the disease. Given that these pamphlets were promoting a specific health behaviour – screening – maximising the severity and susceptibility of breast cancer can be argued here, not only to position women as ‘at risk’, but to work towards the construction of screening as a practice in which women should engage.

Quantification of the benefit of screening

According to protection motivation theory (as well as other similar models of health behaviour), an “individual is most likely to change their behaviour in response to a fear-arousing health message if they believe they are susceptible to disease, that the disease will have severe consequences, they perceive a link between protective behaviours and reduced risk for disease, and consider themselves capable of engaging in them” (Bennett & Murphy, 1997, p.100). In the pamphlets examined here, quantification was employed as a discursive strategy to construct a link between screening (the ‘protective behaviour’) and the reduction of breast cancer

risk. This construction functions to bolster the representation of screening as a practice in which women should engage. The following extracts illustrate ways in which quantification was used in the pamphlets to construct screening as associated with a lowered degree of breast cancer risk.

Pamphlet 3

. . . The majority of women who attend for screening will be reassured that there is no evidence of breast cancer.

Pamphlet 5

Fortunately, as this simplified diagram indicates, of 100 women screened:

- only three will be recalled for further assessment
- of these three, only two will require biopsies
- of these two, only one will have breast cancer. (*Tree diagram followed*)

Pamphlets 3, 4 & 5

. . . It is estimated that for individual women in this age group (women aged 50-69), having a screening mammogram **every two years** reduces the chance of dying from breast cancer by about 40%.

In the first two of these extracts, women are positioned as unlikely to develop breast cancer if they screen. This positioning is achieved by the use of quantification. For example, in the first example above, a form of non-numerical quantification was drawn on to link the category of 'women who screen' with reduced risk of breast cancer. The specific non-numerical terms used in this example - '*majority of*

women', 'no evidence' (emphasis added) – function as extreme case formulations to construct the link as particularly strong. Correspondingly, in the extract from pamphlet 5, instances of numerical quantification - qualified by the minimising term 'only' – function to minimise the number of women who screen and discover breast cancer. In neither of these extracts, however, is a comparison reported between the number of women who screen and develop breast cancer, and the number who do not screen. This selective focus arguably contributes to the working up of mammography as being directly linked with lower rates of breast cancer. It is worth noting again, though, that mammography is not a form of primary prevention; screening will not prevent a woman developing the disease.

In the third example above, screening is directly associated with a reduced risk of dying from the disease. In particular, the form of numerical quantification presented (a percentage estimate of the risk reduction resulting from mammography) is persuasive given the size of the statistic ('about 40%'). However, no additional information was presented to explain how this statistic was calculated, or what a woman's percentage chance of dying from the disease is in absolute terms, with or without regular mammograms. The ways in which the benefits of mammography are calculated (e.g., in terms of relative or absolute risk reductions) have been shown to result in very different statistics, even when calculated from the same data (Gigerenzer, 2002; Slaytor & Ward, 1998). The estimation presented in this extract, therefore, could arguably have been represented in a different way (and potentially with a much lower figure); for example, if it had been presented as an absolute risk reduction. The rhetorical function of persuading women to screen, however, would not be as effectively performed with a smaller estimate. Therefore, I would suggest

that the rhetorical function of the quantification used in this extract is to strengthen the construction of screening as leading to a reduction in risk. Screening can thus be argued to be constructed as the intervening factor between women's 'at risk' status, and the reduced likelihood of developing or dying from the disease.

In these pamphlets, then, particular forms of quantification (rather than others that could potentially have been presented) were employed rhetorically to position women as 'at risk' of breast cancer, and as sufficiently 'at risk' that some action is required. That is, susceptibility and severity of the disease were discursively maximised. Furthermore, a link is constructed between screening behaviour and a reduced risk of developing, and dying from breast cancer. In the next section, I examine how the importance of screening was further worked up in the sampled pamphlets by the use of a particular form of two-part rhetorical structure.

5.5.2 Two-part rhetorical structure

The link between screening and the reduction of breast cancer risk was further constructed in the pamphlets by the use of a particular kind of two-part rhetorical structure. This structure appeared in a similar format to those examined by other researchers (Billig et al., 1988; Wetherell & Potter, 1992) and functioned to manage what could appear as a discursive tension throughout the pamphlets. On one hand, the degree to which any woman is at risk of developing (and dying from) breast cancer was maximised, as examined above. On the other hand, there repeatedly appeared quantifications that minimised the likelihood of a woman being affected by breast cancer. Although these minimisations seemed to contradict the extreme case formulation that all women are 'at risk', I would argue that, if we look closely at the

way the minimisations were formulated, they can also be seen to contribute to the positioning of all women as ‘at risk’, and as therefore needing to be vigilant. They work to construct a need for action; in this case, screening. The following extracts illustrate examples of the minimising strategies that appeared in the pamphlets.

Pamphlet 5

. . . Although nine out of ten breast lumps are not due to breast cancer, any change in the breast should be checked by a doctor without delay.

Pamphlet 7

. . . Most changes are harmless but occasionally may be an early sign of breast cancer.

Pamphlet 8

You will probably never develop breast cancer. But if you do, finding breast cancer early will increase your chances of effective treatment.

In each of these extracts, there is a minimisation of the risk affecting women - ‘nine out of ten breast lumps are not due to breast cancer’, ‘you will probably never develop breast cancer’ and ‘most changes are harmless’. These minimisations, as I have suggested, might initially seem to work in contrast to the maximisations and extreme case formulations discussed above. Despite this, close examination reveals a pattern in the way in which these extracts are structured, which undermines the minimisation and allows the statements to function in a parallel way to the maximisations – to position women as at risk of breast cancer, and consequently, to construct screening as beneficial and even necessary.

Each of these extracts is structured in the general form, 'it's unlikely that anything bad will happen *but* it might'. That is, there is a minimisation of the likelihood that a woman has, or will develop, cancer followed by some other phrase undermining that minimisation. This structure can be seen to reflect two conflicting sides of an argument (Billig et al., 1988), where the description of one possible version of events immediately followed by another works to represent the second version as preferred to the first. Furthermore, the structuring of this information resembles a 'concession/criticism' disclaimer format (Wetherell & Potter, 1992) in which acknowledgment is initially given to one version of events, followed by a conclusion that undermines the initial statement. Typically then, although two apparently factual and unbiased, but opposing, pieces of information are presented in these examples, the second is given preference.

In the specific examples examined here, this two-part rhetorical structure allows the acknowledgement and management of claims that many women do not develop breast cancer. Such claims are accepted, but challenged by an assertion that maintains the positioning of all women as (possibly) 'at risk' to some extent. This positioning of women as 'at risk' allows, in this context, screening to be constructed as necessary.

To illustrate further the rhetorical effect of the sequence in which the information is structured, consider what happens if the two parts are reversed. For example, instead of saying 'it's unlikely that something bad will happen, but it might', presenting the above statements in the format, 'something bad might happen, but it's unlikely'

produces a very different effect. I would argue that although the same two pieces of information are contained in this statement, the eventuality of 'something bad' happening is minimised by the follow-up condition that 'it's unlikely'. Take the extract from pamphlet 8 as a more specific example. If the first and second parts of this extract are reversed, the statement becomes:

If you develop breast cancer, finding it early will increase your chances of effective treatment. But you will probably never develop breast cancer.

The rhetorical effect produced when the information is presented in this format is quite different to the way it was represented in pamphlet 8. Despite the fact that the same information is communicated, by virtue of the persuasiveness of the two-part concession/criticism structure, preference is now given to the second part, to the minimisation of risk. This structure is persuasive in the sense that it displays a claim, which is then rhetorically modified and undermined by the subsequent disclaimer, positioning the second part as the structure as the more balanced statement.

In all the examples that were taken from the pamphlets, however, the minimising part of the statement comes first, leaving the reader with the second part - the warning, recommendation or call to action. I argued that the extracts examined earlier functioned to construct all women as at risk of breast cancer. The use of minimisations in two-part structures, such as those I have just examined, allows the pamphlets to manage the criticism that many women will not get breast cancer, and still construct action, such as screening, as required.

These two-part formulations also do some work towards managing the possibility that women might respond to the discursive maximisation of breast cancer risk with fear and inaction. Cognitive approaches to understanding health behaviours have suggested that 'fear-arousing' health messages (arguably, like those maximising women's risk of breast cancer) "lead to two parallel sets of cognitive processing" (Bennett & Murphy, 1997, p.99): one to evaluate and manage the threat, and one to cope with fear (the dual process model; Leventhal, Safer, & Paganis, 1983). It is suggested that coping with fear is often accomplished by managing the threat. However, sometimes the fear produced is so great that "no coping plan or preventive behaviour ... result[s]" (Bennett & Murphy, 1997, p.99).

It is not my aim to comment on the efficacy of such models of health behaviour. However, it could be argued that discursively positioning women as 'at risk' may function to provide a justification for inaction, rather than the uptake of screening behaviour. The two-part structures examined here, in contrast, potentially function to manage a 'fear' response by allowing for the representation of a minimisation of risk (such as 'you will probably never develop breast cancer'), while still functioning to construct screening as beneficial. Thus, presenting both maximisations and minimisations of women's risk of breast cancer potentially allows for the construction of screening as reasonable, regardless of whether or not a woman believes, or fears, she is likely to develop the disease.

In summary, the pamphlets drew on a range of quantifications to position all women, not just those in 'high risk' categories, as 'at risk' of breast cancer. These quantifications include the maximisation of incidence and mortality rates, and of age

as a risk factor, and the minimisation of family history as a risk factor. Quantification was also employed to construct screening as linked to a reduction in risk. In addition, minimisations of the risk of developing breast cancer, which may form the basis of a potential counter-argument against screening, were persuasively undermined with the use of two-part rhetorical structures, constructing action as required even if the risk is not high. The portrayal of minimisations may also function to manage the possibility that women might respond to the discursive maximisation of breast cancer risk with fear and inaction.

5.6 Positioning women as responsible for risk management

The aim of the next section of analysis is to examine the positioning of women as responsible for their own risk management. In particular, I focus on two recurring textual patterns in the pamphlets: (i) the positioning of women as rational, and as having the 'right' to health; and (ii) the construction of medical technology, and specifically mammography, as fallible. I argue that the emphasis on women as responsible for their own risk management, although unsurprising in this local context of material promoting screening, reproduces a broader discourse of increasing individual responsibility, typical to shifts in modern democratic societies. Furthermore, the reproduction and dominance of this discourse potentially functions to deflect attention away from other sites of intervention and prevention - for example, government spending on investigating causes and prevention of breast cancer (e.g., environmental links) - but also from broader determinants of health and illness, such as poverty.

5.6.1 'We owe it to ourselves'

I have examined already how, in the pamphlets examined, women were positioned as 'at risk' of breast cancer. Given this construction, actions that can reduce and manage risk, or prevent the disease, can therefore be read as warranted and even required. It is unsurprising that in the context of these pamphlets, the action constructed as preferable is screening. However, in this section, I argue that in positioning women as 'at risk' and constructing screening as a necessary practice to manage risk, women are also positioned as responsible for their own risk management. One specific way in which this positioning is accomplished is by locating the problem of breast cancer risk as a personal issue for women.

The following extract is taken from the second page of pamphlet 2 – the booklet produced by BreastScreen Australia as part of a national campaign to promote mammography, featuring Sara Henderson. This extract is the introductory message from Sara Henderson and is one example from the pamphlets that illustrates the construction of the problem of breast cancer as a personal issue for women, positioning women as responsible for their own risk management.

Pamphlet 2

1 Hi, I'm Sara Henderson
2 I've always believed it's important for women to take care
3 of their health - whatever their age. But until recently, I
4 wasn't aware of the importance of having a mammogram every two
5 years.
6 Since there is no history of breast cancer in my family, I
7 didn't think I needed to have a mammogram.

8 Once I found out that for nine out of ten women breast
9 cancer is not hereditary and that age is the biggest risk
10 factor, I decided to have a mammogram.
11 I am proud to be associated with the National Program for
12 the Early Detection of Breast Cancer. I'd like to ask all those
13 women over 50 who, like me, have been avoiding having their free
14 mammogram, not to put it off any longer. It's too important.
15 I think we owe it to ourselves.
16 Sara Henderson,
17 Bullo River Station, Northern Territory

In this extract, health, illness and risk are constructed as the responsibility of individual women. This construction is accomplished particularly by drawing on a discourse of 'taking care of yourself'. At lines 2-3, this concept is explicitly referenced with Henderson's statement that she has 'always believed it's important for women to take care of their health'. At the outset then, the reader is informed of the general message of Henderson's foreword. The claim that women should take care of their health is not elaborated – no specific reason for *why* it's important is given – pointing to the broader currency of the discourse; it is not a problematic claim.

The narrative then moves from the general case – taking care of one's health – to the specific: mammography as one way in which to take care of one's health. The repeated use of the word 'important' (at lines 2 and 4) ties these two clauses together, constructing 'having a mammogram every two years' as a means by which women can look after themselves. At line 15, the word 'important' is repeated for a third time, emphasising that this is a significant and essential issue, not to be taken lightly, or put off.

At lines 4-10, Henderson traces her own personal development from a position of ignorance regarding breast cancer risk and mammography, through a stage of education about the risks of breast cancer, to the point where she made a choice to engage in mammography. (Note again the maximising of age as a risk factor – ‘age is the biggest risk factor’ (lines 9-10) - and minimising of family history – ‘for nine out of ten women breast cancer is not hereditary’ (lines 8-9).) Through this narrative there is emphasis placed on the use of rational language in tracing Henderson’s progress: she ‘wasn’t aware’ and ‘didn’t think’, but then she ‘found out’ and consequently ‘decided’. Thus, her transition is constructed here as cognitive; she gathered knowledge on the basis of which she made a rational choice. This portrayal of progress leading to the take-up of a health behaviour mirrors that proposed in ‘stages of change’ models of health behaviour, for example, the transtheoretical model (Prochaska & DiClemente, 1984). In this model, individuals go through five stages in moving towards engaging in the behaviour, each stage associated with different cognitions. I would argue that the narrative functions to construct the ideal pattern for women to follow, positioning them as rational decision-makers who, once aware of their risk status with respect to breast cancer, will make the choice to have a mammogram to take care of their health. This construction also relates to notions about health education as being a key feature in the development of health behaviours: at lines 8-10, a direct causal link is portrayed between ‘finding out’ about a disease and ‘deciding’ to engage in a particular behaviour. Thus, in this text, health education is constructed as leading directly to the uptake of a recommended behaviour, while still allowing an individual choice over behaviour. In this way, the text in the pamphlet can be argued to be managing issues of stake, given that the

pamphlet itself is engaging in health education. Rather than simply instructing women to engage in mammography, this representation of choice as being facilitated by knowledge allows the mammography-promoting information presented in this pamphlet to be seen as non-authoritarian, and as simply being presented objectively to inform women.

At lines 12-16, the text explicitly links Sara Henderson's experience with that of the reader. She is represented as asking women to have a mammogram, positioning herself as understanding women who have been avoiding screening by constructing herself as belonging to the same group: 'like me'. This shared positioning is further highlighted at line 16, with the pronoun use 'we' and the term 'ourselves'. It has been suggested that receiving a health message from a source that is "considered similar to the receiver" is likely to lead to increased "recall and attitude change" than otherwise would be the case (DeBono and Telesca, 1990, in Bennett & Murphy, 1997, p.101). By positioning Sara Henderson as belonging to the same category as other women in terms of their avoidance of mammography (she was also of a similar age to the target readership of this pamphlet), this text constructs readers as rational decision-makers who will (or at least, should) follow the process Henderson underwent.

At the end of the message, the discourse of 'taking care of yourself' is drawn on again: 'we owe it to ourselves'. This formulation positions women as having value that should be protected and 'taken care of' and, as such, can be seen to have empowering potential. It draws on the notion that women have a right to better health, and a right to prioritise and take care of ourselves; we owe it to ourselves, not

to anyone else. Simultaneously, this discourse locates responsibility for women's health with individual women themselves. In suggesting that 'we owe it to ourselves', the text builds on the earlier claims that women should take care of their health (lines 2-3), implying that women are the key (if not only) providers of care for themselves. As I have suggested, this discourse can be seen to have empowering and agentic potential by virtue of the power and control it attributes to women to protect their own health and implicit value. However, it also works to deflect attention away from other potential sites of improvement for health outcomes for women. Furthermore, it is worth noting that the emphasis here on looking after oneself could be argued to be gendered, given traditional notions of women as looking after others before themselves⁹. Further research might explore the salience of discourses of 'taking care of yourself' in health promotional material targeting men.

Women are, therefore, positioned as responsible for taking care of themselves and their health, which they can do if (like Sara Henderson) they are rational and engage in mammography. Such a construction could be argued to reproduce themes of rational and responsible citizenship that are central in sociological theories about governmentality in modern societies. Furthermore, these discourses can be seen to function to promote autonomous decision-making with respect to health, especially preventative health. Such ways of representing health and individual responsibility for health typify contemporary shifts in public health strategies in the latter part of the 20th Century and at the beginning of the 21st Century. These shifts locate responsibility on rational and autonomous individuals, who are increasingly

⁹ This focus on women prioritising others (especially children) over themselves is particularly evident in the analysis of a popular women's magazine account in Chapter 4, and in Extract 8 in Chapter 6.

positioned as consumers of the health-care system (see Chapter 3 for further discussion on these topics).

The following extracts illustrate some further examples of the ways in which the pamphlets position women as needing to take responsibility for their own health and risk management with respect to breast cancer. These examples typically appeared toward the end of the pamphlets.

Pamphlet 1

. . . If you're over 50 call 13 20 50 now for your free mammogram. And don't wait till you've finished this book to do it!

Pamphlets 4 & 5

Summary of recommended practices

- Women aged 50 to 69 should have a screening mammogram **every two years**.
- Mammograms are recommended **every year** for women aged 40 and over who have a strong family history of breast cancer.
- All women are encouraged to learn and practise monthly breast self-examination (BSE). The Anti-Cancer Foundation can give women a free brochure or lend a video on BSE.
- Women should ask their doctors for a physical examination of their breasts every year.
- A woman of any age who becomes aware of a breast symptom, such as a lump or nipple discharge, **should see her own doctor without delay**.

(Bold & italicised writing in original)

Pamphlet 6

Breasts: what should I know?

What should I know?

. . .

What should I look for?

. . .

What should I be doing?

. . .

All women should have a breast care plan that includes:

Talking with your doctor about your individual breast health at your consultation.

Discussing any family history of breast cancer . . . with your doctor.

Seeing your doctor promptly if you notice any changes, no matter how small, in your breasts.

Joining the screening mammography program as soon as you are 50, and having a free mammogram (breast x-ray) every two years . . .

(Bold writing in original)

Repeatedly in these extracts (as in the Sara Henderson message above), women can be read as needing to take action to manage with breast cancer risk. One particular way in which such positioning is accomplished is through the process of ‘interpellation’ in which individuals are “called or ‘hailed’ by a particular discourse” (Edley, 2001, p.209). For example, in the extract from Pamphlet 1 above, women are ‘called’ by the pronoun use ‘you’ – the text speaks explicitly to the reader. They are instructed about what action to take through the use of an imperative form: ‘If you’re over 50 call ... And don’t wait ...’ Women’s behaviour can be argued to be constructed here as the site of intervention for managing the problem of breast cancer risk, with women therefore positioned as responsible for their own health.

