Changing Families, Changing Food

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LITERATURE REVIEW: *MAKING HEALTHY FAMILIES*

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LITERATURE REVIEW: *MAKING HEALTHY FAMILIES*

1. FAMILY POLICY AND PARENTING: AN INDIVIDUAL RESPONSIBILITY?

Key points

In 1997 New Labour came to power advocating social inclusion through a communitarian model stressing individual empowerment through "opportunity". There were, however, continuities with the ideology of the New Right, namely the emphasis on individual responsibility. Seen from this perspective, healthy families are created when individuals assume responsible citizenship. While government policy is characterised by ambivalence with regard to what constitutes the ideal family form, the dominant model tends to be constructed as the two-parent family in which both parents are in full-time employment. In this context, good parenting is often reduced to a contractual model that appears based on managerialist principles that can be learned from experts in the public sphere. An alternative model considered below is one based on the ethics of caring that emphasise interdependence and mutuality.

(i) New Labour, social inclusion, the family and individualisation

While broad political consensus used to exist in the UK that one important function of government was to try to combat poverty and to reduce social and economic inequalities, a new era began in 1979. A new government was elected, the leadership of which was driven by a radical political philosophy of neo-liberalism. This was a doctrine that valued freedom from both taxation and high public spending on welfare above the need for large sections of the population to be freed from poverty and social exclusion. State intervention necessary to tackle poverty was redefined as being economically harmful (Walker 1997). In this climate the impact of wider social transformations became constructed in popular discourse as symptoms of individual moral failure, thus resonating with nineteenth-century concepts of the "deserving" and "undeserving" poor (Smart 1997: 303). Once more it became possible to attribute poverty to individual apathy and degeneracy, whilst obscuring its links to the decline of particular industries and the widespread restructuring of the economy. In this process throughout the 1980s and 1990s the ideal of individual autonomy came to be widely defined as a necessary prerequisite for social inclusion.

The emphasis on individual responsibility has continued since New Labour's victory in the general election of 1997. Under New Labour, however, there has been a policy shift away from narrow neo-liberal interpretations of citizenship toward a communitarian model in which the creation of "opportunity" is emphasised and individuals are empowered and encouraged to take responsibility for themselves. Drawing heavily on the thinking of Giddens (1998), who has been highly influential in the assimilation of US libertarian thinking into New Labour's 'third way', policy has aimed to promote forms of

welfare that enable individuals to respond to the challenges posed by contemporary society. This is a position which is based on the assumption that individuals hold the power within them to escape from present circumstances, should they chose to do so. Arguably, therefore the categories of the deserving and undeserving poor remain intact. As Greener (2002: 692) points out "…these ideas are redolent of Victorian ideas about 'character'." Education may make people aware of their position in society and provide them with notions of how to 'move up', but achieving the necessary skills, social networks, knowledge and capital to put this into practice may be hindered by a number of obstacles (Greener, 2002).

New Labour's modernising agenda, while stressing individual responsibility, has also placed the "family" at the core of a number of communitarian-focused policy areas aimed at the creation of social cohesion (Driver and Martell 2002: 46-61). In contrast with previous governments that had supported the "family" while nevertheless regarding it a private sphere, New Labour established a Ministerial Group on the family soon after coming to office in 1997. The intention was to promote "joined up" thinking with regard to family policies (Wasoff and Dey 2000: 131) whilst emphasising the role of the institution of marriage in strengthening family life. Transformations in contemporary family relationships, in particular, increases in cohabitation, divorce and separation, lone parenting and people living alone, were viewed as destabilising family values and undermining the practice of good parenting (Edward and Gillies, 2004). In 1998, the then Home Secretary, Jack Straw stated,

> In our manifesto we committed ourselves to strengthening family life. We promised to 'uphold family life as the most secure means of bringing up children. Families are the core of our society.' (Straw 1998 cited in Adams 2002: 113)

Family-related initiatives have been underpinned by two discursive strands that have embedded in social policy since 1997. First, a "social integrationist discourse" (SID) (Lister 2000: 39), which identifies paid employment as a key issue in creating greater social cohesion. SID also constructs employment as integral to good parenting. (Young 2002: 484). While good parenting in the private sphere is to be encouraged, it is dependent on parents providing children with positive role models through their engagement in paid labour. As Land (1999) and Lister (2000: 41) point out, the result can be that work performed in the domestic sphere, such as caring for children, is effectively devalued. SID is interwoven with a second discursive strand, the "moral underclass discourse" (MUD) which attributes social exclusion to a decline in consensual moral values. From a MUD perspective, this has arisen as a result of the decline of the traditional families. SID and MUD combine to underpin a policy direction that has sought to support parenting practice through the development of a wide range of initiatives, which feature prominently in the 2003 government Green Pape*r Every Child Matters*. As Gillies (2005a, 71) points out, "Although it is emphasized that support is relevant to all parents,

close analysis of this policy reveals a class-specific concern with disadvantaged or "socially excluded" families.

Thus, while ostensibly distancing themselves from the narrow individualism associated with the New Right, New Labour has developed a doctrine that draws on communitarian philosophers such as John Macmurrary (1995) and Amitai Etzioni (1994), which identifies social cohesion as a key component of economic and personal well-being. Despite this ideological shift towards communitarianism, the emphasis on the individual has remained largely intact under New Labour. Paradoxically, the cooperation and reciprocity that are seen as underpinning strong families are viewed as the consequence of engaged moral and *individual* citizenship (Gillies, 2005a). At the same time "third way" family policy promotes the apparently contradictory aims of creating strong families while simultaneously stressing principles associated with the inevitability of change and the democratization of personal relationships, as described by Giddens (1998) and Beck (1997). Government policy therefore appears to contain both a commitment to upholding traditional family values whilst also acknowledging the diversity of contemporary family forms (Feather and Trinder, 2001). Rose (1999) argues that this apparently contradictory position is upheld by a stance that locates social relations as ethical problems that must be individually negotiated. Moral principles underpinning family policy are presented as those of the reasonable citizen and those who fail to live up to them place themselves outside the moral community, thereby 'voluntarily' excluding themselves and threatening social cohesion. While autonomy is to be encouraged, it is expected to fall within a clearly defined and normative moral framework

(ii) Parental duties: a contractual model?

New Labour's approach to family life was laid down in the consultation paper, *Supporting Families* (Home Office, 1998), a document which emphasised the Government's interest in the family as a forum in which the values of good citizenship are learned (Maclean, 2002). As Gillies (2005a: 77) puts it, the very instrumental approach adopted in *Supporting Families* "…depicts parenting not as an intimate relationship, but as an occupation requiring particular knowledge and skills", thereby increasingly isolating parenting practices increasingly from the interpersonal context of the private sphere (Fairclough, 2002). Gillies (2005a: 77) also argues that it is based on the premise that parents should be encouraged to reflect on and regulate their performance, through reference to "expert" training. Parenting is therefore seen as quasi-contractural in nature in that it assumes that parents are independent and atomistic beings who have certain duties that they must discharge towards their children. In a paper relating to the culture of contractual exchange that prevails in higher education, Standish (2005: 59) evokes "the good parent" as follows,

> Think first of the responsible parent who, having paid for the good school, bought clothing of decent quality, and provided nourishing food, feels that she has fully discharged her obligations.