Similarly, in the other extracts above, lists of behaviours that women ‘should’ take up are presented, constructing women as needing to be active in their risk management. Typically in these statements, women are positioned as the active subject; for example, ‘*Women ... should have a screening mammogram*’, ‘*Women should ask their doctors ...*’, ‘*A woman ... should see her own doctor ...*’ (emphasis added). Pamphlet 6, specifically, features a series of questions which women are positioned as asking. These all focus on what ‘I’ – an individual woman – should do to take care of my health, again locating responsibility with women for risk management.

The words ‘should’ and ‘ought’ have previously been shown to be used in describing behaviour thought to be morally preferable (Howson, 1999). For example, Howson (1999) reported that in interviews with women in the UK regarding their cervical screening practices, terms such as ‘should’ and ‘ought’ marked screening compliance as an expectation and as located within the moral domain. The repeated use of the word ‘should’ in the pamphlets examined here may, therefore, point to the construction of breast cancer screening as a surveillance activity in which women are morally obliged to participate and engage.

Additionally, in the extract from pamphlet 6 (as well as throughout the pamphlets), there is an emphasis on ‘rational’ language, in line with the notion of health education leading to behaviour change through cognitive processes. For example, the title and first heading ask ‘what should I *know*?’ (emphasis added). This type of formulation can be seen to construct rationality as being central in carrying out screening behaviour, and women as responsibly taking up particular health

behaviours if they have the correct knowledge. Women could therefore be argued not only to be morally obliged to engage in particular health behaviours, but also to gather the correct knowledge.

One of the behaviours that repeatedly appeared in the lists of recommended practices was seeing a doctor. Referring to a doctor's advice may appear to be shifting responsibility away from individual women, but the ways in which this behaviour was represented in the pamphlets, I would argue, still works to position women as morally obliged to take responsibility for their health. That is, as shown in the extracts above, it is repeatedly stated that women should 'see', 'ask' and 'talk with' doctors. Such descriptions function to construct referring to a doctor as a woman's responsibility. Women in this construction are active, with doctors being positioned as relatively passive. Furthermore, almost exclusively throughout the pamphlets, there were references to 'your doctor', or 'a woman's own doctor', again, working to build up a version of what a responsible woman does for her health: she has her 'own' doctor.

The local function of positioning women as being responsible for the prevention of breast cancer can be seen to be to persuade women to screen: the goal of these pamphlets. In terms of wider implications, drawing on such strategies in promotional campaigns for screening practices can be argued to reproduce notions of individuals as self-regulating citizens who manage their own risk, health and illness. Although this positioning is not necessarily problematic, it may function to deflect attention away from other sites of responsibility for health outcomes, and may also allow for a victim-blaming mentality with respect to illness.

In the next section, I examine ways in which presenting mammography as an imperfect technique functions to further the positioning of individual woman as responsible for risk management.

5.6.2 Construction of mammography as fallible

In the pamphlets examined here, screening and mammography were generally constructed as linked to a reduction of breast cancer risk. In contrast, however, in a few instances mammography was constructed as fallible. When this occurred, the emphasis on screening more generally, and on women's responsibility to engage in screening, rather than being undermined, was reasserted. The following are examples of such constructions.

Pamphlet 2

. . . A mammogram can find most breast cancers but, like many other medical tests, it is not 100% accurate. It is recommended that women check their breasts regularly and consult their doctor if they have any concerns.

Pamphlet 3 & 5

. . . While mammograms are the most effective tool for early detection, they do not find all breast cancers. Nor do they prevent breast cancer. Because of this, a woman of any age who becomes aware of a breast symptom, such as a lump or discharge from the nipple, should see her doctor as soon as possible.

In each of these extracts, mammograms are initially portrayed in the terms examined above – as beneficial – but this representation is followed by a disclaimer indicating limitations of the technique. This portrayal of mammography as fallible due to its status as a ‘medical test’ and a ‘tool’, works to construct it here (in contrast to other places in the pamphlets) as different to other screening techniques, which are consequently positioned as being even more essential. Thus, women are positioned as needing to be even more vigilant and self-regulating with respect to their bodies and their health, and to take even more responsibility for their risk management. This construction of women as responsible is particularly accomplished by their positioning as the active agent in managing breast cancer risk, in contrast to mammograms, which may not perform accurately, and doctors, who are a resource to be drawn on.

I also want to highlight that representations of the limitations of mammography here take the form of an absence of perfection, rather than the presence of a flaw or cost of the procedure: ‘not 100% accurate’, ‘do not find all breast cancers. Nor do they prevent breast cancer’. Constructing mammography in this way arguably allows it to be acknowledged as fallible, while not emphasising other drawbacks or points of continuing debate relating to this screening technique. Furthermore, positioning mammography as part of a wider category of ‘many other medical tests’ allows focus to be shifted away from any specific costs of this procedure, and placed on a more general common-sense understanding that no medical procedure is perfect.

It could also be argued that describing mammography as ‘not finding all breast cancers’ functions to protect the legal interests of providers of breast screening

services. It has been reported that there is an increasing number of cases in Australia in which women with terminal breast cancer are taking legal action against doctors (Langlands, 1998). Such legal action is based on the belief that there was a delay in diagnosis, and therefore treatment, of their cancer, and that, had the disease been diagnosed earlier, it would not have developed to a terminal stage. Langlands argues that an increase in such litigation is related to the belief that diagnostic testing is infallible – the notion that if women have a mammogram, they will not die from breast cancer. He claims that by promoting this simplified message, which does not acknowledge the failings of mammography, the medical profession is maintaining unrealistic expectations about the potential cure for breast cancer – that if ‘best practice’ is followed in relation to diagnosis and treatment, the disease is curable. Instead, Langlands (1998) argues that even if current best practice is followed, death from the disease is still possible, even likely for some women. In the context of this kind of argument concerning the promotion of mammography, the pamphlets examined here can be argued to function to promote screening as a practice in which women should engage, while still acknowledging the fallibility of mammography. At the same time, not giving details (or omitting discussion altogether) about possible costs of the procedure enables such disclaimers to be given without undermining the ‘selling’ of the service.

In this section, then, I have examined some discursive strategies functioning to position women as responsible for their own risk management. Specifically, these strategies included: the positioning of women as rational, and as needing to take care of themselves; and the construction of mammography as fallible, functioning to

locate emphasis on other screening techniques, and on women as responsible for their own health and illness.

5.7 Conclusion

This analysis has explored some of the discursive and rhetorical strategies employed in pamphlets promoting breast cancer screening. In particular, I have argued that the pamphlets work to position women as ‘at risk’ of breast cancer, and as responsible for the management of their risk status. Furthermore, screening is constructed as a way in which they can manage and reduce breast cancer risk.

In line with synthetic approaches in discursive psychology (e.g., Wetherell, 1998), the aim here was to highlight both potential local functions of the text, as well as broader cultural implications of the positionings and constructions examined. The immediate function of the discursive strategies employed in these pamphlets can be understood to be furthering the goal of persuading women to screen for breast cancer. At a broader level, the pamphlets analysed here (like the media accounts analysed in Chapter 4) can be argued to be drawing on, and thereby perpetuating, the notion of ‘healthy’ people as ‘patients without symptoms’ (Finkler, 2000). That is, the pamphlets work to develop the idea that concern about illness is not limited to people who are sick nor to the medical profession. Rather, the growing medicalisation and surveillance of ‘healthy’ individuals’ lives, as well as the ever-increasing moral obligation to engage in self-regulation, can be argued to be normalised in these texts. In line with work on the new public health in advanced liberal societies, these pamphlets can be therefore argued to reproduce notions of

individuals as self-regulating citizens who are responsible for managing their own health and risk of illness. Although this positioning is not necessarily problematic, it may function to deflect attention away from other sites of responsibility for health outcomes, and may also allow for a victim-blaming approach to illness. These positionings and their implications are also of note here given that this health promotional material functions to construct screening behaviour as beneficial, and even as necessary, for individual women despite the disputed benefits and costs of such practices.

Before finishing this chapter, I think it is important to point out that, as with much of this research project, I have struggled with many dilemmas and issues in conducting this analysis. While I believe it extremely important to render visible the rhetorical functions, and the resulting power implications, of the language used to discuss and promote 'health' behaviours, I am also aware of the need to be reflexive and to consider implications of my analysis and conclusions. Consequently, I want to reiterate that my aim here has not been to criticise attempts to prevent illness, nor to suggest that health organisations publishing pamphlets to promote screening are not seeking to improve women's health and their lives. Instead, my aim has been to highlight some of the discursive strategies employed to further the rhetorical goal of convincing women to screen, and to contribute to emerging discussion regarding broader cultural implications of such discursive constructions of health and responsibility - discussion which may lead to new and alternative ways of understanding these concepts and, potentially, enhance women's lives.

In the next chapter, I turn to an examination of women's own talk around issues of breast cancer risk, screening and prevention.

Chapter 6

Women's focus group talk about breast cancer screening, risk and prevention

6.1 Introduction

As discussed in earlier chapters, breast cancer is currently reported as the largest cause of cancer death amongst women in Australia, and emphasis has been placed by health promoters on encouraging women to participate in screening and prevention practices. However, public and professional controversy surrounds the various treatments and techniques that are designed to prevent, detect and manage 'risk' of breast cancer, such as mammography, breast self-examination and prophylactic mastectomy (or removal of healthy breasts). This chapter employs a discursive approach (see Chapter 2 for a discussion of the approach) to investigate the management and negotiation of issues of breast cancer 'risk' and screening in women's talk on the topic.

Also of consideration here are changes in understandings of health and health-care that have been argued to be occurring in modern democratic societies, such as Australia (see Chapter 3 for a longer discussion of these changes). For example, it has been argued that health has become a central focus in the formation of modern identities, and one that is inexplicably linked with notions about being a 'good' and 'responsible' person (Crawford, 1994; Crossley, 2003). One aim of this chapter is to contribute to the growing body of empirical research and theoretical developments

relating to the notion of health as a moral phenomenon (Crossley, 2003). Specifically, the aim here is to provide a detailed discursive analysis of some ways in which talk about health risks and responsibility is constructed and deployed.

The analysis makes use of concepts central to critical discursive psychology, such as ideological dilemmas and subject positions, as well as focusing on the specific discursive practices and rhetorical devices that were drawn on by women in the context of focus group discussions. Specifically, the positioning of responsibility for health is of interest, with the analysis examining the flexible ways in which participants account for ‘unhealthy’ behaviours. Furthermore, the analysis highlights variations in the way women position themselves in talk about screening behaviour. That is, the analysis focuses on the discursive strategies and limits employed by participants, and investigates the way they make use of psychological categories and mental states, such as thinking and feeling. The flexible use of language in negotiating issues of risk, choice, and responsibility for health are of interest due to the centrality of these issues in sociological theorising around health-care in modern Western societies (see Chapter 3 for a discussion of this theorising).

6.2 Data and analytic approach

The data analysed in this chapter consist of transcripts of talk produced by women in the context of focus groups gathered for the purpose of this study. The participants were recruited from the general public, informally, through acquaintances of the researcher. Women aged 50 years and over were targeted. This is the age at which BreastScreen SA actively recruits women for mammography. Other than age, no particular requirements were specified for participation. Potential participants were

invited to take part, and were provided with an information sheet (see Appendix 4) that outlined the aims of the study and provided details about participation. The researcher's contact details were provided for interested individuals to ask for further information or to express their willingness to participate.

Three focus groups were organised, each of which involved three participants, plus myself as the interviewer/moderator. The participants had no symptoms of breast cancer. The groups were held at a time and place of convenience to all participants. Discussions lasted for about an hour, on average, and were semi-structured, with some 'prompt' questions to encourage discussion (see Appendix 5). The questions were generally of a factual nature (such as "what sorts of things do you think increase an individual's risk of developing breast cancer?") but also asked about the women's own screening behaviour, and their experiences and opinions regarding such behaviour. These questions were made available to participants before the time of the discussion.

The focus groups were tape-recorded, then later transcribed for the purpose of analysis. At the commencement of the discussion groups, participants were asked to sign a consent form (see Appendix 6), ensuring their informed consent. This form outlined participants' freedom to withdraw from the study at any point, or to request that the tape-recording be paused if they felt at all uncomfortable with the conversation, although this never occurred. Their participation in the study was entirely anonymous, with consent forms kept private following the interview, and with participants being provided with an alias at the point of transcription to ensure their anonymity.

Transcription was based on Jeffersonian conventions (see Appendix 7 for details) and, following this long process, the transcripts were then read and coded for repeated themes and discursive patterns. The analysis in this chapter will focus on the language participants used, in the context of the focus groups, to talk about their own, and others', health behaviours, and on how they managed to account for 'unhealthy' behaviours.

As outlined in Chapter 2, the research presented in this thesis has employed a discursive psychological approach to analysis, primarily informed by the work of researchers such as Edley (2001) and Wetherell (1998). This approach considers the broad historical and cultural context in which talk takes place, but also takes language as being context-specific and as accomplishing social actions. The analysis therefore takes as a starting point the constructive and action-oriented nature of language, and focuses on what the women's talk is accomplishing and constructing, rather than treating their talk as reflecting an internal attitude or cognitive state, or a description of real events. As Hepburn and Brown write (2001, p.712), for discursive psychologists, "participants' responses start to be seen more in terms of descriptions that embody assumptions, judgements and practices – as well as orientations to the context (both local and political) in which responses are given. It follows that those same responses start to look less like some unproblematic 'downloading' of inner states."

This chapter, therefore, investigates the discursive practices and limits employed by women in talk about screening as orientations both to the local context of the focus

group, and to the broader cultural and political context of increasing moral responsibility for health. That is, by exploring talk about breast cancer risk, screening and prevention that has been generated in focus groups, the analysis will have something to say about 'focus group talk' (for example, the management of identity in that context), as well as having implications for understandings of breast cancer risk and health behaviours.

6.3 Analysis

In examining the discursive practices employed in this series of discussion groups, several patterns emerged. Participants tended to construct themselves as self-monitoring with respect to health, as aware of risks and as doing the 'right' thing - that which is recommended. Specifically, in the context of these focus groups, where I was asking about their breast screening behaviours, the women generally presented themselves as complying with recommendations about breast screening, such as attending mammograms and carrying out breast self-examinations. As part of this management of their own subjectivity as responsible, participants also repeatedly constructed an uninformed, irresponsible and irrational 'other' whose behaviours could be seen as unhealthy and even risky. As such, it could be argued that participants engaged in discursive work that mirrored that of much health promotional material, representing recommended behaviours as good, responsible and the right thing to do, and negatively portraying individuals who do not comply.

In providing accounts of their own 'unhealthy' behaviours, however, participants discursively renegotiated the limits of what was constructed as 'healthy' and responsible. That is, although they generally represented themselves as doing what is

recommended in relation to health behaviours, they were also able to provide accounts of their own failure to follow health recommendations. Furthermore, these accounts of non-recommended behaviour were organised in subtle ways such that they did not appear explicitly contradictory to the participants' dominant subjectivity constructions as responsible women. In particular, I will demonstrate how a dominant subject position taken up by the participants was that of individuals who are aware of risks, seek information, and take responsibility for their own decisions, even if that means deciding not to engage in 'healthy' behaviours.

The analysis is presented in three parts. The first focuses on the ways in which participants generally constructed themselves as self-monitoring, and as engaging in recommended behaviours. The second part focuses on the ways in which participants accounted for other people's 'unhealthy' behaviour. The third part of the analysis focuses on ways in which the participants accounted for their own 'risky' or 'unhealthy' behaviours in a way that allowed them to maintain their identity construction as 'responsible'.

6.3.1 Self-monitoring subjectivity constructions

The notion of subject positions is a central analytic concept in synthetic discursive approaches to analysis. Subject positions can be thought of as "'locations' within a conversation" or "identities made relevant by specific ways of talking" (Edley, 2001, p.210). Hepburn (2000) has examined the related concept of 'subjectivity constructions'; the "construction of various mental entities, inner distinctions and features of subjectivity" (Hepburn, 2000, p.612). In the focus group data examined here, participants repeatedly deployed subjectivity constructions that allowed them to

take up a 'location' (or subject position) in the conversation as self-monitoring. This kind of positioning can be seen in the following short extracts:

Extract 1

1 **Anna:** And and the fact that we do go (.) uh and have screenings
2 and I'm: (.) religious about it / S: °Yep° / I go (.) do
3 all (.) 'bout due to go again[↑] (2.1) we don't like it (.)
4 but you go and do it=
5 **Beth:** =You do it

Extract 2

1 **Dana:** I'm not real good about pushing things with my health but
2 I think I am aware with breast cancer

Extract 3

1 **Elizabeth:** I guess I always thought that (1.3) I've (.) always
2 checked my breasts (1.4)

Extract 4

1 **Elizabeth:**... so it's all part of uh (.) keeping yourself (1.2)
2 checked if you like / J: Yeah / y'know just to make sure
3 that / Hmm / you don't get any nasties

Extract 5

1 **Jenny:** Well that keeps it on your mind all the time [doesn't it]
2 **Elizabeth:** [That's right]
3 (.) yeah
4 **Jenny:** [Even ((unheard))] (.) y'know like / E: Yeah / working

- 5 **Elizabeth:** [You're very aware]
- 6 **Jenny:** with someone=
- 7 **Elizabeth:** =And I guess that's not bad (.) because then you are
8 aware / J: O:h yes / and you keep checking
- 9 **Jenny:** Yeah (.)

In these examples, and repeatedly throughout the discussions, the participants presented themselves as engaging in health screening and monitoring behaviours: attending screening (Extract 1, lines 1-3), being 'aware' (Extract 2, line 2; Extract 5, lines 5, 7-8), and 'checking' themselves (Extract 3, line 2; Extract 4, line 2; Extract 5, line 8). Specifically, they repeatedly reported carrying out recommended behaviours with respect to breast cancer, which allowed them to be positioned as doing the 'right' thing. Furthermore, doing the 'right' thing was often (as in Extract 1 in particular) portrayed as not pleasant or enjoyable (e.g., 'we don't like it', line 3, Extract 1). Constructions such as 'I'm religious about it' (Extract 1, line 2) also clearly highlight the moral imperative of the health behaviours under discussion, by linking health behaviours with religion.

One particular feature of much of this talk is the way in which a distinction was worked up between the "monitoring agent and the acting subject" (Hepburn, 2000, p.612). That is, the participants typically constructed themselves as both the acting subject who, for example, is aware of breast cancer, as well as the monitoring agent who is reflecting on her own awareness. A layered self-monitoring can therefore be seen in examples such as 'I think I am aware' (Extract 2, line 2) and 'I guess I always thought that I've always checked my breasts' (Extract 3, lines 1-2), in which the women are constructing themselves as 'looking in' on their own attitudes, cognitions,

feelings and behaviours. This kind of construction allows women to present themselves as able to reflect on their own behaviour and, indeed, on their own *awareness*, with regard to breast cancer and screening. The talk depicts what could be described as a ‘meta-awareness’, where the women are thinking about themselves being aware.

Hepburn (2000) argued that, in her interview data with teachers discussing bullying, such formulations of subjectivity functioned to allow participants to address issues of responsibility, stake, and accountability - issues that are of central concern in talk (Potter, 1996b). By working up such constructions, participants were able to represent themselves as reflecting on, and evaluating, their own behaviour, often explicitly orienting to issues of accountability and responsibility. In terms of the examples in Extracts 1-5, above, it could similarly be suggested that participants’ “distinction between the monitoring agent and the acting subject” (Hepburn, 2000, p.612) works to preserve their accountability. That is, the participants are not simply reporting that they do the ‘right’ thing – what ‘they’ (doctors, health promoters, etc) advise – they are presenting themselves as reflecting on their health behaviour and knowledge, and as checking that they are doing the ‘right’ thing. This evaluation of themselves and their own behaviour allows them to manage their stake in the interaction, by showing that they are not simply saying they are responsible for the purposes of this focus group.