Standish (2005) counters the model of the good parent, who fulfils her duties and obligations, with an alternative model in which virtuousness is to be found in "….the parent (the citizen, the teacher, the student, the lover…) who feels she has never done enough, who has some sense of the infinite possibilities of her relation to the Other." In contrast with the contractual model, this type of obligation can *never* be fulfilled entirely as it cannot be audited or measured by "objective" performance criteria - it is the type of obligation that deepens the more it is responded to… Standish's (2005) argument, developed in response to the closed economy of contractual exchanges within higher education, may be problematic if it is applied uncritically to parenting practices. The construction of motherhood, in particular, inextricably associated as it is with notions of feminine identity (Arendell, 2000), can often contribute to women's burden of guilt in relation to their perceptions (and those of others) of their inadequacy as parents. However, the idea that the contractual fulfilment of obligations and duties does not necessarily lead to "best parenting practice" is an interesting one that deserves further consideration in the light of current social policy. It also resonates with research that focuses on the parents of disabled children in which it is argued that that many parents reject an instrumentalist view of parenting and also distance themselves from individualised interpretations of citizenship that tend to underpin it. Fisher (in press, 2007) argues in relation to the parents of disabled babies studied that narratives were not dominated by notions of the self-sufficient subject who fulfils her duties according to a pre-determined schema of what constitutes effective parenting. Instead, these parental narratives pointed to a sense of identity that is embedded in other-relatedness. To use Frank's term (1985: 35), the "dyadic" subject recognises that '…even though the other is a body outside of mine […] *this other has to do with me, as I with it.* [italics in the original].

This type of subjectivity tends to be associated with values of mutualism and interdependence and is less concerned with the idealised forms of self-sufficiency that so often underpin the delivery of health and social care interventions. According to Williams (2001), these values could form the basis for what she terms "an ethic of care", an ethic which would usefully provide an alternative model to the discourses embedded in current social policy that situate paid work as the first responsibility of citizenship. Such an ethic of caring would validate all caring activities undertaken in both the public and private sphere and would enable both men and women to participate in caring activities and combine these with paid employment. Williams (2001: 474) argues that the current emphasis on paid employment is based upon a traditional notion of a male worker, that is "a relatively mythical self-sufficient being whose care needs and responsibilities are rendered invisible because they are carried out somewhere else, by someone else." Personal autonomy is, according to Williams (2001, 2002), always embedded in relationships of interdependence.

An ethic of caring could, Williams (2001, 2002) suggests, form the basis for a new type of citizenship that recognises everybody as interdependent and having the potential and responsibility to be caring and cared for. Crucially, an ethic of caring would provide the basis for an alternative to counter "third way" orthodoxy that there are three alternative values systems, namely,"the

state collectivist paternalism of Old Labour; the neo-liberal marketised welfare of the New Right; or the responsibilities before rights/positive welfare approach of New Labour/Third Way (Williams, 2002: 504). Based on the principles of autonomy, mutualism and voice, an ethic of caring might offer an alternative to traditional "family values" in a way that would stress the value of diversity and give voice to marginalised groups. It is therefore linked to struggles for "recognition" (Fraser and Honneth, 2003) and, as Willliams (2002: 505) points out, this necessarily raises issues around *how* social and health care services are delivered. An ethic of caring would necessitate a democratisation of the relationships between service users and providers and an acknowledgement of the value of experiential knowledge acquired in the private sphere (Williams, 2002, Fisher, 2007 in press). It would contribute to a culture which enhances the status of both service users *and* the practitioners who provide the services.

2. SOCIAL CONTROL OR EMPOWERMENT

Key points

In late modernity, the responsible citizen is expected to "manage" her or his biography by seeking to improve her or his own "human capital" with recourse to "expert" advice. Government policy encourages the creation of social cohesion through partnerships of various types that aim to work collaboratively with individuals and families. While empowerment is writ large, it has been argued that the type of autonomy that is being fostered is one which remains contained with strictly defined parameters. Reflexivity that questions underlying value systems is not encouraged and expertise that is gained experientially in the private sphere tends to remain unacknowledged.

The creation of partnerships is based on a view of social capital that is overwhelmingly optimistic and tends to underplay structural disadvantage. Through the support provided by partnerships, communities are seen as possessing within themselves the means for their own renewal. To date little research has been conducted into the types of social and cultural capital within organisations involved in partnerships.

Others are suspicious of the emphasis on the community seeing in this a form of "ethopolitics" that operates to rework the government of individuals through the evaluation and regulation of techniques of self-conduct. Individual reflexivity and the complexity of the processes and sites of governmentality, however, provide scope for the development of "resistance" constructed around multiple potential counter-narratives.

(i) Managerialism and social inclusion

The managerialism that characterised the Thatcher and Major eras in the UK was primarily driven by the overarching aim of efficiency savings (Pollitt, 1993). Since 1997 the focus of modern managerialism has been broadened to incorporate new ideas of personhood (Giddens, 1998) that provide the guiding principles underpinning a new ideology of citizenship (du Gay, 2000; Munro, 2003; Newman, 2000; Rose, 1996). The effective citizen is the one who is able to "manage" her or his biography by anticipating and dealing with the risks and opportunities associated with late modernity. Within this paradigm,

notions of risk are heightened and individuals are increasingly expected to seek expert bodies of knowledge and knowledge claims (Lupton, 1999). At the same time, the need to explore personal and social change reflexively is stressed although within the parameters set by “experts”, increasingly defined in managerial rather than in professional terms (Fisher, 2007 in press).

The social inclusion of excluded groups, such as the elderly, people with disabilities, people from minority ethnic backgrounds, and people from economically disadvantaged communities, is sought through the privileging of notions of independence. Citizens are expected to take advantage of all opportunities, often provided through various forms of partnerships, that will invest them with the necessary “human capital” (see Poole, 2000: 109). Social inclusion, some suggest (Ling, 2000: 89) is being attempted through the “colonization of identity” whereby those with marginalised identities are transformed into proponents of mainstream values underpinned by the New Labour vision. This raises the question as to whether interventions organised by state bodies can ever be truly empowering to those on the margins. In response to what she sees as encroaching governance, Nancy Fraser (1997: 81) has suggested that marginalised groups would be better served through the constitution of “subaltern counterpublics” in which they are able to develop “‘counter discourses” and construct oppositional interpretations of their identities and interests.

While empowerment may be writ large in policy documents (see Department of Health, 2004; Department for Education and Skills, 2003) in a manner that acknowledges the creativity of individual employees, self-government is covertly exercised over both service users and service providers in subtle ways (see Gilbert, 2001; Masschelein and Maartins, 2002; McDonald, 2004). Professionals employed within the health and social services are encouraged to transform themselves through self-government into entrepreneurial agents without questioning the underlying value system that limits understandings of autonomy as something to be evaluated, audited and mapped according to pre-determined criteria. Individuality is achieved through the performance of pre-determined learning objectives to be mastered and professional competence is reduced to the process of acquiring skills necessary for efficiency rather than on developing insights that promote critical self-reflection or lead to a greater understanding of people’s diverse lifeworlds (Askhim, 2003).

In relation to an ESRC study on the services and care provided for parents of disabled babies, Fisher (2007, in press) argues that current practices in health and social services can lead to a dismissal of the skills and knowledge that disabled children and their parents acquire in the home environment. In other words, expertise that does not fall within the kind of managerialist framework, famously characterised by Lyotard (1984) as “peformativity”, can be disregarded. Many of the interventions for families with disabled children appear to constitute part of a parent management strategy which constructs knowledge as something that flows from professional to parent and from the public sphere into the private realm. Fisher (2007, in press) suggests that if experiential knowledge, acquired within the private sphere, were to be regarded as legitimate, this might contribute to the creation of more expanded and inclusive forms of care that would not construct difference as a problem

or an abnormality to be resolved through technical and assimilationist programmes. The potential for such a development is not supported in the prevailing culture that values normalisation above diversity and devalues knowledge and skills in the domestic sphere that extend beyond what may be measure and audited. As Tronto (1993: 135) argues, a political order based only on "independence and autonomy […] misses a great deal of experience, and must somehow hide this point elsewhere. For example, such an order must rigidly separate public and private life."

(ii) Community-focused strategies: a site of governmentality?

Influenced by Giddens (1998: 110), who suggested that conventional poverty programmes should be replaced with community-focused approaches, which stress "support networks, self-help and the cultivation of social capital to generate economic renewal in low income neighbourhoods", the emphasis on social capital is strong in "third way" politics. Theoretically, this definition of social capital rests on Putnam's (1995) more optimistic interpretation of social capital as a resource that may be generated along similar lines within communities in spite of their very different social standing. In 1997 Tony Blair, then leader of the British Labour Party (see Etzioni 1997: 139) stated,

> For a society to be communitarian, much of the social conduct must be "regulated" by reliance on the moral voice rather than on the law, and the scope of the law itself must be limited by the moral voice.

Similarly, Straw identified the community as the lynchpin of social cohesion,

> We are trying to develop the concept of "the Active Community" in which the commitment of the individual is backed by the duty of all organisations-in the public sector, the private sector and the voluntary sector-to work towards a community of mutual care and a balance of rights and responsibilities (Straw, 1998, cited in Rose 2000).

Interpreting social capital in overwhelmingly positive terms, Government policy tends to ignore the potential for internally cohesive groups to act in ways that can exclude and marginalise those who do not conform or do not belong (see Wakefield and Poland, 2005). Social capital can develop "in ways that threaten and police more vulnerable segments of marginalised communities." (Cohen, 2001: 273). Amin (2005) takes the view that the current emphasis on local communities has the effect of engendering a new social morality whereby community spirit and participation of a certain kind is viewed as essential for local regeneration. Disadvantaged communities risk being viewed in isolation from wider structural and contextual factors – of being seen as "container spaces that can be rejuvenated through the magic of the community" (p. 629). Failure to do so may result in the effective social pathologisation of areas facing hardships. In a similar vein, it has also been pointed out (Adler and Kwon 2001 in Mackian, 2002) that government policy fails to take account of the fact that the benefits of social capital within one group may potentially be achieved and maintained to the potential detriment of other groups.

Partnerships appear to constitute an important aspect of a public health agenda underpinned by a commitment to the development of social capital (Mackian, 2002). The partnerships, discussed in *The NHS Plan* (DoH, 2000), are intended to promote multi-agency working around common goals, foster the pooling of skills and expertise to reduce ill-health, and bring people together in meaningful interaction in order to create health communities. A new area of research has opened up that focuses on the organisational arrangements needed to promote inter-agency cooperation around a "social model" of public health (O'Keefe and Hogg, 1999). The emphasis in government policy appears to be on links between organisations and the community and the structures required to facilitate this (Googins and Rochlin, 2000). In *Saving Lives* (DoH, 1999), it is explained, "we have introduced a new structure based on partnership working linked to a new duty of cooperation" (DoH, 1999).

A duty of cooperation with communities is not necessarily consistent with the values of community cooperation. It has been noted that with the emphasis on links with the community little attention has been paid to the internal social capital of organisations. Mackian (2002: 208) describes this as, "… a missed opportunity to apply some of this organisational theory to our study of the agencies – within and beyond traditional health care – which are part of these partnerships." There is a need therefore to investigate the culture of the organisations involved in health partnerships in order to explore issues that facilitate partnerships between organisations and between organisations and local communities. Furthermore, an in-depth exploration of the culture and tacit understandings that underpin organisational culture will assist the development of great reflexivity by challenging commonly held assumptions that may be acting as barriers between organisations and hamper links between organisations and local communities. An exploration of organisational cultures needs to take place within a context that acknowledges that partnerships are located within society as a whole (Pratt, et. al., 1999).

(iii) Governmentality and resistance

Rose (2000: 1398) is suspicious of the communitarian emphasis within a framework that also stresses individual responsibility. "Freedom-aspiring" individuals, Rose argues, are encouraged to regard themselves as members of communities, that is of neighbourhoods, associations, regions, ethnicities, and lifestyle sectors. It is from these groupings that individuals should derive the guidelines, techniques, and aspirations by which they think and enact their freedom. The community thus acts as the bedrock of a shared moral framework and its role is to reinforce the ties between individuals within groupings, identified by Rose (2000: 1399) as "shame, guilt, responsibility, obligation, trust, honor, and duty." While the intention is to create a number of "virtuous consequences" such as "reciprocity, mutuality, cooperation, belongingness and identity", Rose sees in this a form of "ethopolitics" that operates to rework the government of individuals in the regulation and evaluation of techniques of self-conduct. This is achieved through the ethical self-regulation of the individual in terms of fixed moral codes and also through

what Rose (2000, 1399) terms “the aesthetic elements in the government of ethics”, that is enabling citizens to create themselves according to a certain art of living. Their willingness to do so is scrutinised by a new moral authorities such as benefits agencies and others. Rose (1999: 192) argues that such “moralizing ethicopolitics” is indicatives of a “will to govern which imposes no limits on itself.”

Nevertheless, the techniques of governmentality can never be simply foisted upon individuals who unquestioningly internalise shared meanings (Foucault, 1980a; Shilling, 1993). Whenever strategies of governmentality are inconsistent with self-image, this may result in personal and/or organised resistance (Burchell, 1991: 119) and the creation of counter-narratives. The term “resistance”, as it is used here, does not primarily denote collective action directed towards challenging specific political ends. Such a definition of resistance is embedded in the modernist notion of a unified self who wishes to overturn the oppressive power of institutions intent on domination. Instead, resistance is being used here in relation to a post-structuralist interpretation of subjectivity as something that is multiple and fragmented. Seen from this perspective, a person may simultaneously subscribe to conflicting views depending on a variety of subject positions that may be adopted. This is consistent with Foucauldian theory that tends to conceptualise power as neither positive or negative but located at the micro level and related to the ways in which individuals either conform, consent or resist the external pressures (Foucault, 1980b). The governed subject may therefore have a highly ambivalent relationship with public health organisations and is likely to both resent state incursions into the domestic sphere whilst simultaneously believing that it is incumbent on the state to take responsibility for citizens’ health (McNay, 1992). The rationales for conformity or non-conformity, compliance and resistance may operate variously or simultaneously within the context of an individual’s lifecourse.

The practices of the “self” are inevitably “mined” from within a range available in a given culture. As Lupton (1995) and Hunter (1993) explain, sites of government include the family, the school, the legal system, and the media and commodity culture. While these form part of the mechanisms of governmentality, they may equally give rise to discourses that counter state imperatives. Rose and Miller (1992: 190) argue that “each actor, each locale, is the point of intersection between forces, and hence a point of potential resistance of any one way of thinking and acting, or a point of organization and promulgation of a different or oppositional programme.” Understanding how individuals negotiate their subjectivity and understandings within competing discourses, both intra-family and public, may be approached through poststructuralist analysis. One advantage of a poststructuralist approach is that it privileges the notion of the self as fragmented and contingent rather than unified. The term “subjectivity” is a less rigid term than identity as it is based on an understanding of the self or selves being changeable, contextual and interdependent although not in a context of their own choosing. Post-structuralist epistemologies tend also to be based on the assumption that there is a ‘…hermeneutic relationship between experience and “story”, in which experience elicits the story, and the story articulates and thereby modifies experience.’ (Widdershoven, 1993: 9). Words cannot be

viewed as separated or merely descriptive of "reality"; instead there is a dialectical relationship between the narratives people draw on and the construction of "realties".