From a discursive perspective, considering the context in which such subjectivity constructions are drawn on (or any utterance is made) is important in understanding how and why such constructions might function in a particular way. The talk

analysed here took place in the context of semi-structured focus group discussions. The questions asked of participants were largely factual and, as the interviewer, I could have been understood as an 'expert' of sorts - somebody who already knew the answers to the questions being asked, for example, with respect to the risk factors for breast cancer. The discussion could thus have been understood as a kind of forum in which to 'test' the women's knowledge. Within this context, then, the construction of a self-monitoring identity could be understood as functioning to present the women as knowledgeable and responsible and, as such, as managing their stake in the specific interaction (Potter, 1996b).

It is also worth pointing out that responsibility and rationality, as well as health, are highly valued attributes within Western culture. Previous research (e.g., Crawford, 1994; Crossley, 2003) has noted the contemporary moral imperative linked to being healthy, particularly as it has been displayed in interview and focus group talk. For example, in Crossley's (2003, p.505) focus group research, "participants' orientation to the basic 'factually oriented' question, 'Do you consider yourself a healthy person?', involved moral justification and attempts to defend the respondent's moral position". This association between health and morality could be seen in Crossley's participants' tendency to refer to themselves as 'healthy', and to offer accounts of ill-health that worked to absolve themselves of any personal blame. In the focus groups analysed here, participants also generally constructed themselves as self-monitoring and as engaging in recommended behaviours.

In the next section of analysis, I will explore how the participants talked about other people's health behaviours and argue that by representing other people as

irresponsible, the participants further managed their own subjectivity construction as good and responsible.

6.3.2 Accounting for others' 'risky' behaviour

A repeated topic of the focus group talk centred on descriptions of (other) people who engage in 'unhealthy' or 'risky' behaviours. These behaviours were typically represented as not the 'right' thing to do. They included: not screening for breast cancer, not getting lumps checked, and not immunising children. Other people engaging in these 'unhealthy' and 'risky' behaviours were repeatedly constructed as uninformed, irresponsible and irrational. Talk about 'unhealthy' behaviour therefore constructed a contrast between the participants and others, arguably functioning to bolster the working-up of a self-monitoring subjectivity for the speakers. This section of analysis will examine ways in which these subject positions were constructed, as well as drawing attention to some of the dilemmas that participants worked to negotiate in the focus group talk.

The following extract (Extract 6) illustrates the kind of rhetorical organisation deployed in sequences of focus group talk concerned with descriptions of others' 'unhealthy' behaviour. In particular, people engaging in 'unhealthy' behaviours are positioned here as emotional, irrational, and uninformed.

Extract 6

- 1 **Shona:** Do you know of people who have made that decision not to
2 (.)
3 **Anna:** Yes I know people that don't (.) do it

4 **Shona:** And (.) what (.) sort of (.) justification °or what sort
5 of°=
6 **Anna:** =They just don't (1.0) want to do↑ it they just don't
7 **Shona:** Yeah (1.0)
8 **Beth:** Any reason?
9 **Anna:** No they just don't want to kno:w (1.3) what it is, they
10 just don't do it, they don't think it's (.) impor- well
11 it's they're too scar↑ed

This sequence of talk illustrates a typical construction of individuals who do not screen as unable to overcome their fear to make the decision to act: they 'don't want to know ... they're too scared' (lines 9-11). There is a distinction drawn here between emotional and rational responses to breast cancer risk and screening: fear (an emotional response) and not 'knowing' are linked with not screening. This association between fear and not screening is also highlighted by the repair at line 10. Anna starts to comment on non-screener's thought processes ('they don't *think* it's impor-', emphasis added), but stops and, instead, shifts to giving an account of the women's emotional state ('they're too scared'). Any rational decision-making involved in not screening is, therefore, down-played and undermined by the overriding representation of women who do not screen as being 'too scared'.

The categories of emotional and rational are therefore constructed as being mutually exclusive: either women 'know' and therefore screen, or they 'don't want to know', are 'too scared' and do not screen. This distinction suggests that, with respect to screening behaviour, women belong only to one of these categories – rational or emotional – rather than, for example, flexibly negotiating them, or taking up different approaches at different times.

Furthermore, this extract draws on the notion of health as a moral phenomenon. Women not engaging in screening behaviour are held morally culpable for their lack of commitment to their health. For example, at line 6, the speaker suggests that other women ‘just don’t want to do it [screen]’. Notice how this construction can be contrasted with previous extracts in which participants described how they engage in screening despite not wanting to (see Extract 1, lines 3-4). Participants are thus positioned as responsible and as morally superior to women who do not screen.

Extract 7 provides another example of talk initiated by the interviewer’s question about people who do not screen. Again, in this extract, these other women are constructed as not taking responsibility for their health.

Extract 7

- 1 **Shona:** D- so (.) oh you mentioned that you haven’t really
2 >spoken about it with other people< do you think there
3 a↑re many people that resist or that s- say (.) °I’m not
4 going to do that° ((unheard)) (.)
- 5 **Jenny:** I think most of the women I kn↓:ow (.) um: take their
6 health seriously (.) a:nd um: and like me they’ve known
7 people who’ve had a ((unclear)) tumour °things happen to
8 them° and we all think we’re far too young to di:e (.)
9 so: um I think most of them (.) um: (.) and I know one
10 of- a friend of mine’s like you ((Elizabeth)) she
11 constantly has (.) atypical (.) tests and she’s back and
12 forth and I know one who’s had ((coughs)) um not breast
13 cancer but other cancers so (.) yeah I think most of us
14 (.) um (.) and of course most of us are well-educated /

15 S: Yes / and that's another thing (.) I think (.) and
16 °although I don't know that might not be a factor° but um

A contrast structure can be seen to be deployed in this extract to position women who do not screen as not 'taking their health seriously'. This can be seen particularly at lines 5-6, where Jenny implicitly draws a contrast between the women referred to in my question at lines 3-4 ('people that resist or say I'm not going to do that'), and the women she knows, who 'take their health seriously' (lines 5-6). Arguably, 'taking one's health seriously' involves a rational process where, by virtue of being aware of risks, one will engage in appropriate and recommended behaviours to preserve one's health. Not screening, in this case, is therefore constructed as an instance of women not engaging in this rational process, of them not 'taking their health seriously'. Furthermore, the description of Jenny and the women she knows as knowing people who have been sick ('like me they've known people who've had a tumour, lines 6-7) presents them as not being fully aware of the prevalence of cancer. In this context, such a representation could, by contrast, suggest that other women who do not screen are in denial about the severity of the risk.

In Extract 7, 'taking health seriously' is discursively constructed as being associated with being 'well-educated', further bolstering its link with rational thought. This linking can be seen through the repetition of the description 'most of' at lines 4, 8, 11 and 12. Having described the actions of 'most of the women I know' who 'take their health seriously' (lines 5-6), the speaker echoes the description 'most of' at lines 13-14 - 'most of us are well-educated'. This repetition ties the two clauses together, equating 'taking health seriously' and being 'well-educated'. The linking together of

these concepts further works to represent screening as the outcome of a rational thinking process, one to which 'well-educated' women may have more access.

Other women engaging in 'unhealthy' behaviours were again represented as being irrational and irresponsible in Extract 8. However, the talk in this extract also works up alternative ways of making sense of non-recommended behaviour: (1) that women are putting others first and not taking care of themselves, and (2) that the following of medical recommendations is dilemmatic. As with Extracts 6 and 7, the talk in this (relatively long) extract begins with a question from the interviewer relating to other people's behaviour.

Extract 8

- 1 **Shona:** Do you know anyone else that (.) doesn't (.) screen? (.)
2 Women who (.) you know are eligible to screen that=
3 **Isobel:** =Oh well my [sisters don't]
4 **Shona:** [°don't have] mammograms°
5 **Isobel:** Um
6 **Shona:** What would their reasoning be (.)
7 **Isobel:** ((coughs)) They're terribly irresponsible (.) ((slight
8 laugh)) ((coughs)) I honestly think (.) in the in the
9 case of my two sisters (.) I honestly think it's an
10 attitude of that they're always out (.) fixing up
11 >everybody el[↑]se's problems< and then they haven't got
12 time to think they put themselves last (1.6) I do I do
13 think they think of themselves last (.) uh but I also
14 think it's an avoidance thing too (1.0) I think that they
15 end up (.) by looking after themselves >a[↑]nd this is just
16 a personal view< but (.) by looking after themselves they
17 actually have to say they're important (.) / Hmm / (.)
18 that's what I think (.) and I think there's a lot of

19 women out there like that (.) um I mean I lectured them
20 last week about (1.3) only because I've just been through
21 I think (.) the bone density thing (.) in case it's
22 genetic[↑] saying to them the same thing you got to go and
23 get yourselves checked out (.) because I'd hate to think
24 that you had low bone density (1.6) um (.) but they took
25 convincing they still haven't done anything about it (.)
26 [((unclear))]
27 **Helen:** [((unclear))] choice the innovation's available / I: Yes
28 that's right / and yet they won't make the decision
29 **Isobel:** But for them yeah they won't but (.) yeah[↓] they won't
30 (.) and yet I would have thought (.) one of my sisters
31 particularly would have because it was her husband who
32 died of a brain tumour (.) and she went through thirty
33 years of hell going through that[↑] / Hm / (.) and yet she
34 doesn't seem to want to go anywhere near a doctor (.) /
35 Hm / ever since she's been through that experience she
36 doesn't want to go anywhere near the medical profession
37 (.) one minute they were telling him he was going to live
38 another fifteen years (.) a week later they told him he
39 was going to die within a few days (.) / Hmm / (1.7) and
40 she went through all that (.) indecision and no one
41 really knowing what was going on (.) so she avoids the
42 medical profession too cos she's lost faith and at the
43 same time (1.2) um (1.9) she's actually being very silly
44 in another way (.) / Hmm / (1.5) so yeah (.) it is (.)
45 quite dilemmic (2.4) to do or not to do

The talk shown in this extract draws on the dominant construction of 'unhealthy' behaviour as 'irresponsible' (line 7) and 'silly' (line 43). Furthermore, Isobel also draws on the prevalent notion that being informed and aware leads to the 'right' health behaviour. This construction is particularly evident from line 19 when she

talks about having ‘lectured’ her sisters. The term ‘lectured’ arguably suggests notions of more informed people instructing less knowledgeable individuals. Indeed, at lines 20-24, she provides a justification for why she might be ‘lecturing’ her sisters – to encourage them to take action to prevent what she’s ‘just been through’. Isobel is referring here to ‘the bone density thing’ (line 21); she had previously told the group that she had been diagnosed with low bone density. She is therefore ‘lecturing’ her sisters because they need to get themselves ‘checked out’ in order to prevent sharing her negative experience related to this health problem. Informing her sisters of her diagnosis and their possible risk is therefore constructed as being linked to their initiation of health checks, drawing on the notion of knowledge as leading to behaviour. Isobel describes, however, how her sisters ‘still haven’t done anything’ (line 25) with respect to their health checks (despite her ‘lecturing’), reaffirming her earlier positioning of them as being ‘irresponsible’.

In the sequence of talk presented in Extract 8, Isobel also offers two alternative accounts of her sisters’ behaviour. At lines 9-19, Isobel positions her sisters as not doing the right thing as a consequence of their prioritising of other people over themselves: ‘they put themselves last ... by looking after themselves they actually have to say they’re important ... and I think there’s a lot of women out there like that’. This representation mirrors the discourse of ‘taking care of yourself’ that was deployed in pamphlets promoting breast cancer screening (see Chapter 5). I argued that in the context of those pamphlets, the notion that women should put themselves first (and, therefore, engage in health behaviours) could be seen both as empowering, and as locating responsibility for ‘taking care’ of health with individual women. In the talk in Extract 8, the account of women not taking care of themselves because of

their prioritisation of other people can again be seen to imply that women have a right to see themselves as ‘important’ and, therefore, to engage in health behaviours. Furthermore, this depiction portrays the issue of putting other people first as gendered; it is something that ‘a lot of women’ do. It is worth noting, however, that accounts of women’s health behaviours often depict women as taking up these behaviours *because* of their obligations to other people (see, for example, the popular magazine account of prophylactic mastectomy analysed in Chapter 4), rather than because they are ‘putting themselves first’. Women are, therefore, repeatedly positioned by reference to their relationships with other people, regardless of whether or not they engage in health behaviours.

Another alternative account for not taking up recommended behaviours is also offered in Extract 8, highlighting a dilemma that appeared throughout the focus groups in relation to following medical advice. Specifically, Isobel (at lines 29-45) represents one of her sisters as avoiding the medical profession because she has ‘lost faith’ (line 42) following her previous negative experiences with them. Isobel describes how, on the one hand, her sister is justified in avoiding the medical profession, having been through a traumatic experience with her husband. On the other hand, ‘she’s actually being very silly’ (lines 43) and her experience with her husband could provide a reason for her *wanting* to be checked (e.g., lines 30-34, ‘I would have thought one of my sisters particularly would have [gotten herself checked] because it was her husband who died of a brain tumour’). Indeed, the dilemma here is explicitly referenced: ‘it is quite dilemmic, to do or not to do’ (lines 44-45).

This specific dilemma is an example of a more general one that appeared throughout the focus groups and that relates to modern citizens' somewhat problematic relationship with experts, including medical professionals. Although the participants repeatedly constructed individuals who do not follow medical recommendations as irresponsible, ill-informed and emotional, a concurrent theme constructed the medical profession (or individuals within it) as potentially providing the wrong advice. This theme was also central in the television account of prophylactic mastectomy analysed in Chapter 4. The repeated occurrence of this repertoire throughout the data analysed in this thesis arguably highlights its broader currency as a contemporary representation of the medical profession.

Despite the alternative accounts offered by Isobel, Extracts 6, 7 and 8 all illustrate the typical construction of not screening as resulting from a lack of information or a lack of rational decision-making. This construction of non-screening behaviour can be argued to relate to the kinds of discourses seen in health promotional materials, like those analysed in Chapter 5. I argued that these texts positioned readers as rational, and as inevitably taking the recommended action (screening) once they became aware of it. Indeed, this belief that individuals will make the 'right' decision as long as they have the information underpins many approaches in health education and health promotion¹⁰.

Extract 9 illustrates a further excellent example of the discussion of other people's 'unhealthy' or 'risky' behaviours. Again, in this extract, other women engaging in these behaviours were constructed as 'silly' and as uninformed. Furthermore, the

¹⁰ See the discussion in Chapter 5 (section 5.2) for more detail on these approaches.

hypothetical other women in this sequence of talk are clearly contrasted with the participants' positioning of themselves as aware of health risks and as taking responsibility for their health. The talk in this extract took place a few minutes into the discussion with Dana, Elizabeth and Jenny, who had been talking about whether or not there are any distinguishing features, such as particular risk factors, amongst women they had known with breast cancer. The conversation had just turned to whether any of them thought they might personally be at risk. The extract begins with a question from me, attempting to extend that discussion.

Extract 9

- 1 **Shona:** Is there any-anything in your (.) you know (.) background
2 or behaviour patterns or anything that you'd say oh that
3 could be
- 4 **Jenny:** Well I do get stressed but I don't think that's a hu- I
5 don't really think that's a (.) / S: °major factor° / a
6 major factor (.) uhm:↑ (1.2) tch well I have regular,
7 well I have had a (.) couple of mammograms um: (.) a:nd
8 uh I started having them when I was (.) about forty I
9 think because I was early menopau-pausal / right / and
10 they said if you are, you should, you know so (.) and now
11 I've (.) um uh regularly go to the doctor and (.) have my
12 breasts checked and so on and there's never been any sign
13 so (.) at you know my age now fifty↑ (.) ish (.)
14 [um::]
- 15 **Elizabeth:** [((laughs))]
- 16 **Jenny:** I'd say probably I don't see myself as at risk (1.2) °but
17 y'know° (.) and given that now with the uh mammograms
18 they can (.) detect very very early si-gns↑ / Hmm / same
19 as with the pap smears so (.) if you do that kind of
20 preventative (.) business then even if it does occur you

correspondingly, irresponsible if they did not engage in health behaviours and follow experts' advice), despite also being reliant on medical recommendations that may not be accurate.

In response to my question at the beginning of Extract 9 ('is there anything in your background or behaviour patterns or anything ...', aiming to extend the previous discussion about risk factors), Jenny positions herself as doing the 'right' thing, having had 'a couple' of mammograms (line 7) and going to the doctor 'regularly' to 'have her breasts checked' (lines 11-12). Such a positioning is in line with a subjectivity construction as self-monitoring and responsible. As discussed above, as a psychological researcher who potentially already knew the answer to many of the questions I was asking, I might have been seen as an 'expert' in the context of these focus groups. It could be argued that, in response to my questions, taking up a subject position as self-monitoring and as participating in screening could function to present the women as knowledgeable and responsible and, as such, manage their stake in the specific interaction (Potter, 1996b). Drawing on screening as a way to represent oneself as doing the 'right' thing and as being responsible also illustrates a dominant interpretative repertoire that emerged throughout the focus group data, whereby preventative health was constructed as a positive behaviour, and something that women *should* do.

Jenny draws on another dominant repertoire in Extract 9 - that of taking the advice of doctors or experts - when she gives her reason for beginning participation in mammographic screening; she was 'early menopausal and they said if you are, you should' (lines 9-10). 'They', in this statement, can be read as referring to doctors or

experts and, as such, positions Jenny as being compliant with recommendations. It could be argued that implicit in this discourse of complying with the recommendations of doctors and medical experts is trust in the accuracy and appropriateness of their advice. As such, doctors and experts are positioned as also responsible in the process of illness prevention. As Jenny says, 'if you do that kind of preventative business then even if it does occur you hope that they catch it at a very early stage' (lines 19-21). Such a formulation can be seen to relate to the ideological dilemma mentioned above, in which there is a potential tension between the attribution of responsibility for illness prevention to individuals, and the idea that they are simultaneously reliant on medical professionals and technology to be responsible. In Extract 9, Jenny manages this dilemma by employing an 'if x, then y' rhetorical structure (Edwards & Potter, 1992) that constructs both individuals and experts as playing a role in prevention, or at least, early detection – if the woman does 'that kind of preventative business', then 'they' (the experts) can 'catch it'.

Other women's 'risky' behaviour was drawn into the speaker's account, unprompted, at lines 22-24: 'the people who resist thinking they've got it, the people with the lumps who don't do anything about it'. These women were explicitly depicted as engaging in 'risky' behaviour ('putting themselves at such huge risk', lines 27-28). Furthermore, as with other accounts throughout the data, the participants could be seen to account for others' behaviour by drawing on a description of irrationality: 'silly girls' (line 33). This 'risky' subject position attributed to other women is worked up as being in contrast to the behaviour of the participants, who, in the same situation would 'be there [the doctor's to get checked]' (line 38). Working up a version of other people's 'risky' behaviour as in contrast to their own could be

argued to function to re-affirm the participants' own subject positions as responsible and good.

The dominant repertoire of being sceptical of doctors was also drawn on in Extract 9: Elizabeth describes that she does not 'trust them' (see lines 40-43). We see, then, in this short piece of interaction the dilemma that was mentioned above emerging again: on the one hand, it is constructed as irresponsible and 'silly' not to see a doctor or to follow experts' advice but, on the other hand, one should maintain caution about believing or trusting experts too easily or too much. This dilemma could be argued to be representative of the shifts thought to have occurred in understandings of health, whereby individual citizens are theorised to be reliant on 'experts' for information, but as also needing to be active and responsible about managing their own health and potential illness. While taking responsibility for one's own health could be seen to empower individuals, and give them control and freedom over their own lives and bodies, this discourse may have possible negative implications for women who are not seen to have taken responsibility for their preventative behaviours.