The link between narratives and the construction of self identity is now well theorised (Giddens, 1991; Plummer, 1983; Ricoeur, 1992; Rosenthal, 1993; Taylor, 1989). Fisher and Goodley (in press, 2007) and Fisher (2007 in press) have explored how narratives can be used in ways that resist dominant discourses that frame disability in terms of individual deficits. While people are inevitably shaped by dominant narratives, they do not generally internalise them uncritically but often engage in sophisticated levels of reflexivity. The term reflexivity, as it is being used here, denotes the ability to question pre-given understandings and the often invisible ideology that underpins them. It is therefore not comparable with the type of reflexivity that has been identified as characteristic of the public sector, which aims for reflexivity within certain given parameters (Fisher, 2007 in press). However, reflexivity is not a quality that is acquired in a manner disconnected from environmental and structural factors. While the dispossessed may have an extra impetus to question hegemonic understandings (Fisher, 2007 in press: McRuer and Wilkerson, 2003), there is also evidence to suggest that they may be also be less likely to overtly challenge authority even though they have little trust in it (Warde and Coates, forthcoming). Drawing on the work of Bourdieu (1984) and Shilling (2002), Warde and Coates argue that living in disadvantaged circumstances may affect people's relationship to symbolic knowledge and their perspectives regarding their own agency to overcome institutional injustices. Ironically, those have the most access to financial, time and cultural capital may be the most likely to exercise their agency by challenging authority.

Any analysis of reflexivity and narratives of resistance may also be hampered by people's natural tendency to show themselves and their community in an unduly positive light. Cornwell (1984) distinguishes between "public" and "private" narratives, suggesting that the former may present a romanticised version when compared with "private" accounts that are more problematic to access. Private accounts are also more likely to highlight the different positions occupied by men and women, the old and the young, ethic groups and people of different employment status. As Graham (1993: 24) puts it,

> The institutions most centrally involved in caring – the family, the community and the state – take on a different form. They emerge not as monoliths, solidly uniform and sexless, existing "out there" in the social fabric, but as social structures which carry within them the class and gender relations of a social order which is both capitalist and patriarchal.

Others (see for instance Frankenberg, 1986) dispute this dichotomy between public and private accounts while Finch and Mason (1991: 365) find the "private/public" distinction helpful but argue that it can be "potentially misleading, in that it implies that people have two fixed views of the world, one for public and one for private consumption.

From a poststructuralist perspective, we shall attempt to establish a dialogue with our interviewees in which we seek to uncover "regimes of truths" and taken-for-granted assumptions that frame social reality. Lather (1993: 675) said of such framing, "It is not a matter of looking harder or more closely, but of seeing what frames our seeing – spaces of constructed visibility and incitements to see which constitute power/knowledge." Similarly, Denzin (1997) suggested that good reflexive work is found in what he calls "messy texts", these are "texts that are aware of their own narrative apparatuses, that are sensitive to how reality is socially constructed, and that understand that writing is way.

3. PUBLIC HEALTH: TOWARD INDIVIDUALISATION

Key points

Food interventions were introduced as part of the Government's focus on community renewal through partnerships and multi-agency cooperation. The existing literature tends to focus only on discrete areas such as food mapping, evaluation, and on examining the particular needs of households in disadvantaged areas. The ideology underpinning food interventions appears to be based on the neo-classical economic theory of consumerism and individual choice. The impact of the psychosocial model of social capital is considered and how this may be linked to individualised understandings of health inequalities and a psychologised view of class in terms of personal qualities. Such considerations are also linked to the apparently didactic approaches adopted in much health education practice. While little research has been conducted in this area, it seems that health education programmes often apply techniques that owe much to either the "the process school of education" or a social marketing discourse. The social marketing discourse, in particular, is underpinned by contemporary ideas around the "body beautiful". This rests on an underlying perception of the body as a "commodity", a discourse that is both gendered and closely linked to social class.

(i) Food Policy background

What is sometimes termed "the food economy" (Hitchman et al., 2002) is linked to wider political and social developments. 1979, for instance, is sometimes identified as a year that heralded "a new era of inequality" (Hitchman et al., 2002: 15). The following year, 1980, saw the publication of the Black Report which highlighted inequalities in health linked to diet, among other things. This was effectively dismissed within the new political climate. Little changed for over a decade. *The Health of the Nation* White Paper, published in 1992, set out to decrease death from disease and address health-related issues such as smoking whilst only making a passing reference to the role of poverty and inequalities.

In 1997 New Labour came to power on a political agenda based on a strong commitment to social inclusion. One of the incoming government's first initiatives was the launch of Health Action Zones (HAZ) which were intended

to focus on 3 broad strategic objectives: 1) to identify and address public health needs within local areas; 2) to increase the efficiency and effectiveness of the services; and 3) to foster multi-agency partnerships that would harness local expertise (Bauld et al., 2005). The HAZs were followed by a plethora of other initiatives and "zones" that aimed to tackle a range of issues relating to social inclusion, such as crime, unemployment and teenage pregnancy. These were established in response to growing recognition that a new approach was required to assist "failing" communities and culminated with the development of Local Strategic Partnerships (LSPs) (DETR, 2001) that were set up to consolidate and promote partnership structures, including those within HAZs.

Within this climate of partnerships and "joined up" approaches, a more holistic approach to health was taken up in the White Paper *Saving Lives: Our Healthier Nation* (DoH, 1999) which addressed the complexities underpinning individual health-related, identifying these as linked to early childhood, social, economic and cultural environments as well as individual characteristics. In 1999 the Social Exclusion Unit's Policy Action Team (PAT13) made a significant contribution to the debate by linking food policy with transport, planning, urban and rural regeneration. The development of the connections between food policy and other policy areas was slow to become established (Hitchman et al., 2002) but by 2004 a more "holistic" approach was apparent in the Wanless Report (see Cordell, 2004) which showed growing concern with both personal and structural factors. The Wanless Report identified the key themes in public health as 1) lifestyle factors – for instance, smoking, drinking, diet and lack of exercise; 2) lifecourse approach, that is behaviour learnt in childhood; health inequalities; and, 3) wider determinants, including housing, environment. Targets and evidence were also identified as crucial in focusing efforts and in assessing what workings in public health. In *Choosing Health* (DoH, 2004), these issues were developed in more detail although the main responsibility was remained with the public itself. As the problem was identified as resting mainly with ill-informed individual consumers, the logical choice was to attempt to reduce ill health through public nutrition education programmes (Coveney, 2003).

(ii) Food interventions

A range of health and social care practitioners and agencies are currently advising families on food purchase, preparation and consumption. These practitioners include members of primary care teams - GPs, practice nurses and district nurses - as well as secondary care specialists, such as midwives, nutritionists and dieticians. Other recent developments include initiatives in community and social care settings, embodying attempts to directly influence the daily diets and eating practices of families. Examples of these include "Five-a-Day" projects in day-centres and other community and institutional settings, and "cook and eat" classes within the Sure Start programme. Some of these initiatives are led by Family Support workers, "community food educators" or others in recently developed roles, while others are led by people in established health professions. Current policy documents and

analyses suggest that interventions of these kinds will continue to multiply over the next five years. These developments have been paralleled by an unprecedented concern with healthy eating in the media, especially in popular television.