Extract 10 comes from a section of talk much later in the same conversation (about two thirds of the way through the interview) after a short discussion of the appropriateness of a hypothetical scenario in which the government might pass legislation to force people to screen or take up other health behaviours. This extract provides another example of talk from the focus groups where 'risky' or 'unhealthy' behaviours were discussed. Again, in line with the general pattern throughout the

focus groups, this extract illustrates the construction of other people's 'unhealthy' behaviour as being based on a lack of information.

Extract 10

1 **Jenny:** And it does bring up a lot of issues about um civil
2 liberties of course (.) um (.) I mean we can't even get
3 everyone to immunise their children against terrible
4 diseases that we know still exist (.) and so we have had
5 that resurgence of kids with whooping cough (.) a whole
6 lot of other things that people think they've gone away
7 because nobody's had them for a long time but of course
8 they don't have them because they've been immunised (.)
9 so (.) um (1.5) erm (2.5) so I I I: don't see that as um
10 something that's going to happen / S: No / very soon↓
11 (.) I think anyway the education angle and (.) um (.)
12 providing people with the (.) knowledge to make an
13 informed decision (.) is um (.) is healthier (.) you know
14 than saying to people well you will have this done to you
15 whether you like it or not (.) those sorts of programs
16 usually don't wo↓rk (.) I mean people subvert them and
17 get around them / S: Hmm / in a whole range of ways
18 anyway so (.) um ((clears throat)) (.) I think it's much
19 better to to work on that

This extract provides an example of the working up of the construction of other people's behaviour as resulting from a lack of information, misunderstanding and ignorance. Particularly, at lines 3-4, Jenny refers to people who do not 'immunise their children against terrible diseases that we know still exist'. This description works up both the 'risky' and 'unhealthy' nature of not immunising – it leads to 'terrible diseases' ('whooping cough' is mentioned as an example at line 5) – while

simultaneously positioning the speaker as outside of such behaviour by the use of the pronoun 'we'. This pronoun use ('*we* can't even get everyone to immunise their children against diseases that *we* know still exist', emphasis added) positions the speaker as being on the same side, with the same knowledge, as medical professionals and health promoters attempting to convince people to immunise their children.

Subsequently, in accounting for why people might not immunise their children and prevent such negative outcomes (despite the knowledge of the existence of such diseases), these other people are positioned as not possessing the correct knowledge: 'people think they've gone away' (line 6). Thus, these others are positioned as belonging to a different, and more ignorant, category to the speaker. She, along with other informed people, knows that these diseases still exist, and is therefore trying to 'get everyone to immunise their children'. This position is contrasted with those people who believe the diseases have disappeared and are, therefore, misinformed. An implication follows that if these people had accurate information about the existence of these diseases, they too would be advocates of immunisation. As in other extracts, 'risky' behaviour is, therefore, constructed as resulting from ignorance and misinformation.

An implication of the sequence of talk illustrated in Extract 10 is that information and awareness leads directly to the take-up of recommended health behaviours; a notion that was repeatedly drawn on throughout the focus groups, and is also central in approaches to health education and health promotion. This construction continues to be worked up in Jenny's talk at lines 11-19. Here, Jenny works up a version of

events in which the best way to change people's behaviour so they do the 'right' thing, is the 'education angle' (line 11), rather than restricting their choices. People are positioned as active in their resistance to restrictions on their choices ('those sorts of programs usually don't work ... people subvert them', lines 15-16), however, a 'container' metaphor of knowledge is deployed with respect to providing knowledge. That is, people are constructed as passive recipients of information that leads necessarily to informed decision-making. Subsequently, providing information and knowledge (which is presented as being taken up without resistance) is portrayed as preferable.

The talk in this extract, therefore, relates to another dilemma concerning contemporary health-care: on the one hand, there are behaviours that everyone *should*, responsibly, engage in, but on the other hand, to force people to carry out such behaviours is potentially an infringement of 'civil liberties' (lines 1-2) and individuals' rights to make their own choices – freedoms valued in modern democratic societies. This dilemma between responsibility to do the 'right' and 'healthy' thing, and the freedom and right to choose to do otherwise is relevant to theorising around governance in advanced liberal democratic societies (Nettleton, 1997; Petersen, 1997; Rose, 1993), and is further illustrated in Extract 11. This extract presents talk that occurred in the same focus group as that in Extract 10, but earlier in the discussion, when I first raised the possibility of a hypothetical situation in which it might become illegal not to screen¹¹. The extract provides another example of the dilemma between freedom of choice and society's need to get people

¹¹ This question was asked in each focus group.

to make 'healthy' decisions. Once again, it also constructs the people who do not make 'healthy' decisions as 'other' to the participants.

Extract 11

- 1 **Shona:** Can you imagine (.) at all (.) y'know hypothetically that
2 there'd ever be a time when they'd legislate that you (.)
3 would (.) have to go and screen?
- 4 **Elizabeth:** They probably will, they legislate for everything else
- 5 **Shona:** Hmm (.) what do you think about that? °Is that° (.)
- 6 **Elizabeth:** I'd say up them and I wouldn't vote for them (.)
7 ((everyone laughs)) well seriously=
- 8 **Shona:** =Well why? Do you think that's sort of (.) going against
9 your right (.) to (.) choice? Or is that (.) y- y'know
10 if you think that it's a good thing to screen anyway
11 (1.3)
- 12 **Jenny:** I get ye::ah↓ (.) there's sort of like the two sides of
13 it isn't there / E: Yeah / there's like the personal you
14 know, how dare they tell me what to do business (.)
15 [um:: on the other] san- on the other side of that
- 16 **Elizabeth:** [((unheard))]
- 17 **Jenny:** is uh the fact that there are people who don't (.) um (.)
18 make what we would what we would see: (.) as uh good
19 health choices / S: Hm / in terms of screening for
20 instance (.) um: immunisation's another one / E: True /
21 that's a big issue for me (.) um (.) so (.) erm (.)
22 y'know (.) it's like, we have to vote↑ you know / D:
23 It's / like that's a=
- 24 **Dana:** =It it is actually very much related to the wearing of
25 seat belts and and safety helmets because those
26 [a:re]
- 27 **Elizabeth:** [°That's right°]
- 28 **Jenny:** They're [legis]lative [yes]

29 **Dana:** [Preven-] [yep]
30 preventative measures to keep us from (.)
31 **Jenny:** Yep
32 **Elizabeth:** But then again [(unheard)] they're really directing
33 **Dana:** [(unheard)]
34 **Elizabeth:** your life and / D: it is / telling you

We again see here the construction of other people (not the participants) as being those who do not make appropriate choices – ‘there are people who don’t make what we would see as good health choices’ (lines 17-19, emphasis in original) – functioning to position the participants as good and responsible. This contrast between the participants and the people not making ‘good health choices’ (as in Extract 10) is worked up, in part, by the use of the pronoun ‘we’. This pronoun works here to construct a group identity for the focus group members, functioning to position members as united and in agreement about what constitute appropriate health decisions. The participants are positioned as engaging in ‘good health choices’, in contrast to other people.

Additionally, the dilemma between individuals’ right to make their own choices and the broader public health interest in achieving compliance with recommendations is explicitly oriented to here (lines 12-20, ‘there’s ... the two sides of it’; ‘those are preventative measures’, lines 25-30, vs. ‘but ... they’re really directing your life’, lines 32-34). It should be noted here that, as the interviewer, I initiated the topic of legislation for screening, and actively participated in the discussion (see lines 1-3, 5, 8-10). This example of my contribution to the conversation highlights my role as a ‘co-constructor of meaning’ in the focus groups (Wilkinson, 1998b). However, the participants also engaged with the topic in particular ways and drew on specific

interpretative repertoires, such as (what could be called) the ‘right to resistance’ (Crossley, 2003, p.510). This discourse can be seen at several points in Extract 11 (e.g., ‘I’d say up them and I wouldn’t vote for them’, line 6; ‘how dare they tell me what to do business’, line 14, ‘we have to vote’, line 22). Similarly, in Crossley’s (2003) focus group data relating to health as a moral phenomenon one of the themes identified was concerned with ideas about ‘resistance’ to health promotion. Crossley reported that discussion of this topic related specifically to the “relationship between health, individual freedom and government intervention” (2003, p.501).

In the extract above, the ‘right to resistance’ discourse was deployed initially by Elizabeth in her turns at line 4 and then lines 6-7. Here, she explicitly condemns government intervention (via legislation) into individuals’ screening behaviour by claiming that she would refuse to vote for ‘them’. The shared response of the group here – a pause, followed by laughter – potentially indicates some support for Elizabeth’s claim, but also acknowledgement that such a claim is somewhat defiant. In this sense, both the pause and the laughter may mark some surprise or awkwardness in response to Elizabeth’s statement. Indeed, it could be argued that she orients to the pause and laughter as a (minor) challenge to her claim, indicated by her rejoinder, ‘well seriously’. My question at line 8 (‘well why?’) can be read more explicitly as indicating a challenge to her claim.

Subsequently, Jenny references the ‘two sides’ of dilemma between individual freedoms and rights, and (government) interventions to improve public health. The former is clearly couched in the ‘right to resistance’ discourse - ‘how dare they tell me what to do’ (line 14) – lending support to Elizabeth’s claim. However, the latter

constructs a need for structural intervention based on (other) people's bad health decisions ('there are people who don't make what we would see as good health choices', lines 17-19). The two sides of the dilemma are repeated again before this sequence ends: actions in which citizens are forced to engage ('wearing of seat belts and safety helmets', lines 24-25) are depicted as beneficial for 'us' (line 20), but it is reasserted that 'they're really directing your life' (lines 32-34). These two notions are linked by the phrase 'but then again' (line 32), which can be seen to position them as in conflict with each other.

The notion of 'resistance' to health promotion, and to authorities (specifically, governments) impinging on individuals' rights by forcing them to take up particular health behaviours (even in the name of public health), arguably provide discursive resources with which speakers can account for 'unhealthy' choices. The potential for these discourses to be used in such accounts is, I would argue, highlighted by the ways in which they were often oriented to as dilemmatic in the focus group talk (as illustrated in Extracts 10 and 11). They were not (necessarily) rejected as irrational, uninformed, or as only being taken up by others, but were also challenging for, and negotiated by, participants. However, in the extracts analysed here, the perpetrators of 'unhealthy' or 'risky' behaviour remained other people, who were defined in opposition to the participants. The ways in which participants accounted for their own 'unhealthy' behaviours will be the focus of the next section of analysis.

In summary, the extracts examined in this section illustrated instances in the focus group discussions where participants specifically discussed other people's 'unhealthy' or 'risky' behaviour. I have argued that the dominant discourses that

were drawn on constructed 'unhealthy' behaviours as the result of misinformation, ignorance, or a lack of rational decision-making. As such, other people (generally described in the abstract, rather than as specific individuals) were worked up in explicit contrast to the participants. I would argue that drawing this contrast functioned to bolster the participants' subjectivity construction, in the context of the focus groups, as good, self-monitoring and responsible. With respect to broader implications, such depictions of 'unhealthy' and 'risky' behaviours, and the people who engage in them, can be seen to reproduce and support notions of health education as the key to public health improvements. That is, individuals were typically positioned as likely to change their behaviours if they are aware of recommendations.

Another dominant repertoire in this data constructed health as a moral phenomenon, whereby individuals not engaging in recommended health behaviours, such as screening, were positioned as irresponsible and as morally culpable for their health. Although this discourse can be seen to have wider benefits in terms of constructing health behaviours as desirable, it could also be argued to have negative implications. For example, such discourses make available particular subject positions for women who do become ill, or who are not seen to have taken sufficient responsibility for their health: women may be positioned as guilty or to blame for illness. This individual focus on responsibility and blame potentially functions to deflect attention away from other, more structural, causes of illness. Health becomes constructed principally as resources of an individual, rather than as influenced by broader social and environmental determinants.

There were occasional alternative constructions of health and responsibility offered. For example, an account that emphasised a social determinant - gender - was included in Extract 8. In this instance, women were depicted as more likely not to engage in recommended behaviours given their tendency to prioritise other people. Furthermore, I have also highlighted two dominant ideological dilemmas that appear to have shaped participants' responses in the focus groups. These related to: (1) the placing of responsibility for health with individuals, while also constructing individuals as reliant on medical experts; and (2) the expectation that individuals should engage in 'healthy' behaviours, while also acknowledging their right to make their own choices and their 'right to resistance'. These dilemmas were not resolved in the focus group talk but were topics which were often taken up as challenging, and which participants worked to negotiate in their talk. The variable elements of these dilemmas provided discursive resources either to bolster the construction of screening and other recommended health behaviours as being 'good' and the 'right' thing to do, or to reject and resist such recommendations.

In the next section of analysis, I will examine instances in which the participants talked about their own 'unhealthy' behaviours, and examine the ways in which they can be argued to resist and negotiate the discourse of 'doing the right thing'.

6.3.3 Accounting for the participants' own 'unhealthy' behaviour

Having constructed themselves as self-monitoring and as doing the 'right' thing, in contrast to other people who engage in 'risky' behaviours, the participants could be seen to be presented with some discursive tension when talking about behaviours that they themselves engage in that are *not* recommended by health authorities. To

maintain their subjectivity as self-monitoring and responsible, which I have argued was desirable in this context, they needed to provide a rhetorically persuasive and culturally appropriate account for their own *unhealthy* behaviour. I would argue that this was particularly so given the working-up of an emotional, irrational and irresponsible 'other' who engages in 'unhealthy' and 'risky' behaviour.

The analysis in this section focuses on sequences of talk in the discussion groups that were concerned with the issue of the participants' own 'unhealthy' or 'non-recommended' behaviours. Although all the focus group participants talked about their own and other people's health behaviours, only those accounts that explicitly discussed specific examples of participants own 'unhealthy' behaviours - seven extracts - were considered in this section of analysis. Out of these, one sequence was chosen as best representing the patterns of talk in participants' accounts of their own behaviours; this extract includes three explicit descriptions of participants' own non-recommended behaviour. The analysis is intensive, focusing on the detail of this sequence and on some of the flexible ways in which ideas about health, and responsibility for health, were constructed and deployed.

In particular, I will show how the patterns drawn on in accounting for other people's 'risky' behaviour – presenting such behaviour as uninformed, emotional and irresponsible – are reframed in the context of participants' accounts of their own 'unhealthy' behaviour. Such reframing allows participants to maintain their positioning as good and responsible women. The talk in this extract (Extract 12) immediately followed that presented in Extract 9 above, and also includes the section of talk that was shown in Extract 2.

Extract 12

- 1 **Dana:** I'm not real good about pushing things with my health but
2 I think I am aware with breast cancer / hmm / °but yeah
3 if I found a lump° (.) mind you I I I'll admit that I
4 don't (.) um feel my breasts as you're supposed to do,
5 they say you should be doing that regular on a weekly
6 basis and I don't↓ (.) I (.) I'm no longer just 50 I'm
7 well up in my 50s ((laughs)) so I've already had two of
8 the um mammograms that they (.) are sort of regulation
9 and (.) thank (.) goodness everything's been (.) fi:ne so
10 (1.5) I have never really worried terribly much about
11 breast cancer (.) but at this stage if there was any
12 suggestion I would move fast yes ((laughs))
- 13 **Shona:** Do you think there's anything that you can do to prevent
14 it? (2.4) Any measures you can take?
- 15 **Jenny:** Well there doesn't seem to be does it, there doesn't seem
16 to be any (.) well I don't know of any there could well
17 be (.) some research (.) findings that I haven't heard
18 about but um (.) in all the advertising and so on there's
19 (.) what they talk about is prevention through / Yeah /
20 regular tests and you know being checked out and so on
21 (.) there's nev- and I mean I (.) would have thought that
22 if there was something we could do: (.) um they'd be
23 telling us that (.) so you know don't eat (.) kiwi fruit
24 or
25 [something or you know and you wouldn't eat it I guess]
26 [((everyone laughs))]
27 um:: but there doesn't seem to be any um well at this
28 stage any research I guess any (.) indicators (.) uh it's
29 not like saying well you know if you smoke you're likely
30 to get lung cancer (.) you know then you take your
31 cha:nces, I still smoke, I don't care, but um (.)

32 ((slight laughter)) very old habit, very hard to break
33 ((laughter)) but you know if (.) I'm su:re if there was
34 something they could tell us (.) that then (.) you know
35 people would make (.) °informed decisions or uninformed
36 decisions >depending on how you like to think about it<°
37 (.) about (.) whether or not they'd put themselves at
38 risk so (.)

As with most talk-in-interaction, there is much that could be examined in this extract. I will focus on the discursive themes, ideological dilemmas and subject positions constructed in this talk and, in particular, on the ways the participants accounted for their own 'unhealthy' or 'risky' behaviour. In particular, I aim to highlight ways in which the speakers drew on and negotiated issues around responsibility and rationality. Specifically, focus group speakers repeatedly did this in three main ways that can be seen in this extract: (1) using admission of 'unhealthy' behaviour as a form of stake inoculation in ways that made other claims appear authentic; (2) reframing the previously constructed relationship between emotion and health behaviours; and (3) renegotiating and re-constructing what it means to be responsible with respect to health behaviours.

Firstly, though, I would like to point out that the talk in Extract 12 provides further examples of the self-monitoring subjectivity constructions that were dominant throughout the focus group discussions. During this extract, the speakers repeatedly represented themselves as self-monitoring and as doing the 'right' thing (e.g., 'I think I am aware with breast cancer', line 2; 'I've already had two ... mammograms', lines 7-8; 'if there was any suggestion I would move fast', lines 11-12; 'if there was something we could do, they'd be telling us that ... you know don't eat kiwi fruit ...

and you wouldn't eat it', lines 22-25). Such positioning functioned to present the women in ways that could be seen as desirable in both the local context of the research focus group discussion, and more broadly.

In the sequence of talk under examination here, however, there were also descriptions of non-recommended behaviour ('I'm not real good about pushing things with my health', line 1; 'I'll admit that I don't feel my breasts as you're supposed to do ... I don't', lines 3-6; 'I still smoke, I don't care', line 31). These statements worked to renegotiate and reconstruct the relationships between emotion, responsibility and health behaviours, functioning here to allow the women to maintain their subject position as 'good'. I will examine each of these sections of the extract in turn, focussing on the ways in which they are constructed.

'I'm not real good'

The first of representation of 'non-recommended' behaviour is shown at line 1 ('I'm not real good about pushing things with my health'). This statement regarding the speaker's general health behaviour precedes her specific claim that she is 'aware with breast cancer' (line 2). The acknowledgment of not being 'good' can, therefore, be seen as an example of stake inoculation (Potter, 1996b). Stake inoculations function to head off accusations of interest. For example, where accounts or descriptions may be undermined by virtue of the speaker's stake or interest, "stake inoculation presents a counter-interest" (Potter, 1996b, p.128). In Extract 12, by admitting a shortcoming upfront, Dana demonstrates that she is not simply saying what she thinks she should in this context. Consequently, her claim about being aware with respect to breast cancer can be read as authentic, rather than as serving to

present her in a positive light. The specific formulation of this stake inoculation is also typical. The speaker presents the inoculation first (in this case, negative information), then follows with the presentation of the authentic claim.