The existing literature in this area tends to focus either on the discrete area of food mapping (Coufopoulos et al., 2003; Donkin et al., 2000; Dowler et al., 2003) or is based on evaluation (Hackett et al., 2002, 2003) while a number of studies have examined community involvement in community-based health interventions (Rifkin et al., 2000; Sustain, 2000). Research in health promotion and allied areas has focused on debates concerning the affordability and accessibility of healthy food (Cummins and Macintyre, 2002); on evaluating whether or not health promotion messages are being communicated effectively (Kennedy, 2001; Adamson et al., 2000) and on examining the particular needs of households in disadvantaged areas. Here, the notion of "family" itself is often taken for granted, although the importance of recognising lay perspectives on food and health, as well as professional ones, is noted by some (Holm, 2003) and professionals and para-professionals are increasingly being encouraged to work towards a partnership model which values clients' perspectives (Avdi et al., 2000: 329). In contrast, research in social sciences has addressed the ways in which food and mealtimes are discursively embedded in social relationships and powerfully associated with identity (Wiggins, 2004) and with gendered divisions of labour (Kemmer, 2000). While the health related and social policy research bodies form two distinct and fairly extensive bodies of work, there is an absence of rigorous research in which the intersections between both are considered.

Food programmes, first highlighted in the local Health Action Plans as the local answer, have been criticised for channelling national objectives and funding through to deprived communities but without shared agendas and community ownership (Dowler and Caraher, 2003). The view has been put forward that they continue to operate within a policy framework dominated by models of consumer and individual choice rather than public health and citizenship. As Dowler and Caraher (2003: 63) put it, in areas where water is difficult to provide, citizens are not expected to organise a chain of buckets to a community standpipe, so why are people expected to form cooperatives in order to access food? "We don't expect rich people to get up at 4.30 a.m. to buy vegetables for forty-five families for a week, and then spend all morning weighing and bagging them up, unpaid: why should poor people have to do it every week?"

Relating to this last point, it has been noted that the goals of health education have too often focused on changing individual behaviour rather than addressing the underlying causes that promote their behaviour. This issue, which has sometimes been referred to as "victim blaming", is not limited to the UK (see Holm, 2003) and is more generally related to neo-classical economic theory which tends to attribute the production of low quality food to a lack of discretion on behalf of consumers. An interesting finding in Holm's (2003)

study is that, contrary to free-market rhetoric which assumes that producers will attend to quality to attract a market share, competitive marketing practices can lead to practices that decrease the quality of food.

(iii) Social Capital and the individualisation of social class

Two main schools of thought influence debates about social capital. First, Putnam (1995: 67) conceived of social capital as a community level resource and defined it as "features of social organisation such as networks, norms and social trust that facilitate coordination and cooperation for mutual benefit." Putnam (1995) places great emphasis on the importance of "bonding" social capital, a term that refers to the network of ties which holds families and groups together. Bonding social capital is often seen as a particularly valuable resource for disadvantaged groups (Wakefield and Poland, 2005; Ziersch et al., 2005). However, while Putnam (1995) assumes that social involvement is generated in a similar fashion through participation in social groupings, regardless of a particular community's access to these, there are others, (Bourdieu 1986a; Morris and Braine 2001: 25) who argue that "the social construction of identities, ideologies and symbolic systems is intimately embedded in the major systems of domination structuring a society." Social capital is seen as embedded in economic capital and arguably accrues to those with existing economic and cultural capital. This effectively bars those belonging to disadvantaged groups from gaining access to groups of higher social standing and to the benefits associated with membership of these groups.

Szreter (2002) points out that disadvantaged groups, rich in bonding social capital, have more restricted access to bridging and linking social capital that provide links beyond the immediate community. Differences in social capital are therefore shaped by a group's relative position within socio-economic hierarchies and social positions are reinforced by their differing degrees of access to bridging capital. As certain practices are identified and come to be essentialised as typical of particular groups, those associated with disadvantaged groups are more likely to be viewed negatively or even regarded as pathological and/or deviant (Bourdieu, 1979). Drawing on the work of Bourdieu, Morrow (2001) has put forward a model of social capital that underlines the importance of bonding social capital but places this within a structural context. In relation to a study undertaken in relation to young people's explanations and experiences of social exclusion, Morrow (2001: 53) asserts that while "bonding" social capital is important, it does not enable young people to "escape disadvantage" by facilitating access to power structures and influential others' outside their immediate groups.

The psychosocial model of social capital, by shifting attention away from the material and structural roots of inequality, tends to sanction a psychologised view of social class in terms of personal qualities (Gillies, 2005b). Consistent with Giddens' (1998) theory of the reflexive modern agent, it is based on the assumption that a meritocratic society will be created if people capitalise on the opportunities afforded by individualised citizenship. This not only obscures structurally grounded inequities, it also reinforces the notion that the

socially excluded are failures in self-governance (Rose, 1999). Parenting alone comes to be seen as the one critical determinant of children's future life chances while the link between parenting and socio-economic status is ignored. The tendency to individualise the determinants of social class is particularly worrying in the light of growing health inequalities in the UK (Shaw et al., 1999) which have been strongly linked to a range of structural factors including employment, education attainment, social circumstances across the lifecourse and the characteristics and amenities of areas people live in. Moreover, health-related behaviour, including diet, is strongly influenced by the social environment. Gillies (20005b) argues that disadvantaged families parent according to different imperatives than those adopted by the middle classes as their children have to survive within less privileged contexts. Similarly, parents from ethnic minorities will be more likely to adopt child-rearing strategies that will enable their children to withstand discrimination from the dominant culture (Ochieng, 2003) and working class parents were far more likely to apply strategies that would help their children negotiate disadvantages that would be unlikely to affect children from middle class families. Whereas the latter adopt strategies that enable their children to "stand out" and excel, in other words practices based on individualism, the working classes and ethnic minorities are more likely to seek security through "fitting in" (Gillies, 2005b: 845; Ochieng, 2003). This may be why parenting practices among minority ethnic groups have been identified as fostering values such as interdependence and cooperation as primary socialization goals for children (Lorrie et al., 1995).

(iv) Communicating public health: a didactic model?

In the context of the USA two contrasting approaches to health education practice, the didactic on the one hand and the participatory and democratic on the other, have been identified (Brouse et al., 2005). Much health education practice appears to be premised on a didactic model directed towards achieving goals established by the "health authorities" rather than on models that stress community members formulating goals and objectives. Others have pointed out that social change is required in order to create the circumstances in which an individual is *able* to modify her or his behaviour (Dowler, 2002; Draper and Green, 2002; Freudenberg, 2000; Graham and Power, 2004; Hitchman, et al., 2002; Lu et al., 2004). Draper and Green (2002) also highlight the high level of scepticism expressed by members of the public concerning the trustworthiness of official advice about food, a problem that may in part be attributable to a didactic style that fails to take account of the wider context of food poverty. As Brouse et al. (2002: 474) point out,

> Too often in a didactic model, the role of the educator is reduced to disseminating information. The educator is seen as the one who has knowledge that must be acquired by the learner. […] While more sophisticated didactic approaches may try to tailor educational messages to a particular population of learners, the tailoring is often cursory with respect of psychological, emotional, and interpersonal communication factors.