'I'll admit that I don't feel my breasts'

A second statement of non-recommended behaviour can be seen at lines 3-6 ('I'll admit that I don't feel my breasts as you're supposed to do ...')¹². By explicitly 'admitting' her behaviour, the speaker herself orients to her actions as not being 'right' or 'recommended'. This description, then, can be seen to illustrate notions of health as a moral phenomenon; health practices are represented as behaviours in which individuals should engage, or have to 'admit' to not doing. This discourse was dominant throughout the focus groups analysed, as well as being a theme reported in Crossley's (2003) focus groups.

Dana's 'admission' in Extract 13, therefore, produces a point of discursive tension, and a challenge to her preceding construction of herself as someone who is 'aware' of breast cancer. Several features of the talk are indicative of this tension: repetitions ('I I'll admit ...', line 3; 'I (.) I'm no longer just 50 ...', line 6), hesitations and pauses ('I don't (.) um feel my breasts', lines 3-4; 'I don't (.) I (.) I'm no longer just 50', line 6), and laughter ('I'm well up in my 50s ((laughs))', lines 6-7). Indeed, Dana orients to such a tension by then working to provide an account of her behaviour with respect to breast cancer screening. In managing the contradiction

¹² Dana says that 'they say you should be doing [breast self-examination] regular on a weekly basis' (lines 5-6). However, recommendations at the time of the focus groups were that women should carry out *monthly* breast self-examination (not weekly). Nevertheless, the focus here is on the participants' orientation to, and accounts of, 'non-recommended' behaviour, rather than any objective criteria regarding recommendations. For that reason, I have taken Dana's description as an account of 'non-

between her positioning as 'good' and 'responsible', and her admission of a non-recommended practice, she firstly reaffirms her earlier subjectivity construction: she is still 'good', having had 'two of the um mammograms that they, are sort of regulation' (lines 7-8).

Subsequently, Dana downplays the role of emotion in her behaviour ('I have never really worried terribly much about breast cancer', lines 10-11). This formulation works to present 'not worrying' as a justification for non-recommended behaviour, and is in contrast to the depiction of other people's 'unhealthy' as being motivated by emotion. The role of emotion in health behaviours is thus re-constructed here. Despite the pattern throughout the discussion groups of connecting 'unhealthy' or 'non-recommended' behaviour with emotion, irrationality and irresponsibility, the speaker in this sequence draws on a lack of anxiety to account for her own 'non-recommended' behaviour. Furthermore, her lack of anxiety and emotion around breast cancer is depicted as a justifiable and rational response to the mammograms she has had: 'everything's been fine' (line 9).

I will examine Jenny's sequence of talk in more detail shortly, but it should be noted here that in accounting for her 'unhealthy' smoking behaviour, Jenny can also be seen to minimise the role of emotion (in this case, 'caring' - 'I still smoke, I don't care', line 31). This formulation, as with Dana's account earlier in the extract, functions to present 'not caring' as a part of an explanation for 'non-recommended' or 'risky' behaviour.

recommended' behaviour because she orients to it as such; the features of her account can therefore be

These accounts of ‘unhealthy’ or ‘non-recommended’ behaviour are particularly notable when considered in light of the analysis of media accounts presented in Chapter 4. In these reports, I argued that emotion was constructed as leading to ill-formed decisions regarding preventative health behaviours and, correspondingly, that appropriate decisions are marked, in part, by their basis in rational thought. In the reports I examined, prophylactic mastectomy was accounted for in a popular magazine article, to some degree, by representing the choice to undergo surgery as rational, while the unsuccessful surgery depicted in a current affairs television program was presented as having been based on a decision motivated by emotion. Furthermore, in the focus group accounts of other people’s behaviour analysed above, a dominant way of accounting for ‘unhealthy’ or ‘risky’ behaviour was to construct (usually hypothetical) others as being motivated by emotion, rather than a rational decision-making process. This motivation was largely represented as flawed, and was contrasted with the participants’ own behaviours. As with the media accounts analysed in Chapter 4, the focus group talk typically presented appropriate decisions as being rational, not emotional.

In Extract 12, in accounting for their own ‘unhealthy’ or ‘non-recommended’ behaviours, the speakers depicted themselves in terms of a lack of emotion. In doing so, the focus of their accounts was arguably the process motivating the behaviour, not the behaviour itself. That is, the behaviour - despite being ‘unhealthy’ – was, in part, justified because it was not motivated by emotion. Therefore, although the talk in this extract was concerned with ‘non-recommended’ behaviour, it drew on a

seen as relevant here.

pattern that was prevalent throughout the data analysed in this thesis: decisions that are not based in emotion were constructed as superior.

In this general pattern, emotional decisions were, correspondingly, depicted as being problematic. In the talk in Extract 12, however, an implication follows that ‘worrying’ or ‘caring’ (which can be considered emotional states) can be read as potentially motivating recommended health behaviours. That is, if Dana and Jenny worried or cared more, they would potentially change their behaviour.

Edwards (1997, p.170) has argued that what he calls ‘emotion discourse’ is “rich and various, full of contrasts and alternatives, and marvellously useful in working up descriptions of human actions, interpersonal relations, and in handling accountability”. That is, by investigating the use of emotion discourse in talk-in-interaction, Edwards has demonstrated how emotion talk can be drawn on flexibly to work up either side of a series of dichotomies, for example, *emotions as irrational versus rational*. He argues that, in relation to this dichotomy, emotion discourse can be seen to construct emotions as both irrational feelings in contrast to cognitions (as in the *60 Minutes* account of prophylactic mastectomy examined in Chapter 4), and as rational and understandable in particular circumstances (as they potentially could be seen to be if they motivated health behaviours). For example, Dana’s description of her lack of worry can be seen as rational in the context of her non-problematic mammograms.

Accordingly, although emotions have often been argued to be defined as “irrational and subjective, unconscious rather than deliberate, genuine rather than artificial,

feelings rather than thoughts” (Edwards, 1997, p.170), understanding emotion from a discursive perspective allows us to see it in more complex, flexible and even contradictory terms. Emotions can therefore be seen, in talk and text, to be constructed as either (or both) irrational, or as “sensible and rationally based”, despite the inherent contradiction in these meanings.

In the focus group data analysed in this chapter, emotion discourse can be seen as deployed flexibly in accounts of both screening and not screening. In Extract 12, for example, a lack of ‘worrying’ or ‘caring’ can be argued to contribute to an account of not screening. By implication, engaging in these emotions could be seen to lead to screening behaviour. In contrast, in accounts of other women’s behaviour, the focus group participants presented rationality, information and awareness as necessarily leading to the uptake of recommended behaviours. This contrast, arguably, points to the flexible ways in which speakers can account for their own and others’ behaviours. More specifically, these differences highlight the ways in which the categories of ‘emotion’ and ‘reason’ can be drawn on flexibly to accomplish different results. That is, the categories of emotion and rationality can be seen to make sense of a range of variable activities, and to negotiate complex issues of accountability.

In Dana’s talk in Extract 12, ‘not worrying’ can be seen to minimise the problematic nature of her lack of screening behaviour. Further, immediately preceding her statement about not worrying, Dana can be read as demonstrating appreciation for her lack of symptoms (‘thank goodness everything’s been fine’, line 9). This utterance functions to position her as appreciative of her health and aware of the

severity of the issues, again bolstering her subjectivity construction as responsible: she is not careless or uninformed with respect to breast cancer. This statement could also be read as providing weight to her lack of worry, by constructing this as being a reasonable response to her non-problematic mammograms.

Having accounted for not carrying out recommended health behaviours (lines 1-11), Dana reaffirms that she is still a responsible woman who takes the threat of breast cancer seriously ('if there was any suggestion I would move fast, yes ((laughs))', lines 11-12). The focus group talk then continues following her turn, without any noticeable pause, suggesting that her management of responsibility and rationality in accounting for her breast screening behaviour is taken up as unproblematic in this context. Specifically, it is me, as the interviewer/moderator of the group (and, therefore, arguably the principle arbiter of acceptable answers in this context), who takes up the next turn in the interaction. By beginning a new topic, marked by the question at lines 13-14, I indicate approval and acceptance of Dana's account of her behaviour, and of her turn as having appropriately 'closed' the last topic.

In closing her account ('if there was any suggestion I would move fast yes', lines 11-12), Dana could be argued to be using a similar 'closing' device to those that Wilkinson and Kitzinger (2000) identified in focus groups with cancer patients. Their participants tended to finish a speaking turn, particularly one where they had been discussing negative experiences, by talking about 'thinking positive'. The authors argue that the use of this idiom functioned as a discursive strategy to wrap up a turn in the focus group context, and to allow the conversation to move on. Furthermore, it allowed participants to assert a representation of themselves as someone who 'thinks

positive’ – a characteristic which is argued to be highly desirable and even morally preferable in a cancer patient – despite having provided a negative account of their experience. In this way, it was argued that the use of the idiom ‘thinking positive’ potentially functioned to facilitate the expression of negative experiences or emotions, what Wilkinson and Kitzinger (2000) referred to as ‘troubles telling’: “[i]f a speaker can establish that she is basically someone who thinks positively, then she can speak about her pain, suffering and distress without unsettling others or attracting censure” (p.806).

Despite having talked about not doing what ‘they’ recommend, and as not really worrying about breast cancer, Dana ends her turn by drawing on a claim about what she would do if there was ‘any suggestion [of breast cancer]’ (‘I would move fast, yes’), followed by laughter (lines 11-12). It could be argued that, as with the idiomatic use of ‘thinking positive’, this strategy is effective in “keeping the conversation moving and creating the opportunity for someone else to speak next” (Wilkinson & Kitzinger, 2000, p.803). Furthermore, this discursive strategy allows Dana to assert that she is someone who takes breast cancer seriously and responsibly, subsequent to speaking about undesirable behaviours.

The ‘yes’ uttered by Dana before her laughter at line 12 could also potentially be read as a positive answer to some earlier question. The last question explicitly asked by the interviewer before the talk in Extract 12 took place was about whether the participants thought they had any characteristics that would place them at risk (see Extract 9 above). The subsequent talk (also in Extract 9) was dominated by the other two participants in this group (Elizabeth and Jenny), and included a contrast between

‘the people with lumps who don’t do anything about it’ (lines 23-24, Extract 9) and the participants, who would ‘be [at the doctor’s]’ (line 37, Extract 9). In this context, Dana’s turn of speech, and specifically her ‘yes’ at line 11, can be read as allowing her to establish a sense of agreement with the other participants, and as taking up a shared subject position as ‘good’ and ‘responsible’, while still voicing an account of ‘negative’ behaviours.

‘I still smoke, I don’t care’

A third account of ‘unhealthy’ behaviour presented in this extract occurred in Jenny’s section of talk. Specifically, at line 31, Jenny states that she ‘still smoke[s]’. I now turn to an examination of this sequence of talk, with a particular focus on the ways in which her account of smoking is introduced and managed. I have presented Jenny’s turn in the extract again for ease of reference.

15 **Jenny:** Well there doesn’t seem to be does it, there doesn’t seem
16 to be any (.) well I don’t know of any there could well
17 be (.) some research (.) findings that I haven’t heard
18 about but um (.) in all the advertising and so on there’s
19 (.) what they talk about is prevention through / Yeah /
20 regular tests and you know being checked out and so on
21 (.) there’s nev- and I mean I (.) would have thought that
22 if there was something we could do: (.) um they’d be
23 telling us that (.) so you know don’t eat (.) kiwi fruit
24 or
25 [something or you know and you wouldn’t eat it I guess]
26 [(everyone laughs)]
27 um:: but there doesn’t seem to be any um well at this
28 stage any research I guess any (.) indicators (.) uh it’s
29 not like saying well you know if you smoke you’re likely
30 to get lung cancer (.) you know then you take your

31 cha:nces, I still smoke, I don't care, but um (.)
32 ((laughter)) very old habit, very hard to break
33 ((laughter)) but you know if (.) I'm su:re if there was
34 something they could tell us (.) that then (.) you know
35 people would make (.) °informed decisions or uninformed
36 decisions >depending on how you like to think about it<°
37 (.) about (.) whether or not they'd put themselves at
38 risk so (.)

In the turn of talk presented here, the relationship between emotion and health behaviours was again reconstructed. I will also examine how the speaker (Jenny) reframed what it means to be responsible. Initially though, I will demonstrate how Jenny's talk repeated patterns that appeared throughout the focus group data. In particular, Jenny positioned herself as aware of recommendations with respect to breast cancer, and as doing everything she can to prevent the disease, despite the dilemma inherent in reliance on 'experts'. The working-up of this self-monitoring and responsible subject position thus functioned to present her in a favourable way in the context of the focus group, while also managing her stake in the interaction.

This portrayal of Jenny as aware of recommendations, and as following them, was in particular worked up in the first part of the extract, where Jenny responded to my question regarding preventative measures for breast cancer. Jenny acknowledged the possibility that there is some way to prevent breast cancer that she does not know about, but presented this as not being a likelihood: 'there doesn't seem to be does it' (lines 15-18). This rhetorical question ('does it') could be read as managing the possibility that others in the group (including the interviewer) did know of ways to prevent the disease. Similarly, Jenny drew on the formulation 'there doesn't *seem* to

be' (emphasis added), rather than, for example, 'there's not'. This more hesitant claim potentially allows her, again, to manage a possible challenge from others in the group. Given Jenny's pause and repair at line 16 ('there doesn't seem to be any (.) well I don't know of any'), and the subsequent modifier at lines 16-18 ('there could well be some research findings that I haven't heard about'), she can be read here as managing potential challenges to her initial claim. Further, at line 18, her 'but um', followed by a pause, could also mark some hesitation in her turn, which is followed by a move to indicate a source of her information (and, correspondingly, the reason for her *lack* of information if, in fact, there are research findings she hasn't heard about). By referring to 'advertising and so on' (line 18), Jenny is able to show that she does the 'right' thing by paying attention to the information being disseminated in the wider community – she is positioned as aware and informed - while shifting emphasis away from herself as responsible for researching and finding out herself.

This shifting of responsibility between individuals (to be aware of recommendations, and to carry them out), and health promotion and doctors (to provide the correct information) was a theme that ran throughout the focus group data. It was also central in the television account of prophylactic mastectomy analysed in Chapter 4, in which a woman relied on information from her doctor, whose judgement was later questioned. I argued that, ultimately, the account positioned the woman (rather than the doctor) as responsible for her negative, and possibly unnecessary, surgery. A similar dilemma was noted in Lyons and Griffin's (2003) analysis of self-help texts related to menopause. In these texts, there was a tension between women being expected to take individual responsibility for the 'management' of menopause, while menopause was simultaneously constructed as a medical 'condition'. The

representation of menopause as a medical condition functioned to afford the medical profession expert status and thus position women as reliant on their guidance and information. In Extract 12 above, a parallel dilemma is worked up in Jenny's talk: she takes up a position as someone who tries to be aware of research findings, but she is reliant on information from 'advertising and so on' and, as such, there could be relevant information regarding prevention of which she is not aware. This lack of awareness, however, is portrayed as not due to the inadequacy of her attempts to be informed.

The construction of information as coming from other (expert) people is further worked up in lines 19-25. Here, Jenny refers to an undefined 'they'. This could indicate advertisers, given the reference to 'advertising' at line 18, but could also indicate a broader category of doctors, medical researchers, and health promoters who might know how to prevent breast cancer. It is 'they' who are charged with the responsibility, at line 22, of 'telling us' what to do. A logical, rational series of events is subsequently built up, in which, if women such as the speaker knew how to prevent the disease (e.g., 'don't eat kiwi fruit', line 23), as responsible women, they would do so ('you wouldn't eat it', line 25). As such, it could be argued that Jenny presented herself as a rational, responsible woman, who is compliant with health recommendations.

Jenny then draws on a contrast between preventative strategies for breast and lung cancer ('it's not like saying ... if you smoke you're likely to get lung cancer', lines 28-29), to bolster the point that no such preventative recommendations exist for breast cancer. As a smoker herself, though, Jenny can be seen to be subsequently

faced with a dilemma, a challenge to her earlier construction of herself as a rational, responsible woman who does the 'right' thing. This dilemma can be seen in the talk particularly by virtue of the laughter, which could be seen to be indicating some conversational awkwardness.

In accounting for her 'unhealthy' smoking behaviour, the speaker here downplays the role of emotion in her behaviour ('I still smoke, I don't care', line 31). This construction functions to position her as making a decision not to engage in such behaviour, despite her knowledge of the risks involved ('you're likely to get lung cancer', lines 29-30). Additionally, Jenny deploys the idea of 'habit' to account for her behaviour ('very old habit, very hard to break', line 32). This discourse of addiction points to the long-term nature of her smoking, and functions, in conjunction with her lack of 'care', to justify her behaviour. Furthermore, it could be argued that Jenny's lack of 'care' is explicable in terms of the more powerful state of 'habit' (or addiction): a feature of addiction could be seen to be a lack of caring about the behaviour. In this sense, the description of her smoking behaviour as long-term and habitual could be seen to provide a reason why she does not 'care'. As with Dana's admission of not following recommendations with respect to breast self-examination analysed above, Jenny's talk here could be argued to position her as aware of the risks involved in her behaviour. That is, she is not simply uninformed or emotional, in contrast to the description of other women who do not follow recommendations or engage in 'risky' behaviour.

Furthermore, Jenny redefines what it means to do the 'right' thing; that is, to have information regarding the prevention of cancer, and to do the appropriate thing with

such information. Rather than arguing, as she had with the hypothetical 'kiwi fruit' example, that if 'they' recommend a behaviour, 'you' in turn follow whatever their recommendations are, at lines 30-31, she introduces the notion of 'taking your chances'. That is, the talk here constructs a scenario whereby, having been informed about preventative strategies, risk-assessment (rather than simply following recommendations) is an appropriate response. Indeed, from lines 33-38, Jenny continues this redefinition of her earlier claim that a rational response to knowledge of illness prevention is to do what 'they' recommend. Subsequent to accounting for her 'non-recommended' smoking behaviour, she presents a revised version of what rational people would do given information about how to prevent illness. Instead of simply acting as recommended, as she previously argued, she now draws on a construction of informed decision-making, rather than specific behaviours, as the desired outcome of health promotion.

Notice, in particular, the 'if X, then Y' formulation of Jenny's claims about appropriate responses to medical recommendations. Prior to her admission of smoking, she claimed that 'if there was something we could do ... [then] they'd be telling us that ... and you wouldn't eat it [for example]' (lines 22-25). Later, at lines 33-34, the first part of this clause is repeated, but the second part is reconstructed: 'if there was something they could tell us ... then ... people would make informed decisions ...' (lines 33-34). Such a reconstruction clearly demonstrates the reframing of a reasonable response to expert's advice and recommendations.

That is, Jenny now allows for the possibility of being aware and rational, and making a risk assessment and subsequent decision *against* what is recommended. In this

amended construction, it is appropriate for women to make their own informed decisions and risk-assessments of their behaviour. These decisions are depicted as incorporating both medical recommendations, as well as how the women feel, and the degree to which they 'care' about the risks they are taking. This construction allows for a representation in which it is appropriate, acceptable and rational to make a decision against what 'they' recommend, when the decision is informed and women take responsibility for the possibility that they are 'taking their chances' and 'putting themselves at risk' (lines 30-31, 37-38). Defining appropriate and accountable health behaviour in this way, at this point in the talk, arguably functions to maintain Jenny's own subjectivity construction as a responsible, rational person, despite her potentially 'risky' smoking behaviour: she is aware of the understood connection between smoking and lung cancer, but chooses to 'take her chances' nonetheless. More broadly, this rhetorical organisation demonstrates a way in which individuals can subtly engage in resistance to health recommendations.

I have focused, here, on instances in which focus group participants talked about 'unhealthy' or non-recommended behaviour. Firstly, Dana talking about not 'pushing things with [her] health' and not engaging in breast self-examination and, also, Jenny talking about smoking. In these instances, the women both constructed themselves as self-monitoring and as engaging in recommended behaviours. I have argued that such positioning contributes to a positive self-presentation in the context of the focus group interaction, and in our culture more widely.

Having worked to construct themselves as responsible in this regard, they both then faced a dilemma when they described behaviour that may challenge this subjectivity

construction. To resolve this tension, they accounted for their 'risky' or 'unhealthy' behaviour in ways that allows them to maintain their position as responsible. Specifically, both participants could be seen to construct themselves as feeling a lack of emotion with respect to their health behaviours. This construction was in contrast to the representation of other women's 'non-recommended' practices as being based on emotion, misinformation and irresponsibility. Furthermore, in the final account analysed here, this reframing of the reasons for non-recommended behaviour was extended more explicitly. In this sequence of talk, it was constructed as reasonable and appropriate to reject recommendations, as long as individuals are informed and aware.

In summary, I want to highlight how the psychological categories of thinking and feeling were drawn on at different points in the women's talk, depending on what they were trying to *do* with their talk. That is, we could see them talking about 'knowing', 'being aware' and 'making decisions' when they were working to construct themselves as 'good', 'moral' and 'rational'. In contrast, they talked about not 'worrying' and 'caring' when they wanted to minimise behaviour that is not recommended. This was despite the repeated construction of other people's unhealthy behaviour as being the result of emotion and a lack of rationality, and therefore flawed.

6.4 Conclusion

This chapter has examined the ways in which talk about health risk and responsibility was constructed and deployed in the context of focus groups. Hepburn argues that "to understand a social problem ... we have to be aware of the discursive limits

employed in the way that the problem is constructed” (Hepburn, 1997, p.27). If we understand screening compliance as a problem then, we need to investigate the discursive limits employed in talk about screening, and in justifying ‘problem’ or ‘risky’ health behaviour. Such an investigation may help us to better understand the representations and subject positions that are currently available to women and which may influence why they screen or do not screen, or more widely, why they do or do not engage in recommended ‘health’ behaviours.

In examining the discursive limits employed in this series of discussion groups, several patterns emerged. Participants tended to construct themselves as self-monitoring with respect to health, aware of risks and as doing the ‘right’ thing - that which is recommended. Specifically, the women generally presented themselves as complying with recommendations about breast screening, such as attending mammograms and carrying out breast self-examinations. As part of this management of their own subjectivity as responsible, the participants repeatedly constructed an uninformed, irresponsible and irrational ‘other’ whose behaviours were seen as unhealthy and even risky. As such, it could be argued that participants engaged in discursive work that mirrored that of health promotional material, representing recommended behaviours as good, responsible and the right thing to do, and negatively portraying individuals who do not comply.

In providing accounts of their own ‘unhealthy’ behaviours, however, participants discursively renegotiated the limits of what was constructed as ‘healthy’ and appropriate. That is, although they generally represented themselves as doing what is recommended, they were also able to provide accounts of not following

recommendations. Furthermore, these accounts of non-recommended behaviour were organised such that they did not appear contradictory to the participants' subjectivity constructions as responsible women. The accounts did this primarily by: (1) using admission of 'unhealthy' behaviour as a form of stake inoculation in ways that made other claims appear authentic; (2) reframing the previously constructed relationship between emotion and health behaviours; and (3) renegotiating and re-constructing what it means to be responsible with respect to health behaviours. That is, a dominant subject position taken up by the participants was as individuals who are aware of risks, seek information, and take responsibility for their own decisions, even if that meant deciding not to engage in 'healthy' behaviours.

These constructions can be seen to reflect a series of ideological dilemmas for individuals with respect to health behaviours. For example, individuals can be seen as reliant on experts for information, but also as morally required to be active and responsible about managing their own health and potential illness. Additionally, although individuals are constructed as expected to do the 'right' thing, they are also afforded the freedom to make their own choices about their health behaviours (even the 'wrong' ones) without restriction. The participants also oriented to a tension between the notion that individuals should do what is recommended, and the representation of recommendations as multiple and sometimes contradictory, thus precluding straightforward compliance. That is, although participants negatively portrayed those who do not follow recommendations, they also drew on the notion that it would be impossible to follow *all* health recommendations, thus warranting some negotiation (and possible resistance) of medical guidelines and advice.

This management of risky behaviour could be argued to lead to two implications. Firstly, participants provided rhetorically persuasive accounts of their own 'unhealthy' behaviour that allowed them to maintain an identity constructed as good and responsible in the local context. The production of these accounts, that could have appeared contradictory and inconsistent, illustrated the ways in which language can be used flexibly to accomplish a range of actions. Secondly, the ways in which participants managed their identity discursively has implications for the broader subject positions that are culturally available. That is, the ways in which speakers presented as not caring about health risks, while also representing themselves as responsible and informed, may indicate some of the broader ways in which individuals discursively engage in resistance to health promotional messages. These kinds of findings can therefore be seen as having relevance for the design of health promotional campaigns and public health messages, which have tended to work from the notion that education is the key to behaviour modification. Instead, the analysis here has drawn attention to some of the ways in which speakers can take up a position as educated, but still resist behaviour modification.

This analysis has thus shown a range of sequences of talk-in-interaction where we can see participants using language to manage and negotiate complex issues of responsibility and accountability with respect to health behaviours. Particularly, I have illustrated some of the ways in which women drew upon various discourses of responsibility and constructed various subject positions for themselves and medical experts. For example, the women represented screening, and following doctors' or medical experts' advice, as responsible and the right thing to do. Correspondingly, engaging in 'risky' behaviour was constructed as 'silly'. However, the participants

also drew on a discourse of scepticism with respect to doctors, as well as renegotiating issues of responsibility when accounting for their own 'risky' behaviour.

It is important to consider that these discussions took place in a specific context and, as such, the women's talk can be seen to be functioning to position them in specific ways and manage issues of accountability within that context. However, I hope to have demonstrated how aspects of the participants' talk can be seen to be illustrative of, and have implications for, the wider political and cultural context in contemporary Western societies. It has been argued that, in this wider context, health is increasingly about assessing and managing risks, and about individuals being more active and responsible for their own health. At the same time, as can be seen in the focus group talk analysed here, the notion of responsibility for health is clearly complex. From a health promotional perspective, this analysis provides further evidence that persuading more women to screen needs to involve more sophisticated and nuanced strategies than simply attempting to make women aware that screening programs exist and are recommended by medical experts.

By providing a close examination of ways in which speakers negotiate, challenge and provide alternative (often contradictory) constructions in talk, I hope to have shown how participants orient to the local context of their talk (in this case, focus groups for research purposes). Additionally, participants have been shown here to draw on broader interpretative resources that have specific histories and relevance in contexts outside of the immediate conversation. That is, the participants' talk can be seen as (re)producing dominant repertoires surrounding health, risk and responsibility. It is

therefore hoped that this analysis has indicated some of the benefits of taking a synthetic discursive perspective to investigate issues around health behaviours, particularly in terms of highlighting the multiple and flexible ways in which meanings can be deployed in talk.

As well as adding weight to critical and discursive analyses of health psychological issues, the analysis presented here also raises some important issues for health promotion and public health. For example, while placing responsibility on individuals for managing their own health and potential illness can be seen as potentially empowering, the simultaneous construction of health as a moral phenomenon may have negative implications for people who do become ill. It has also been suggested that attaching moral value to health behaviours allows for the possibility of individuals expressing subversive or alternative moral values through ‘unhealthy’ behaviours, for example, as has been discussed in relation to young people, or some sections of the gay community (Crossley, 2003). In this sense, engaging in ‘risky’ behaviours can be framed in terms of resistance to authority, and to stereotypical middle-class norms of security and safety (Rofes, 1998, cited in Crossley, 2003).

In my analysis of media accounts and health promotional pamphlets in Chapters 4 and 5 respectively, I argued that, in line with theorising around developments in modern democratic societies, women were positioned as ‘patients without symptoms’, who are responsible for the accurate assessment and successful management of their own health risks. In the focus group talk analysed in this chapter, notions around responsibility for health were more flexibly constructed and

deployed as the participants engaged, in their talk, in the local business of meaning-making, accounting and managing stake. The participants repeatedly positioned themselves as responsible and as doing the 'right' thing throughout the discussion. In contrast, other people who do the 'wrong' thing (in terms of not following health recommendations) were typically positioned as uninformed, irresponsible and emotional. This construction of other people is similar to the ways in which the young woman undergoing a prophylactic mastectomy was positioned in the *60 Minutes* television account examined in Chapter 4. I argued that the woman was positioned as emotional, misinformed and as not taking responsibility for appropriate health behaviours. Ultimately, these features were constructed as leading to her unsuccessful surgery, and as inappropriate in relation to the management of health and illness. This discursive theme around emotion, misinformation and irresponsibility was evident in both this media account and in the participants' focus group talk.

However, there were also instances in which the focus group participants oriented to their own unhealthy behaviours. They accounted for such non-recommended behaviours by reconstructing what is reasonable and appropriate with respect to emotion, responsibility and health behaviours, in ways that enabled them to maintain a subject position as responsible. Related to this was the repeated discussion of choice, and freedom of choice, as well as the negotiation of issues concerning rights and responsibilities. The themes I have explored here also highlight some important contradictions, variations and dilemmas that have currency in talk around health, and that are particularly relevant to health promotion and public health strategies.

In the final chapter, I will provide a summary of the analytic chapters of the thesis, before proceeding to look in more detail at the sorts of implications that can be drawn from the analysis.

Chapter 7

Conclusions:

Moving towards a critical public health psychology

7.1 Introduction

This dissertation has been concerned with providing a discursive analysis of accounts of breast cancer screening, risk and prevention. As such, the thesis has provided an analysis of empirical data (media texts, health promotional campaign material and women's focus group talk), investigating the ways in which language is used flexibly to negotiate issues of risk and responsibility for health. A further aim was to consider implications of dominant discursive practices surrounding issues of breast cancer screening and prevention.

Chapter 2 outlined the analytic approach that informed the analysis in later chapters: broadly speaking, a critical discursive approach based on a social constructionist conceptualisation of language. Chapter 3 then outlined some background concerning breast cancer screening, risk and prevention; public health; and sociological theorising about contemporary health-care, to provide a context for the analysis in the thesis.

Specifically, Chapter 3 highlighted that debate and controversy in public, academic, and professional medical forums surround the various treatments and techniques that are currently used in detecting breast cancer, and in managing risk of the disease

(see, e.g., Baxter & The Canadian Task Force on Preventive Health Care, 2001; Langlands, 1998; Meiser, Butow, Barratt et al., 2000; Meiser, Butow, Friedlander et al., 2000; Nekhlyudov & Fletcher, 2001). For example, despite health promotion strategies recommending screening to women, there is no consistent 'expert' medical or public health opinion regarding the efficacy of mammography, or the age at which women should be targeted for such screening. As a result, there are varied recommendations for women across nations and from different organizations. Breast self-examination has also been the topic of ongoing debate. Furthermore, there is no generally-accepted course of action for women with a family history of breast cancer, and those who are categorized as being at 'high risk' due to the results of genetic testing. One option for these women, which is the focus of ongoing research and debate, is bilateral prophylactic mastectomy, or the removal of their healthy breasts. In Chapter 3, I provided further discussion of the debates and research surrounding these preventative health-care options for women at risk of breast cancer.

Additionally in Chapter 3, I discussed the broader historical and theoretical context of current risk management and preventative strategies for breast cancer. In particular, it was suggested that there have been shifts in understandings of health and health-care in modern liberal democratic societies that have led to an increased emphasis on risk, as well as an increased focus on individual responsibility for health and risk management (Bunton, 1997; Nettleton, 1997; Petersen, 1997; Petersen & Lupton, 1996). The societies in which these shifts have taken place are typically those in Western democratic nations that are governed by liberal principles of freedom and (regulated) autonomy for citizens. It has been argued that, in these societies, public health strategies have been extended over time to now include

interventions in ‘healthy’ people’s lives on the basis of ‘risk’. Individuals are now more often encouraged, and even feel obliged, to take responsibility for their health, scrutinise their lives and make appropriate changes. That is, not only has focus shifted away from illness *per se* to include risk of future illness, it has also, arguably, been shifted further on to individual responsibility for managing health and potential disease. Breast cancer risk, and the associated management and detection techniques, can be seen as a contemporary public health issue that demonstrates these shifts in conceptualisations of health and health-care.

Given the debate surrounding the various techniques that are currently available to detect and manage breast cancer risk, and the sociological theorising about shifts in understandings of health and health-care, the analytic chapters in this thesis focused on exploring the ways in which issues around breast cancer screening, risk and prevention were discursively worked up and negotiated in a range of data. I will now present a summary of the analytic chapters of the thesis (Chapters 4-6), and go on to look in more detail at some implications that can be drawn from the analysis presented.

7.2 A summary of the analytic chapters

The analytic chapters in this dissertation were shaped around three sources of data: media accounts, health promotional material, and focus group talk.

Chapter 4 focused on a discursive analysis of media accounts of prophylactic mastectomy. Two reports (one from a popular women’s magazine, and one a transcript of a current affairs television program) were chosen to be analysed in

detail, given their contrasting depictions of prophylactic surgery. The media has been argued to have a powerful influence on public understandings of health and illness and, as such, the aim of the analysis in this chapter was to explore the ways in which prophylactic mastectomy was constructed, and in which women undergoing the procedure were positioned, in these popular media accounts.

Both accounts that were analysed focused on individual women with a family history of breast cancer who had undergone a bilateral prophylactic mastectomy. However, one report presented the procedure as reasonable and warranted, whereas the other represented the decision to have surgery as emotionally-motivated, potentially misled, and, ultimately, flawed and leading to unsuccessful surgery.

In particular, I examined how a popular women's magazine article, 'Fiona farewells her breasts', worked up a construction of the removal of a woman's non-symptomatic breasts as rational and reasonable. This is despite the procedure being subject to considerable debate and controversy in the public arena, and in the academic literature where some researchers have argued that women's decisions to undergo such radical surgery have more to do with 'high anxiety' and 'overestimation' of breast cancer risk. It was argued that this magazine account drew on traditional gendered discourses of femininity and motherhood to position the woman in the account almost exclusively as a mother. Furthermore, the woman was constructed as almost certain to develop breast cancer and die without preventative surgery. The decision to undergo prophylactic mastectomy, while depicted as involving an implicit personal sacrifice, was therefore presented as a way in which

she could manage both her personal responsibility for her own health, and her responsibility to protect and care for her children.

I also explored ways in which a second woman's prophylactic mastectomy was accounted for in the transcript of a popular current affairs television program, *60 Minutes*. In this account, in contrast to the other report, the operation was constructed as a failure – the woman in the account was represented as unhappy with her reconstructed breasts, and as enduring more pain and negative consequences than she expected. In addition, she was given a second version of her 'at risk' status following her surgery. Further, based on this second risk calculation, the report represented a second doctor as questioning the recommendation of surgery. This account thus drew on the conflicting (and potentially inaccurate) opinions of medical experts in order to depict this young woman's decision to undergo prophylactic mastectomy as uninformed, irrational, and potentially unnecessary.

The *60 Minutes* television account of prophylactic mastectomy, like the magazine article 'Fiona farewells her breasts', was argued to draw on and perpetuate a construction of individuals as 'patients without symptoms' – a notion salient in theorising about contemporary public health. Furthermore, both accounts were argued to reproduce the notion of individuals in contemporary Western cultures as needing to take responsibility for the rational, objective and independent management of their own health risks. In the television report, the woman was positioned as not taking this responsibility but, rather, as being emotional and misled in her risk assessment and management. Her surgery was depicted as unsuccessful, and her story 'compelling', 'dramatic' and a warning to other women. In the

magazine account, on the other hand, the woman was positioned as taking rational responsibility, not only for her own health, but also regarding her obligations as a mother.

In *Chapter 5*, I examined another important site at which meanings around health and illness (and, more specifically, risk management) are worked up: health promotional material publicising breast cancer screening. Discursive analysis was undertaken on a sample of pamphlets, and focused on the pamphlets' positioning of women as 'at risk' of breast cancer, and as responsible for the management of their risk status.

Specifically, I argued that the pamphlets drew on a range of forms of quantification to position all women, not just those in 'high risk' categories, as 'at risk' of breast cancer. These included the maximisation of lifetime risk and mortality rates, and of age as a risk factor, and the minimisation of family history as a risk factor. Quantification was also employed to construct screening as linked to a reduction in risk. In addition, minimisation of the risk of developing breast cancer was persuasively undermined with the use of two-part rhetorical structures, constructing action as required even if the risk is not significantly high. This form of minimisation was also considered as managing the possibility that women might respond to the discursive maximisation of breast cancer risk with fear and inaction.

In addition, the pamphlets were argued to position women as responsible for their own risk management. In particular, I focused on the positioning of women as rational, and as having the 'right' to health, as well as the construction of

mammography as fallible. I argued that the emphasis on women as responsible for their own risk management, although unsurprising in this local context of material promoting screening, reproduces a broader discourse of increasing individual responsibility, typical to shifts in modern democratic societies. Furthermore, the reproduction and dominance of this discourse potentially functions to deflect attention away from other sites of intervention and prevention, and also from broader determinants of health and illness, such as poverty.

Finally, *Chapter 6* focused on an analysis of women's focus group talk about breast cancer risk, screening and prevention. Given current debate surrounding these issues, and recent theorising about shifts in understandings of health and health-care, the aim in Chapter 6 was to explore the way women themselves talk about these issues.

There were several patterns in the women's focus group talk. Participants tended to construct themselves as self-monitoring with respect to health, as aware of risks and as doing the 'right' (i.e., recommended) thing. Specifically, in the context of being asked about their breast screening behaviours by a researcher who was (to some extent) an expert, the women generally presented themselves as complying with recommendations about breast screening, such as attending for mammograms and carrying out breast self-examinations. Participants constructed other people who do not comply with recommendations as uninformed, irresponsible and irrational. As such, it could be argued that participants engaged in discursive work that reflected the recommendations encouraged in health promotional material; they represented recommended behaviours as good, responsible and the right thing to do, and were critical of individuals that do not comply.

In providing accounts of their own 'unhealthy' behaviours, however, participants discursively renegotiated the limits of what was constructed as 'healthy' and responsible. That is, although they generally represented themselves as doing what is recommended, they were also able to provide accounts of not following recommendations that did not appear contradictory or lead to abandonment of their subjectivity construction as responsible women. They did this primarily by reframing and reconstructing their description of what it means to engage appropriately with health recommendations. That is, where previously, other people not complying with 'good' health behaviour were positioned as uninformed, emotional or irresponsible, the participants reframed their own non-compliance in terms of a legitimate lack of worry or care, and making an informed decision to 'take their chances'. Appropriate health behaviour was thus reconstructed as not necessarily doing the 'right' thing, but as being aware, as making an informed choice, and as taking responsibility for one's own decisions.

I also argued that the women's focus group talk indicated a series of contemporary ideological dilemmas around health and health behaviours. For example, individuals were constructed as morally required to take responsibility for managing their own health and potential illness, but they were also positioned as reliant on experts for information. This dilemma was also evident in the media accounts analysed in Chapter 4. Another dilemma related to the positioning of individuals as having the freedom to make their own choices about their health behaviours (even the 'wrong' ones) without restriction, while also being constructed as being expected to do the 'right' thing. Furthermore, there was some tension in the participants' talk between

the idea that individuals should do what is recommended, and the construction of recommendations as multiple and sometimes contradictory, thus precluding straightforward compliance. The analysis in Chapter 6 thus illustrated a range of sequences of talk-in-interaction where participants could be seen to be deploying language to manage and negotiate complex issues of responsibility and accountability with respect to health behaviours.