Similar observations have also been made in relation to media campaigns by public health bodies which have tended to be based on what is termed "the

process school of education" (Lupton, 1995: 107). This is primarily based on the stimulus-response model of communication whereby the media is viewed as the "sender" of a health message and the audience are constructed as the "receivers". It is based on the assumption that provided a message is successfully and frequently transmitted, it will eventually be taken on board by the audience. The role of the media is to "establish a health problem as a priority concern" among the general public, to "increase knowledge and to change beliefs" that impede the adoption of health-promoting attitudes and behaviour, "motivate change" by demonstrating how various barriers to behaviour change can be overcome", "teach self-management techniques for sustaining change" and "provide supports for maintaining change by stimulating interpersonal communication" leading ultimately to "broad changes in perceived social norms" (DeJong and Winsten, 1990: 32). If members of the target audience do not respond in an appropriate way, they are deemed to have adopted defence mechanisms or to be lacking in the required level of personal control or self-efficacy.

A more nuanced approach to health promotion has been framed within a social marketing discourse (Lupton, 1995). This presents health as a commodity and members of the public as "consumers" with whom the health promoter must empathise. For this reason it has been portrayed as a "bottom up" rather than a "top down" strategy and the idea is ostensibly to persuade through seeking to make the product desirable. (Lefebvre, 1992). However, as Lupton (1995) points out, while social marketing aims to be perceived as meeting consumers' needs, in reality it is directed towards creating needs or anxieties where they previously may not have existed. Similar to commercial advertising, much contemporary health promotion applies discursive strategies to provoke concern about body image by routinely constructing a dualism around the "civilised" and the "grotesque" body. The audience is constructed as requiring information but also as capable of individual self-control and discipline. Individuals who fail to do so are perceived as in need of further education and often categorised as "a member of lower socio-economic groups." Typically, health promotion has addressed the individual rather than the family, relying upon the model of the rational, unified self who consciously makes decisions in relation to his or her conduct (Lupton, 1995) This is also linked to a dominant discourse in the affluent West which identifies the body as a project which should be accomplished as part of an individual's self-identity (Lupton, 1996).

People may be aware of the facts but very often do not modify their behaviour accordingly (Hesketh et. al., 2005). A major problem in promoting health by engendering anxiety is the challenge of asserting dominant meanings in a context in which a variety of symbolic meanings already abound. What health promoters may be characterised as attempting to do is to recreate pleasure as risk. In relation to sexual encounters, for instance, it is only within the discourse of medicine that sex is constructed as a health issue. For most people, it is also connected with pleasure, which may be heightened by feelings of risk and danger (Lupton, 1995). As Lupton (1995: 125) points outs "Any attempt to 'force' a cultural value upon such behaviours is doomed to failure."

In addition, late modern societies are characterised by growing levels of mistrust (Ward and Coates forthcoming). The dichotomy between "lay" and "expert" opinion is for a number of reasons becoming more contested and, consequently, the supposed superiority of biomedical models is more open to challenge. In a study examining the perspectives of the health care needs of Pakistani and white people in a disadvantaged community in the North of England, Ward and Coates (forthcoming) discovered that levels of inter-personal trust were inextricably linked to trust in institutions and in abstract systems. Whereas previous research has identified these as separate areas of concern, Ward and Coates (forthcoming: 9) identify an "inter-connectedness of mistrust in GPs, mistrust in the healthcare system, and also, general levels of mistrust in wider institutions and systems." Levels of mistrust are also linked to people's experiences of under-investment and dis-investment and the general depletion of services within their disadvantage community. Pakistani residents, in particular, were likely to take a holistic view of health and view "health" and "happiness" as associated with environmental factors as well as access to employment and services.

Despite this, classical modernist approaches persist with "expert" opinion and "science" still constituting dominant discourses in the promotion of public health (Fisher, 2007 in press; Lupton, 1995). One exception to this view is presented by Burrows et al., (1995) who argue that public health approaches are increasingly characterised by features of late modernity or postmodernity. Their assumption is based on an observation of current trends towards multisectoral and multi-disciplinary approaches that emphasise the "active participation" of individuals. "Health promotion and the new public health represent new forms of social mediation in relation to health and illness" in their emphasis on approaches "based upon contingency, a plurality of rationalities and, ultimately, to the abandonment of truth claims" (Burrows, et. al., 1995: 8). While optimistic in relation to the benefits of new public health, Burrows et al., (1995) share the view of others that the managerialism and audit culture of rationality, costs, outcomes and systematic evaluations owe much to modernist paradigms.

Brouse et al. (2002), noting that no published studies could be identified that examined the quality of relationships between educators and programme participants, have recommended that more in-depth enquiry should be carried out to establish when programmes are successful in influencing behaviour

(v) Body and health: physical capital and a new morality

Diet is now overtly directed towards the accomplishment of an idealised body aesthetic and there is a perceived elision between the healthy body and sexual attractiveness (Featherstone, 1991; Lupton, 1995). The body beautiful is constructed as a moral accomplishment or what Bourdieu has termed "physical capital". This notion rests on a underlying perception of the body as "commodity", which must be presented or "marketed" to others in order to "maximise its exchange value" (Lupton, 1995: 140).

This discourse is not gender neutral and the link between emotionality and femininity has also been associated with irrationality, loss of control and the "grotesque" body. Perceived as nearer to nature, women are constructed as members of lower orders with their supposed emotionality associated with their bodies. As Grosz (1994) writes, "the female body has been constructed not only as a lack or absence but with more complexity, as a leaking, uncontrollable, seeping liquid: as a formless flow; as viscosity, entrapping, secreting; as lacking not so much of simply the phallus but self-containment". This lack of control is not only associated with the fluids emitted by the female body but also with its fleshiness. In a culture in which thinness is privileged, women are more pressurised than men to limit their food intake in order to conform to norms of appropriate feminine body sizes (Orbach, 1988). The rounded female body is represented as a sign of lack of self-discipline (Bordo, 1993, Grosz, 1994). However, more recent studies are suggesting that men are now becoming more concerned with accessing the cultural capital that can accrue though achieving an idealised body form (Robertson, 2006; Grogan and Richards, 2002).

There is also an interesting class dimension to this. Bourdieu (1984) has argued that the working classes have a more instrumental relation to the body than the middle classes. This means that the body is seen as a means to an end or as a means to "getting by" in life and by forms of temporary "release" from those demands. Being healthy is regarded as important insofar as it enables an individual to undertake employment and other forms of work. Working class women, in particular, tend to develop orientations to their bodies strongly marked by the needs of a family and may value health insofar as it enable them to fulfil family responsibilities (Calnan, 1987). In contrast the dominant classes have the resources to treat the body as a project "with variants according to whether the emphasis is placed on the intrinsic functioning of the body as an organism … or on the appearance as a perceptible configuration, the "physique", i.e. the body for others (Bourdieu, 1985: 212-213). However, the "instrumental body" of the working class is not without symbolic value as a healthy body is associated with hegemonic notions of masculinity such as action and strength (Robertson, 2006).

4. CONSTRUCTION OF SUBJECTIVITIES WITHIN FAMILIES

Key points

Food poverty is a complex issue that often affects mothers disproportionately as they have primary responsibility for food practices within families. A focus on an "ecocultural" model of the family sees the construction and reconstruction of subjectivities as closely bound up with discourses and practices linked to parenthood, gender, kinship and marriage as well as structural factors. Such practices must also be considered alongside the routine under-acknowledgement of emotional labour which rests on a perceived dichotomy that is highly gendered between the private and public spheres. Health promotion, however, has been traditionally targeted at the

individual and there are signs that the boundaries that define roles in families are becoming more fluid and more open to negotiation.