In conclusion, this dissertation has focused on providing a discursive analysis of three different data sets to explore the discourses surrounding breast cancer risk, screening and prevention. Chapters 4 and 5 focused on textual data, in which, I have argued, women were typically positioned as ‘patients without symptoms’, and as responsible for the accurate assessment and successful management of their own health risks. Furthermore, these texts (particularly, the media accounts of prophylactic mastectomy) functioned to normalise the range of interventions women can be expected to consider and possibly take up in the name of their health-care. As examined in the analysis of ‘Fiona farewells her breasts’, such normalising can intersect with the reproduction of traditional discourses of femininity, linking women’s responsibility for health to their responsibilities as mothers. In contrast to the earlier chapters, in the focus group talk analysed in Chapter 6, notions around responsibility for health were more flexibly constructed and deployed as the participants engaged, in their talk, in the local business of meaning-making, accounting and managing stake.

Typically, material in each of the data sets represented screening and prevention as beneficial and important. Moreover, in each of the data sources analysed in this

thesis, a dichotomy of emotionality/rationality was deployed in constructing ‘good’ health behaviour, with preference given to rationality. This preference can be seen in the repeated discussion, across all sites, of autonomous and informed decision-making as being a key aspect of responsible health behaviour. Only in the women’s focus group talk were the dominant notions of rationality and responsibility, with respect to preventative health behaviours, constructed differently. In this context, a form of ‘resistance’ to recommended behaviours was drawn upon. This type of accounting was absent from both the media data and the health promotional material, and will be discussed further below.

Another repeated feature that appeared in all three data sets related to the issue of gender. The specific ways in which rationality and responsibility were worked up across all sites, involved the reproduction of traditional notions of femininity and womanhood. The dominance of gender in accounts of responsibility for health was most notable in the media representation of successful prophylactic mastectomy that was analysed in Chapter 4, but it also appeared in the discourse of ‘taking care of yourself’ that was identified in the health promotional material analysed in Chapter 5, as well as in the construction of women as prioritising others’ needs that was drawn upon in some of the focus group talk analysed in Chapter 6.

7.3 Implications of the findings

In this section, I will consider possible implications of the analyses that have been presented. First, I will discuss implications for public health and health promotion, and then, also for critical work in the area of public health psychology.

7.3.1 Implications for public health and health promotion

The analysis in this dissertation has highlighted some important variations and dilemmas in talk and text around health and illness prevention that are relevant to, and have implications for, broader health promotion and public health strategies. Firstly, I want to highlight the repeated construction, across each of the data sets, of health as a moral phenomenon. That is, in the media accounts, health promotional material, and in the women's focus group talk, screening and preventative health were represented as morally required. In particular, participants in the focus groups typically claimed to do the 'right' thing, with respect to breast cancer screening and other health behaviours. Furthermore, they criticised those who do not. This dominant theme in the women's talk can be seen as a positive finding for health promotion, indicating that messages regarding the importance of screening are being taken up in women's talk.

Despite this finding, however, focus group participants also worked to account discursively for their own 'unhealthy' behaviours, by redefining 'good' health behaviour in this context. This second point is arguably the main analytic point from this research for public health and health promotion: despite the dominant construction of screening behaviour as reasonable, rational and responsible, women have available to them the discursive resources to negotiate what is considered healthy and responsible. That is, this analysis draws attention to discursive means by which individuals can resist health promotional messages. This 'resistance' is achieved by the reconstruction of 'appropriate' health behaviour, and the making available of a subject position for women that allows them both to be seen as reasonable and responsible, and to account for non-recommended behaviours. As

Lupton (1994b, p.161) writes, there is “the possibility of resistance as long as there are attempts to access or develop alternative discourses from which individuals may construct subjectivity”. In relation to these data, then, it can be argued that although the women in the focus groups typically represented themselves as complying with public health (or medical) recommendations (and, as such, (re)produced contemporary understandings of individuals as responsible for their own health), they simultaneously drew on persuasive discourses to resist such recommendations while maintaining an identity as responsible and informed.

It should be noted here that the participants in the focus group discussions analysed in Chapter 6 were all middle-class, Anglo or European descent Australians, and the majority were also well-educated. Women from other demographic groups, particularly those with lower income and/or education levels, and those from some ethnic and racial groups, have been reported not to participate in regular mammographic screening, relative to other groups of women (Breen, Kessler, & Brown, 1996). The extent to which the findings from this analysis can be generalised to other groups of women is, therefore, uncertain.

Furthermore, there are potentially many ways to ‘resist’ compliant, recommended health behaviour (see, for example, Crossley’s (2001, 2002, 2003) work on resistance and health behaviours, particularly regarding the prestige afforded resistant health behaviours in particular societal groups or cultures, e.g., some sections of the gay community). However, what is specifically of note about the focus group talk analysed in this dissertation, is that the women were accounting for ‘resistant’ behaviours, without taking up subject positions as ‘resistant’. That is, they talked

about non-recommended behaviours, but were able to account for them while still constructing themselves as informed and responsible. The notion of responsibility for health can thus be understood as complex and able to be negotiated, challenged and reproduced in talk. As such, from a health promotional perspective, persuading women to screen (or other individuals to take up recommended health behaviours) is clearly a more complex task than making them aware that screening programs exist and are recommended. Considering the ways in which women engage discursively in resistance may assist in understanding the reasons why some campaigns may not work, and in producing campaigns that are more effective.

For example, the ways in which participants were able to put together accounts of their 'unhealthy' behaviour and maintain their identity as good and responsible in the local context may have implications for broader subject positions that are culturally available with respect to health behaviours. If it is not problematic to present oneself as 'not caring' or 'not worrying' about health risks in the context of a research focus group, this points to a potential resource in our culture to account for not complying with recommended behaviours. As examined in Chapter 5, health promotional material tends to draw on constructions of health behaviours and decisions as the outcome of a rational subject. However, based on the analytic findings in Chapter 6, it could be argued that such campaigns might become more effective by deploying the kinds of discourses that women drew on in accounting for their non-compliant health behaviours. These kinds of findings, therefore, have potential relevance for the design of health promotional campaigns and public health messages.

It is also hoped that the research presented in this dissertation has contributed to the move towards consideration of the social and discursive aspects of understanding health, and the benefits of qualitative and discursive analyses in informing public health, health promotion and health psychology. By providing a close examination of the discourses deployed in examples of media accounts and health promotional material, and of the ways in which speakers negotiate, challenge and provide alternative constructions in talk, I hope to have shown some of the benefits of taking a discursive approach to health psychological research. Furthermore, it is hoped that the multiple and flexible ways in which meanings can be drawn on and constructed in talk and text have been highlighted. The representations of health and illness that have contemporary currency are of particular importance because such portrayals have functions and implications. Most notably, they construct individuals' ideas and beliefs about health and illness, create and reproduce meaning, and (perhaps most importantly), mediate lived experiences (Lyons, 2000).

7.3.2 Implications for critical (public) health psychology

It is also hoped that the analysis in this thesis makes some contribution to the growing fields of critical (public) health psychology. As discussed in Chapter 2 (section 2.3), critical health psychology can be thought of as being concerned with examining assumptions and implications of health psychological research and practice, and dominant understandings of health and illness. The aim of such critical work in health psychology is not to be oppositional to other health research and practice but, rather, to contribute to the development of an ethical, reflexive and critical field as a whole (Murray, 2004b). In this section, I will first reflect on the research process, and on the approach to research taken in this thesis, in terms of its

usefulness for critical public health, and critical health psychology. I will then turn to a consideration of the implications of the research findings for critical (public) health psychology.

Reflections on the research process and approach

The research presented here aimed to draw on a synthetic discursive approach to analysis in order to examine and reflect critically on the assumptions and implications of talk and text concerned with breast cancer screening, risk and prevention. This approach, which was outlined in detail in Chapter 2, was chosen due to its dual focus on the talk and text analysed: both the local, detailed functions, as well as broader implications were considered. I would argue that this approach to analysis did prove to be valuable in the research process. Specifically, it enabled me to consider a broader range of features of the data than would have been the case had the analytic focus been, solely, on either the fine detail of the language used, or the historically- and culturally-located nature of the truths constructed in the language.

The advantages of the synthetic discursive approach were, perhaps, most obvious in the analysis of the focus group talk. The nature of these data - women's talk - allowed the conversation-analytic perspective to be taken up more fully than at the other, textual data sites. Particularly, the detailed transcription of the focus group talk contained immense detail that was able to be considered in the analysis. However, in all three data sets, the action-oriented and constructive nature of language was considered at both the micro and macro levels. Consequently, the analysis throughout the thesis considered how particular historically- and culturally-located constructions

of health, risk, and responsibility were worked up in each local context, as well as the functions such constructions might have.

Furthermore, the specific data sites that were chosen for analysis in this thesis allowed for examination of constructions of health, risk, and responsibility in three *different* local contexts. Accordingly, different local functions were served by the specific accounts of breast cancer screening, risk and prevention. However, similarities between the discourses drawn on across the sources of data – for example, discourses relating to rationality, responsibility, and femininity - allowed for a consideration of the broader implications of dominant social constructions. These will be discussed below.

Reflections on the implications of the findings

The analysis presented in this thesis has highlighted ways in which notions around health and responsibility are worked up in a variety of talk and text, such that there is an increasing emphasis on risk and prevention, which is linked to an increasing medicalisation of ‘healthy’ individuals’ lives. I have argued that this construction corresponds with the notion of ‘patients without symptoms’ (Finkler, 2000), whereby individuals, who would previously have been considered ‘healthy’, are now taking up roles as ‘patients’, engaging (and increasingly being expected to engage) in surveillance of their bodies, including undergoing preventative medical procedures. As Thornton and Dixon-Woods (2002, p.725) write, “[s]creening is the business of changing identities; it is the business of producing patients”. Amongst the potentially problematic implications of the ‘patient’ identity, it has been argued that the emphasis on screening, risk and prevention has created a “risk conscious citizen”

who “demands” screening services (Thornton & Dixon-Woods, 2002, p.725). Despite on-going debate and inconclusive evidence regarding many screening procedures (including those surrounding breast cancer screening and preventative techniques), medical professionals can, thus, be seen to be positioned as service-providers who must supply ‘patients’ - consumers of the health-care system - with screening. That is, through the ‘normalising’ of screening and medical interventions that aim to prevent illness, “a new subjectivity is constituted ... one that constitutes the person as both patient and consumer” (Hogle, 2001, p.330).

Despite these critiques, the shift towards increased medicalisation can potentially be seen as a positive development for improving the overall health of the public, and my aim has not been to criticise attempts to prevent illness or to suggest that breast cancer screening and prevention should not be carried out. However, as part of a critical approach to public health, I have endeavoured to draw attention to potentially problematic implications of the ways in which such increasing medicalisation is being carried out. For example, it could be seen as problematic that extreme preventative behaviours, such as prophylactic mastectomy, are being normalised with reference to traditional discourses of femininity. Such ways of sense-making are therefore reproduced, subsequently locating women within specific dominant gendered subject positions, such as ‘mother’, that carry with them a range of political implications, including those affecting areas outside of health outcomes. The repeated reproduction of these particular constructions of women, and of their roles and responsibilities with respect to health, makes them readily available as commonsense accounting practices in relation to risk management and preventative behaviour. It could therefore be argued that women’s risk management and broader

health decisions are potentially shaped by the kinds of discourses and subject positions examined here.

The dominant construction, in the data analysed here, of individuals as ‘at risk’ and as ‘patients without symptoms’ also functions to perpetuate notions of individual responsibility for, and self-regulation of, health risks. Again, this construction is not necessarily problematic *per se*; however, I hope to have contributed to work aiming to reflect critically on ways in which such a construction is reproduced, as well as to consider its potential implications. For example, the increasing emphasis on individual responsibility for health and health-care, and the linking of such responsibility to moral obligations, could be argued to have negative implications for individuals who become ill. Additionally, such constructions of risk and responsibility may also produce increasingly restrictive subject positions for individuals, as more and more behaviours become associated with ‘lifestyle’ diseases. Consequently, individuals can increasingly be seen as ‘at risk’. As discussed above, this state of being ‘at risk’ and, therefore, medicalised, produces new identities and subjectivities. That is, the process of medicalisation shapes “the way in which individuals think about their health and their bodies” (Hogle, 2001, p.329). Furthermore, the ‘at risk’ status subsequently afforded to individuals becomes a “lived or experienced state of ill-health ... a state of being” (Gifford, 1986, p.215). In this way, risk itself becomes an illness to be diagnosed and managed, and one for which individuals must take responsibility.

Another way in which the developing emphasis on risk and prevention - what Armstrong (1995) has referred to as ‘surveillance medicine’ - is re-defining health

and illness, and the identities available to individuals, is by incorporating a temporal component. That is, illness comes to be seen as having a specific history, and individuals (and populations) are encouraged to engage in early detection (to stop illness early in its history), or prevention (to intervene even earlier). Furthermore, this temporal dimension of illness impacts on the identities of individuals, positioning them in relation to this “temporal space of possibility” (Armstrong, 1995). Thus, within surveillance medicine, individuals have to manage the possibility that they *will* develop (or are always already developing) illness; they are ‘perpetual patients without symptoms’ (Finkler, 2000).

This shifting of the boundaries of what, and *who*, we consider to be ‘healthy’ and ‘ill’, thus allows for a focusing of attention onto specific medical technologies, such as genetic testing and chemoprevention. Although such technologies are often associated with discourses of promise, there have been cautions raised about their potential impact in public health practice, and their capacity to produce new forms of surveillance, control and marginalisation (Hogle, 2001; Petersen, 1998).

While acknowledging the potential benefits of such technologies, and of preventative health-care more generally, I would argue that the emphasis on individual responsibility for health could become problematic if it deflects attention away from interventions aimed at other, more structural, influences of health and illness. For example, poverty remains the strongest determinant of ill-health and death in the world (Marks, 2004; Murray, 2004a). Advancing genetic technologies, increasing numbers of preventative surgeries, and concern with the lifestyle factors influencing health – typically developments occurring within the privileged sections of Western

nations – could all be argued to be drawing attention and resources away from the need for equitable access to services and resources for disadvantaged individuals and communities within Western nations, as well as from the worsening poverty crises continuing to affect individuals in developing nations.

7.4 Concluding thoughts

In titling this conclusion chapter, I have drawn on Lerner's (2003) notion of moving 'towards' a critical, ethical and reflexive endeavour¹³. In writing about moving 'towards' critical therapy, he commented that "a critical therapy is open-ended, something we continually approach rather than arrive at" (p. 26). Similarly, I would argue that the aims of a critical public health psychology – to build an ethical, reflexive and socially-engaged public health and health psychology (Murray, 2004b) – are part of an ongoing project, with shifting goalposts. That is, there is not really a final or conclusive point at which we will have created a critical, ethical health psychology or public health but, rather, this endeavour is a continually shifting one, in which what it means to be critical and ethical with respect to health and health-care continually need to be reflected upon.

Therefore, I feel that it is important, in concluding my thesis, to note that in attempting to highlight some of the ways in which preventative behaviour is discursively constructed, my aim has not been to argue against, or criticise attempts to prevent illness. Nor has my aim been to make recommendations for individual women about screening and preventative behaviours with respect to breast cancer.

¹³ I was also influenced in this by the title of Murray's conclusion chapter in his edited book, *Critical Health Psychology*, "Towards a Critical Health Psychology" (Murray, 2004a).

Rather, as part of the move towards a critical (public) health psychology, the aim was to examine critically some of the ways in which accounting for screening and preventative behaviour takes place, and to contribute to the opening up of a space in which the implications of such construction might be further explored and debated. Talk and text about health and illness, and particularly gendered illness, are sites at which cultural constructions of the body, health, and gender are reproduced. By subjecting such representations to continued detailed examination - exploring, for example, how particular positionings and implications are accomplished - we increase the potential for challenge to these dominant constructions, and open up space for possible alternatives. There remains a strong responsibility for health psychologists and health promoters to reflect critically on the ways in which discourses surrounding breast cancer risk, screening and prevention (as well as those relating to other illnesses) shape the subject positions, and ways of being and living, that are available for all individuals.

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Appendices

Appendix 1: ‘Fiona farewells her breasts’, *New Idea*, March 30, 2002

Appendix 2: ‘Stieve’s story’, *60 Minutes*, March 3, 2002

Appendix 3: Pamphlets 1-8 analysed in Chapter 5; reproduced with the permission of BreastScreen Australia, BreastScreen SA, The Cancer Council SA, and the National Breast Cancer Centre

Appendix 4: Information sheet given to potential focus group participants

Appendix 5: ‘Prompt’ questions / discussion topics used in focus groups

Appendix 6: Consent form for focus group participants

Appendix 7: Transcription conventions used in transcribing focus groups

Appendix 1: 'Fiona farewells her breasts', *New Idea*, March 30, 2002

1 **In order to safeguard her family's future - and her own**
2 **life - one woman has taken the boldest step yet against breast**
3 **cancer**

4 Just a short walk from the hub of Brisbane's city centre,
5 Fiona Lobegeier is sitting inside her modest motel room
6 anxiously staring at the clock on the wall. The only thing on
7 the young mum's mind as the traffic whirls past on the street
8 below her balcony is that time is quickly running out before
9 she must follow through on the most difficult decision of her
10 life.

11 Fiona, from Bundaberg, Qld, has only hours to go before
12 she makes the short trip to a nearby hospital, where she is
13 booked in for a procedure at 6am the next day. Yet she has
14 chosen to speak exclusively to *New Idea* to tell why - even
15 though she has a clean bill of health - she has opted to have a
16 double mastectomy.

17 'The reason I've decided to do this is simple - I just
18 want to live,' says 35-year-old Fiona, who admits her tragic
19 family history led her to her painful decision.

20 'I lost my mum Dawn to ovarian cancer, and she lost not
21 only her mother to breast cancer but also one sister at 32 and
22 another at 40 to the disease.

23 'My own sister, who is only 43, has had one breast
24 removed due to cancer and has had her other breast taken off as
25 a preventative measure.'

26 Fiona sadly reveals that she has also lost four cousins
27 on her mother's side of the family to the disease.

28 'Unfortunately, like so many women in my family, I too
29 carry the gene mutant for breast cancer. While I may be fine at
30 the moment I'm doing this as a life insurance policy. I want to
31 be around to be a mother to my children.'

32 Fiona - mum to Ben, 12, Hayden, 10, and Lauren, 6 - says
33 she's been a size 18DD 'forever', but call her brave and she
34 quickly corrects you.

35 'It's nothing to do with being brave. I'm actually a
36 coward, but I didn't see that I had a choice in it,' she says.

37 'When Mum was diagnosed she was told she had three weeks
38 to live. Instead she survived for three agonising years, and
39 that was a hell and a suffering I don't ever want my own
40 children to see their mother go through.

41 'It has taken me six months to make up my mind to go
42 ahead with this. Recently I was helping my best friend get her

43 daughter ready for prom night, and Lauren looked up at me and
44 said: "Mummy, will you help me look like a fairy princess on my
45 prom night?"

46 'She's only six, and that's along way off, so I'm going
47 to do everything I can to make sure I'm here to make that dream
48 come true for her.'

49 Fiona says her decision was made much harder because of
50 negative attitudes from her friends.

51 'I'm a Christian, and one woman told me I had no right to
52 play God by doing this. That really hurt and I don't understand
53 that attitude.'