(i) Families and food poverty

Food poverty, defined as the inability to enjoy an adequate diet, is not new to Britain. Perhaps, surprisingly, it has become a salient issue in a period of strong economic growth. While it is mainly attributable to a lack of money, it is also linked to a range of complex factors, including structural ones, which give rise to a situation in which the majority of the population becomes more prosperous while the relative exclusion of the poorest increases. As Hitchman et al. (2002) point out, "The food retailing system caters better for the time poor, cash rich than for the time poor, cash poor; the transport system better for car owners than those dependent on buses". The expression "food desert" was first used in the 1990s in relation to a public sector-housing scheme in Scotland (Cummins and MacIntyre, 2002: 436). In 1996 it was defined as "areas of relative exclusion where people experience physical and economic barriers to accessing healthy food" (Reisig and Hobbiss, 2000: 138). Other studies adopt a wider interpretation, pointing out that proximity to appropriate shops does not necessarily make health food accessible to everyone (Wrigley et al., 2002; Williams and Hubbard, 2001). Financial resources, mobility, expertise in cooking could mean that areas well resourced with fresh food outlets might constitute "food deserts" for some. A study by Hitchman et al. (2002) concluded that cooking and budgeting skills, along with transport and ability to access shops, were key factors in enabling people to overcome food poverty on low-incomes. Success can, however, only be achieved at a price, namely family stress, self-denial and in changes in diet and shopping habits.

The available research suggests that consumers on low-incomes generally take a highly responsible attitude towards the budgeting and purchasing of food although budgetary restraints take precedence over issues of taste, cultural acceptability and healthy eating (Dobson et al., Dowler, 1998). People either economise on food by buying cheaper or different items or by omitting meals altogether. A study conducted by DEMOS in 2002 (Hitchman et al., 2002) showed that people went to enormous trouble to seek out the best bargains and tended to avoid experimentation on the basis that this might be costly if children refused to eat new types of food. A Joseph Rowntree funded study (Dobson, et. al., 1994) showed that children received more of their preferred foods, such as burgers and chips, in low income families as this was less likely to result in waste. Families appeared to be aware of the fact that they were eating food that was less than optimal in nutritional terms and also that their poverty excluded them from the consumer choices available to the mass population. Rather than adopt innovative eating habits, people living on low incomes tend to adopt cheaper imitations of conventional eating patterns. Their patterns of shopping in budget retail chains such a Lidl and Netto underlined their sense of exclusion, which can only be reinforced by a withdrawal of basic services and amenities, including the major food retailers,

who increasingly locate their stores out of town for car-owners or in the prosperous areas in towns (Dowler and Caraher, 2003).

While the costs of low-income budgeting fall on entire households, it is predominantly women who continue to be responsible for budgeting, shopping, choice of menus and food preparation (Mennell et al., 1992: 55-111). As a consequence, they suffer disproportionately (Charles and Kerr, 1988; Dobson et al., 1994; Caraher et. al., 1999; Silva, 2000). All the studies show that stresses involved in managing on a low-budget are huge, particularly for the person who is assigned the task of attempting to remain in touch with "mainstream" eating habits (Charles and Kerr, 1988; Dobson, et al., 1994) among other things, to avoid the risk of embarrassment to children and partners. Despite the fact that women undertake most of food-related work in families, many aspects of their activity are determined by men (Charles and Kerr, 1988, Murcott, 1983). Mothers are also more likely to sacrifice their own preferences and go without food themselves in order to satisfy others' wishes. In a study relating to lone-parent families, Dowler and Calvert (1995) state that a quarter of the women interviewed admitted to going without food regularly because they did not have enough money although none would admit to allowing their children to go hungry. The family is therefore a site of ambivalence for many women (Lupton, 1996).

When considering mothers' narratives in relation to the care of their children, it should be taken into account that people draw on dominant cultural notions of right ways of doing and being. Presenting a self as a responsible mother involves self-governance around what can and cannot be voiced (Miller, 2005). Experiences that are not consistent with the construct of ideal motherhood may be suppressed and can lead women to question their own abilities as women. Miller (2005) found that over time mothers reconstruct and reshape versions of experiences. Distance from an event provides a sense of safety and the risk of revelation is not perceived as being so great. Therefore, in later accounts of events mothers tend to be more critical of expert and professional knowledge. In addition, research has suggested (Fisher and Goodley, in press, 2007) that mothers are suspicious of the motives underpinning professional help and often challenge its legitimacy. Professionals are regarded as "policing the family" (see Peckover, 2002) and mothers may view the surveillance in a threatening light. Some mothers have explained that they have been deterred from seeking counselling for themselves as they were afraid that *they* could be seen as posing a potential risk to their children. So often, it seems that mothering is an activity that remains practically unrecognised unless a mother is seen as 'not coping' (Seymour, 1999).

As Morris (1989: 24 cited in Seymour, 1999) explains, whatever problems mothers may be experiencing, there is a pressure 'to cope' without expressing any grief or emotion. There is research to suggest, too, that informal relationships among kin are limited in the amount of support they provide individuals as they tend to be based on notions of reciprocity and a sense that informal resources are "carefully measured and saved up for emergencies,

and on behalf of *vulnerable dependants* [my italics] (Pearson et al, 1993: 45 cited in Seymour, 1999).

To date, welfare-related research in relation to stress and coping strategies has tended to over-represent psychological, sociological and epidemiological perspectives with far less attention being paid to practitioner and lay discourses (Seymour, 1999). The *Making Healthy Families* study may therefore provide an opportunity to address this gap by investigating the differing approaches, interpretations and understandings of stress and coping strategies that are adopted and applied by managers, practitioners and family members participating in food-related programmes. As Seymour (1999) points out, practitioners are a particularly interesting group in that they span they the traditional divide between professional and lay understandings as they draw on knowledge that is acquired both formally (through professional training) and informally (that is experientially in their professional and personal roles). At the same time few studies exist that examine the interaction between practitioner and service user perspectives and the way this informs how the latter experience the services they receive. The available research (see Seymour, 1999) suggests that practitioners, influenced by the relatively short-term objectives of welfare intervention, may place the focus on individual life events and fail to see the overall context of people's lives. Edwards and Popay, (1995, cited in Seymour, 1999) argue that practitioners recognised the structural determinants of stress in clients' lives but nevertheless tend to concentrate on individualised coping skills in their interventions. In doing so, practitioners may run the risk of pathologising service-users in ways that construct vulnerabilities that do not reflect people's lives and experiences. In particular in relation to families who have a disabled child, the general tendency has been to overlook the positive sides to parenting and caring (Fisher, in press, 2007; Fisher and Goodley, in press 2007). More generally, it seems that the scant research in relation to lay perspectives strongly suggests that people's experience stress and coping in diverse ways (Seymour, 1999). However, Seymour (1999) reminds us that people do not experience stress in isolation but as members of complex social networks. Their ability to cope, therefore, will inevitably be shaped by those they come into contact with, in formal and informal settings.

(ii) The "ecocultural" model of "family"

Research relating to families has traditionally concentrated on either a structural or a functional approach. Whereas the structural approach tended to lead to the identification of different types of family as defined by social positions or roles, the functional approach offered a way of looking at activities that families do together in order to meet their needs within a context of mutual responsibility (Cheal, 2002). While this latter approach enabled an examination of the different roles and distribution of tasks within families, for instance food preparation and the care of elderly family members, it tended to stress the positive benefits and leave unanswered questions as to why families do not always function well. More recently, in response to the perceived shortcomings of both the functional and structural approaches to family research, a new perspective, sometimes termed an "ecocultural

approach" (Christensen, 2004) has been developed that focuses on family practices in their everyday life (Cheal, 2002; Silva & Smart, 1998). The family is no longer conceptualised as a static unity of the nuclear family but as linked to multiple practices and processes, of which health-related practices are "only part of the picture".