54 But Raymond, her husband of 17 years, is supportive of
55 her decision.

56 'He just wants me alive and has basically left the
57 decision in my hands. But he reassured me that even if I didn't
58 have reconstruction surgery he'd still love me.

59 'Basically he said he'd rather have me with him than a
60 pair of boobs in a coffin.

61 'The only thing I know for sure at the moment is that
62 while some people may question what I'm doing, a lot of women
63 have never had a choice. I count myself as one of the lucky
64 ones.'

65 POSTSCRIPT: Fiona has now endured the 11-hour marathon
66 surgery and pauses to reflect on her decision.

67 'The operation has been a huge financial drain on our
68 family. It's also caused some problems with my husband, but
69 that's understandable, because from a male point of view I went
70 into hospital with natural breasts and came out without them,'
71 explains Fiona.

72 'I no longer have any sensation in my breasts and I still
73 have to have a further operation to reattach my nipples.

74 'It's been a tough three months in more ways than one,
75 but I'm a fighter. Since the operation another one of my
76 cousins has had a breast removed, and she's only 39,' Fiona
77 adds sadly. 'If I ever have any doubts I just tell myself that
78 because of my decision, the reward is that I get to live.

79 'That's a very big incentive.

Appendix 2: 'Stieve's story', 60 Minutes, March 3, 2002

1 It was a year ago that Tara Brown met a young woman called
2 Stieve. With a family history of breast cancer, Stieve was
3 frightened.

4 She'd become convinced that she had the breast cancer gene and
5 that gene could lead her to contract the cancer that kills more
6 women in Australia than any other.

7 Her story was so compelling that Tara followed her for many
8 months as Stieve wrestled with an awful decision – should she, at
9 just 29, surgically remove both her breasts?

10 This is a story to make every woman stop and think – with a
11 most dramatic outcome.

12 INTRO –

13 TARA BROWN: It was a year ago that I met a young woman called
14 Stieve. With a family history of breast cancer,
15 Stieve was frightened. She'd become convinced that
16 she had the breast cancer gene and that gene could
17 lead her to contract the cancer that kills more
18 women in Australia than any other. Her story was so
19 compelling that we followed her for many months as
20 she wrestled with an awful decision. Should she, at
21 just 29, surgically remove both her breasts? This
22 is a truly moving story, with a most dramatic
23 outcome.

24 STORY –

25 TARA BROWN: Stieve Duke is 29 years old. An Australian who now
26 lives in London, she has a family history of breast
27 cancer and fears she's a prime candidate. Soon,
28 she'll have an operation to have both her breasts
29 removed. This plaster cast is to remember them by.
30 "Cancer" must have been a word that you were
31 familiar with from a very young age.

32 STIEVE DUKE: I grew up with it. I don't remember ever not
33 knowing it. It's similar to knowing you're adopted
34 and never questioning it. I've always known that
35 there was cancer in the family. I've never not
36 known it. It's like living with a shadow behind you
37 the whole time, waiting for the day. It's like it's
38 the day that I – I go to bed and I feel for lumps
39 and I think, is this the day I find one? Was that
40 there yesterday? Am I imagining it? It plays on you
41 every day.

42 MARGARET DUKE: She's not on her own being afraid of it because
43 there are many, many people that are afraid.

44 TARA BROWN: Margaret is Stieve's mum. Margaret's mother, sister
45 and, she believes, her grandmother all had breast
46 cancer. In 1981, concerned by her family history,
47 Margaret had a double mastectomy. She understands
48 why Stieve is about to go through the same
49 operation. Stieve talks about breast cancer being a
50 shadow that's followed her since about the age of
51 four.

52 MARGARET DUKE: She had a lot of fears and this was one of her
53 fears, one of them, and you know, when we talked
54 about it she'd quite often go away and say, "I
55 don't want to know," because it frightened her,
56 yes.

57 TARA BROWN: Two years ago, Stieve, a part-time model and
58 painter, found a lump in one breast. Although
59 benign, it scared her into thinking seriously about
60 having her breasts removed.

61 STIEVE DUKE: I have the looming idea of more lumps coming, more
62 operations, more tests, more scans, and I'm sick of
63 it. I don't want it any more.

64 NIGEL SAX: How long have you been thinking about doing this?

65 STIEVE DUKE: Two years.

66 TARA BROWN: Stieve's fear is real, and for a small number of
67 high-risk women, a double mastectomy will save
68 their lives. In most cases, those women have
69 inherited a defective breast cancer gene, located
70 by genetic test. In other cases, so strong is the
71 family history, doctors are convinced there are
72 other defective breast cancer genes science has not
73 yet identified. Although the genetic test for
74 Stieve's family was negative, she still feels she
75 can only achieve peace of mind through a double
76 mastectomy and a breast reconstruction. So, last
77 April, Stieve went to Nigel Sax, an Australian
78 surgeon practising in London. Stieve provided him
79 with information about her family history.

80 NIGEL SAX: As we discussed, there is a very strong family
81 history which means there's almost certainly a
82 breast cancer predisposing gene in your family, as
83 you know.

84 STIEVE DUKE: Yep, yep.

85 NIGEL SAX: They haven't been able to identify which gene it is
86 as yet.

87 STIEVE DUKE: Yes.

88 NIGEL SAX: And as you know, there's a 50-50 chance that you
89 will have inherited that gene.

90 TARA BROWN: There's discussion about how Stieve's reconstructed
91 breasts might look.
92 STIEVE DUKE: Is it at all possible instead of ... to have them
93 sort of literally just straight rather than
94 initially ...
95 NIGEL SAX: Facing out?
96 STIEVE DUKE: Yes.
97 NIGEL SAX: They will tend to do that a bit...
98 TARA BROWN: And advice on some of the possible side effects.
99 NIGEL SAX: You know there won't be any feeling in the nipple?
100 STIEVE DUKE: Yes, I know that.
101 TARA BROWN: Did her age worry you at all?
102 NIGEL SAX: No, because if the whole reason for doing an
103 operation at that age is you get a greater
104 percentage benefit. If you operate on somebody at
105 the age of 50, a lot of their risk has already
106 passed by then, so the potential benefit is less.
107 TARA BROWN: Who would you not do this operation on?
108 NIGEL SAX: I wouldn't do it on someone I didn't think was
109 properly understanding as to what their real risks
110 were and what the potential benefit was.
111 TARA BROWN: Are you frightened at all?
112 STIEVE DUKE: A little and then I'm a little excited as well. I'm
113 excited that I'm going to get on with the rest of
114 my life and I'm not going to have ultra sounds
115 every six months. I'm not going to have to watch
116 for lumps, I'm not going to worry people around me
117 who love me. I'm just going to live normally, like
118 normal people do, and I've never lived like that.
119 TARA BROWN: So, you're quite prepared to lose your breasts so
120 you can live like that?
121 STIEVE DUKE: Yep. I think given the same choice, a lot of people
122 would. A lot of people wouldn't and I respect that,
123 I really do, but for my peace of mind, I need to do
124 it for my peace of mind.
125 TARA BROWN: Before the surgery, Stieve seeks reassurance.
126 STIEVE DUKE: You're happy – in your mind, you're happy with
127 that?
128 NIGEL SAX: Yes.
129 STIEVE DUKE: So just – I want to hear it from you.
130 NIGEL SAX: I'm very happy, yes. I'm happy. I mean, if
131 possible, yeah – I mean, given the size of your
132 breasts, I think putting the implant under the skin
133 should be fine. If the skin is a little bit thin or
134 the blood supply is not so good, then it will have
135 to go under the muscle.
136 STIEVE DUKE: Yeah.

137 TARA BROWN: Are you sure this is what you want to do?
138 STIEVE DUKE: No, it is actually the self-determination of what
139 I've done that makes me not nervous.
140 TARA BROWN: Nine days after her first consultation, Stieve goes
141 under the surgeon's knife.
142 NIGEL SAX: She's young, she's very well informed, I think
143 she's thought about it carefully. I think it's
144 reasonable. Given her family history, I think if it
145 was my sister, I'd strongly consider it.
146 TARA BROWN: It's a three-hour operation – a mastectomy and a
147 reconstruction. Do you expect her to recover
148 quickly, considering her age?
149 NIGEL SAX: Considering her superb surgeon, I expect her to
150 recover very quickly ... and her superb anaesthetist.
151 Yeah, I mean, it's quite a big operation. I would
152 think she'd probably be out of hospital by Monday
153 or Tuesday. It will probably take her another two
154 or three weeks to recover completely.
155 TARA BROWN: And that was to be the end of it. But six months
156 later, it's a different story. The two to three
157 weeks recovery period has turned into many months
158 of pain.
159 STIEVE DUKE: I was told that I'd be back at work in three weeks.
160 In three months, I was in no condition. I was
161 still, you know, unable to get myself off the couch
162 at that stage. I couldn't eat, I couldn't sleep, I
163 just was so ill, so it's going to be a long time
164 before I can get back to full-time, daily life
165 again.
166 TARA BROWN: In regards to your breasts, how are you feeling
167 about them today?
168 STIEVE DUKE: I think they're bloody awful. I honestly, and I'm
169 not kidding, I would rather have nothing than have
170 them. They feel that bad.
171 TARA BROWN: Stieve has side-effects she didn't expect.
172 STIEVE DUKE: This nipple has collapsed and gone flat, whereas
173 this one is different. At least this one has tissue
174 behind it and you can move, this one hasn't, and
175 it's changed the whole shape and this – the
176 implants have all rippled and gone out of shape and
177 if I lay down, move, lay back, lift anything, they
178 all – this happens.
179 TARA BROWN: And there's more. The whole of Stieve's breasts
180 have lost sensation. Desperate to reverse the
181 effects of the operation, Stieve seeks help from
182 Professor Robert Mansell.
183 PROFESSOR ROBERT MANSELL:

184 That is the gel you can see moving around.
185 STIEVE DUKE: I can feel the plastic through that.
186 PROFESSOR ROBERT MANSELL:
187 Yes, you can, you can feel the wall. That's very
188 dramatic. You can see the rippling there.
189 TARA BROWN: Professor Mansell is one of the top breast cancer
190 surgeons in Britain.
191 PROFESSOR ROBERT MANSELL:
192 Could I just test whether it's on the muscle, this
193 business of – if you put your hands on your hips.
194 Now press in hard and relax. Press in hard. You can
195 see here what that does – it accentuates the
196 rippling over here.
197 TARA BROWN: Should the surgeon have done anything differently?
198 PROFESSOR ROBERT MANSELL:
199 Well, the trouble is, one of the things is, it's
200 hard to predict precisely what the result is going
201 to be in an individual in enormous detail.
202 TARA BROWN: Professor Mansell sees vision of the operation and
203 consultation.
204 PROFESSOR ROBERT MANSELL:
205 In that interview, you focused on a lot of areas of
206 the shape, the height, which means to me, if I was
207 talking to you about this operation, I would want
208 you to think long and hard about it because I would
209 be telling you that maybe these things wouldn't
210 turn out as well as you would hope.
211 STIEVE DUKE: See, I was under the impression that this was
212 standard fare, easy ...
213 PROFESSOR ROBERT MANSELL:
214 Yes. It's not. One of the things we do here is make
215 sure that people are counselled in great depth,
216 that they see photographs of the scars, that they
217 ideally talk to somebody who has had it done so
218 they can actually talk woman to woman to someone to
219 say, "This is what it's like," and they talk at
220 length to the breast care nurses and counsellors.
221 TARA BROWN: But Stieve is in for a bigger shock yet. All her
222 life, she's believed she's a high-risk candidate
223 for breast cancer. Professor Mansell believes
224 otherwise.
225 PROFESSOR ROBERT MANSELL:
226 I'm going to ask you some simple questions, and
227 then it will tell you what your risk is. So, for
228 instance, your age when your periods started?
229 STIEVE DUKE: 15.

230 TARA BROWN: Using a recently developed test, databanks many
231 geneticists in Britain now rely on, Professor
232 Mansell does some calculations.

233 PROFESSOR ROBERT MANSELL:
234 Okay. Just by pressing a simple button like that,
235 you get a risk. I know it's going to shock you –
236 your lifetime risk is 8.5 percent.

237 STIEVE DUKE: Right. That doesn't take into account my aunt or
238 the fact that my mother had a mastectomy to prevent
239 breast cancer.

240 PROFESSOR ROBERT MANSELL:
241 No, it doesn't matter. It doesn't increase your
242 risk at all. If you haven't got a first-degree
243 relative – a mother or sister – with breast cancer,
244 you're unlikely to be in a very high-risk group.
245 They've not found a gene when they tested the
246 family, so on that simple calculation, I would not
247 have advised you to have this operation.

248 STIEVE DUKE: I find that very subjective.

249 PROFESSOR ROBERT MANSELL:
250 Staggering, isn't it?

251 STIEVE DUKE: No, subjective, because it doesn't count my mother
252 because of her surgery.

253 PROFESSOR ROBERT MANSELL:
254 Okay. But you're in your late twenties now. Even if
255 you're carrying a gene in the family, you don't
256 expect to see the rise in breast cancer until mid-
257 30s. So, you're not even at a time of risk at the
258 moment because risk isn't even throughout all your
259 life.

260 TARA BROWN: Are you okay?

261 STIEVE DUKE: Yeah, fine.

262 PROFESSOR ROBERT MANSELL:
263 But nobody is saying – you see, it may be the right
264 thing for you. I'm not saying it's the wrong thing.
265 I'm not saying you've done a wrong thing. What I'm
266 saying is, you may feel that for you the fear was
267 so great, you had to do it. But you were given a
268 lot of information – a lot of people have told you
269 that you are at high risk, haven't they?

270 STIEVE DUKE: Yes, all my life.

271 PROFESSOR ROBERT MANSELL:
272 Yes.

273 STIEVE DUKE: And then for you to turn around and say that I'm
274 not, it's like ...

275 TARA BROWN: The doctor has said to me that he was driven by her
276 anxiety, that Stieve was so anxious about one day

277 developing cancer, that he was motivated to help
278 relieve that fear. Is that justification for what
279 he has done?

280 PROFESSOR ROBERT MANSELL:
281 We do that every day of the week. That's part of
282 our job. It doesn't mean you have to do surgery to
283 do that. You need explanations, you need to say
284 what the real risk is and you need to give
285 counselling – that's what it should be.

286 TARA BROWN: Dr Nigel Sax declined to take part in another
287 interview with *60 Minutes*. Through his lawyer, he
288 said he had followed best practice guidelines and
289 had recommended Stieve undergo counselling before
290 her operation.
291 For you emotionally, how do you move on from here?

292 STIEVE DUKE: I don't know. I honestly don't know.

293 TARA BROWN: If a 29-year-old woman came to you today and said,
294 "I think I've got a pretty good chance of getting
295 cancer some day in my life?" what would you advise
296 her to do?

297 STIEVE DUKE: I'd advise her to research it properly, which is
298 really, really tough to do if you're not a doctor,
299 but I'd tell her what happened to me and go and
300 find out for herself and then make it with a clear
301 conscience in her mind.

302 TARA BROWN: The National Breast Cancer Centre says just five
303 percent of Australian women have a high risk of
304 breast cancer based on their family history. They
305 recommend that women consult their doctor
306 immediately if they notice any change in their
307 breasts. For more information, you can visit our
308 website after the program.

NOTE: The images on pages 319-335 are in the print copy of the thesis held in the University of Adelaide Library.

Appendix 3: Pamphlets 1-8 analysed in Chapter 5

Appendix 4: *Information sheet given to potential focus group participants*

INFORMATION SHEET

I am seeking volunteers for a study concerned with women's understanding of breast cancer risk and prevention techniques. It does not matter if you have never had breast cancer, or whether you believe yourself to be at risk of breast cancer or not. The purpose of the study is to investigate women's understanding of breast cancer, and their feelings about screening or preventative programs, such as mammography and breast examination.

Participation would involve taking part in a small group discussion with other women – like a focus group. The interview will be tape-recorded, but will be entirely private and confidential. In the reporting of this research, participants' names and any information that might identify them will be changed to ensure anonymity. The tape-recorder can be stopped at any point in the discussion and if there is any issue you would prefer not to discuss, that is fine. A list of the sorts of topics to be discussed in the group will be made available for you to read beforehand. I am estimating that the interviews will take up to an hour, but they could be shorter or longer depending on how much is said. They will take place at a time and place convenient to all participants.

The researchers involved in this study are Dr Amanda LeCouteur (Senior Lecturer in the Department of Psychology, ph: 8303 5557), Dr Deborah Turnbull (Senior Lecturer in the Department of General Practice and the Department of Psychology, ph: 8303 5228) and myself, Shona Crabb (PhD student in the Department of Psychology). If you think you may be interested in participating, or would like further information, please contact me on 8303 3855 or via e-mail (shcrabb@psychology.adelaide.edu.au). Should you have any questions relating to ethical issues relevant to the study, you are invited to contact the Convenor of the Departmental Ethics Sub-Committee, Dr Peter Delin (ph: 8303 5007, email: pdelin@psychology.adelaide.edu.au).

Thank you for your time.

Shona Crabb.

Appendix 5: *'Prompt' questions / discussion topics used in focus groups*

1. Do you think some women have more chance of developing breast cancer than others?
2. What sorts of things do you think increase an individual's risk of developing breast cancer?
3. Do you consider yourself to be at risk of developing breast cancer?
4. Do you think breast cancer can be prevented?
5. Are there behaviors that you believe can influence risk of breast cancer? Or that can prevent breast cancer?
6. What do you think about so-called 'screening' behaviors, e.g. mammography, breast self-examination?
7. Do you engage in any of these screening behaviors? Why/why not?
8. What do you think you would you do if you discovered a lump in your breast?
9. Some women are believed to be at an increased genetic risk of developing breast cancer. One solution that is currently offered is to have their healthy breasts surgically removed to prevent the disease. What do you think about this?
10. If you were in a position where many of your female relatives had suffered from breast cancer, what do you think you would you do?

Appendix 6: Consent form for focus group participants

CONSENT FORM

Participants' name (capitals):

Project title: Women's talk about breast cancer

Name of responsible investigator or supervisor: Dr Amanda LeCouteur, Department of
Psychology, Adelaide University.

Name of person who issues the form: Shona Crabb

1. I consent to participate in the above project. The nature of the project, including questionnaires or procedures, has been explained to me, and is summarized on an information sheet I have been given.
2. I authorize the responsible investigator or the person named above to use these questionnaires or procedures with me.
3. I understand that:
 - (a) I am free to withdraw from the project at any time.
 - (b) The project is for the purpose of research or teaching, and not for treatment.
 - (c) The confidentiality of the information I provide will be safeguarded.
 - (d) There are no known adverse effects of questionnaires or procedures.
 - (e) I can decline to answer any questions if I wish.

Signed:

Date:

(Participant)

Appendix 7: *Transcription conventions used in transcribing focus groups*

[] - overlapping talk

// - interjecting, eg / S: Hmm /

underlining - emphasis

°softer° - indicates speech that is notably softer than that surrounding it

(.) – pause less than 0.1 second long

(0.8) – timed pauses, where 1.0 refers to a second

= - no discernible gap between different speakers

((description)) - description or clarification by transcriber, usually referring to a non-verbal action, e.g. laugh, clap, point

↑↓ - arrows indicate rising or lowering intonation

Lo::ong – colons within words indicate the lengthening of a word; the number of colons is proportionate the lengthening of the sound

>faster< - indicates speech that is notably faster than that surrounding it

Cut o- - sound that is cut off

Commas and question marks also used where necessary to clarify meaning.