Finch and Mason (1993: 61) have utlilised the term "developing commitments," arguing that family obligations and responsibilities develop over time rather than being fixed around the notion of duty. Through interactions, negotiations, and through receiving and providing help, responsibilities are therefore created rather than flowing automatically from specific relationships. The notion of "developing commitments" provides a useful analytical framework for understanding the processes involved in family roles and practices. Negotiations in families, which may be either implicit or explicit, create moral identities which get carried forward over time and are reshaped in the light of repeated negotiations. As Finch and Mason explain (1993) if the image of the "caring sister" becomes a valued component of someone's identity, it becomes increasingly difficult to avoid commitments that contribute to the way that identity is expressed and confirmed. The idea that commitments develop over time rather than being linked immutably to particular relationships is somewhat at odds with current Government policy that is attempting to reinforce notions of recognised duties between family members. Paradoxically, this is being encouraged through an emphasis on individualised responsibility.

The ecocultural approach also enables family practices, that are perceived of as dynamic processes, to be linked to dominant discourses around issues such as parenthood, gender, kinship, ethnicity and marriage. While commitments developed over time, the understandings that frame and shape them can vary significantly (Finch and Mason, 1993). Excuses women provide for not offering assistance are far less likely to be seen as legitimate as those put forward by men. In Asian families, sons are expected to take responsibility for elderly parents although, as in the white community, the work involved in caring will largely be regarded as women's work. As a rule, Asian communities tend to stress norms of collectivist obligation to family and society whereas western societies orientate more towards individualism and independence (Pyke, 2005). While western cultural expectations encourage siblings to lead separate lives, Asian families often confer a central role to the sibling relationship. Older siblings are expected to discipline and care for their younger brothers and sisters. In terms of commitments to other family members immigrants from West African tend not to distinguish between relationships between siblings and relationships between parents and children. Similarly, distinctions between parents and grandparents are often undistinguishable (Notermans, 2004). Ethnic minority families are also more likely than white families to identify their "family" as distributed over several households perhaps as a result of socio-economic status and discrimination, which may have encouraged the survival of extended family structures (Ochieng, 2005). In cases where extended families have broken up through immigration, many Asian and African-Caribbean families develop complex relationships with people of the same ethnic group (Othieno, 1998). These

networks develop over time as substitute extended families and provide mutual support to people as well as offering as well a sense of belonging that may otherwise be absent.

Research relating to immigration has investigated the acculturative differences between immigrant parents and children and assumed that children tend to become more assimilated than their parents into the dominant culture (Gold, 1993; Wolf, 1997; Usita & Blieszner, 2002). Based on the assumption that over time immigrants gradually cast off their traditional ethnic values and practices in favour of mainstream ways, this linear idea of assimilation has now been discredited and replaced by a diversity of acculturative possibilities (Pyke, 2005). In a study relating to Vietnamese and Korean immigrants in the USA, Pyke (2005: 497) identified "traditional" siblings and "assimilated' siblings, often within the same family. Interestingly, food preference was mentioned by some of the interviewees in relation to acculturative differences. Assimilated siblings tended to prefer mainstream American food whereas their more traditionally-minded brothers and sisters favoured Vietnamese or Korean cooking. However, the most salient indicator of whether a particular sibling orientated towards assimilation or the cultural values and practices of their ethnicity was the extent to which they took an individualist or collectivist orientation in their family relationships. As Pyke (2005: 509) writes, " … family dynamics becomes the stage on which cultural battles between ethnic retention and assimilation are played out.

When considering ethnic differences, Karlsen and Nazroo (2000) highlight the importance of not considering ethnicity in isolation from a myriad of other factors. Family practices in relation to health are not shaped by ethnicity alone but by multiple intersecting factors, including gender and class. With its multi-dimensional approach, the ecocultural model takes account of the fact that families have varying levels and forms of socio-economic and cultural resources at their disposal. Factors such as social networks, employment, financial resources, time, and the moral and cultural meanings that underlie and influence practices are also considered important. However the "ecocultural" approach seeks to examine how families construct different practices within similar circumstances (Christensen, 2004). Families "are" therefore "…what families 'do'" and institutional definitions of families are less important (Silva and Smart, 1998: 11). This seems entirely appropriate in an age in which diverse families forms are on the increase and the boundaries of what constitutes a family are blurred and may cut across several households and other points of overlap such as work, community and school.

Importantly, the ecocultural approach defines all family members, including children, as agents who potentially can promote or adversely influence family health. Traditionally children have been regarded as the object that is acted upon rather than the subject or agent of change (Woodhead & Faulkner, 2000). More recently, however, there has been a growing recognition that children come into contact with many different and often contradictory health and life values and practices, which may be either rejected or incorporated into family practices (Christensen, 2004). Food and eating practices may be the sites of extreme tension and disputes between family members and as

Lupton (1996), explains children's preference for "junk food" may, in part, be interpreted as an act of resistance.

By considering the agency of family members of different generations, including possibly the influence of the deceased, family practices may be investigated from a life course perspective (Allatt et al., 1987; Morgan, 1985, 1996; Notermans, 2004; Warde and Abercrombie, 1994). One of the advantages of a life course perspective is that it enables time and age to be linked by separating the different roles and practices that people assume in families at different stages in their lives. In relation to family practices, for instance, it has been noted that, women's domestic work is the most onerous when they have young children, however, once there are teenagers around, there is a tendency for family meals to become less frequent (Warde and Abercrombie, 1994). However, a lifecourse perspective should not be viewed through the lens of a purely linear understanding of life stages fixed to chronological age. There is also a strong performative aspect to the different family roles people assume, and these often involve taking multiple and varied paths (Notermans, 2004; Morgan, 1996). Individuals do not simply move from one stage to another in linear progression, they also have memories of their earlier life or the lives of others that are necessarily selective and at least partially constructed. As Harris (1987: 27-28) explains "… a life course is not a progress through a structure but the negotiation of passage through a changing environment." More recently research has started to explore intergenerational transfers of care and material resources in families. Brannen (2006) argues that family identities are transmitted across generations while culture also changes as family members in different generations draw on the culture of their times and differentiate themselves from one another.

(iii) The Changing role of fathers

Numerous studies have documented the links between motherhood and femininity (see for instance, Arendell, 2000; Choi et al, 2005; Stoppard, 2000). There is also a growing body of woman-centred psychological and narrative research into women's experiences of motherhood (Miller, 2005; Nicolson, 1998; Woollett & Marshall, 2000). This research, which is usually qualitative and based on feminist epistemologies, has given "voice" to women's subjective experiences of motherhood, which are often quite different to the idealised cultural depictions.

Constructions of motherhood and femininity must be considered within change within contemporary society towards what may be termed more emotionally "involved" fathering (Dermott, 2003). Prior to the late 1970s, most research relating to child-parent relationships focused on mothers as the dominant influence on child development whilst fathers were thought to play a less important role (Zaslow et al., 1991). More recently, researchers have started to consider the role of the father in meeting the caring needs of his child; a development that is linked with societal changes, especially as a result of women's increased participation in the workforce (LaRossa et al., 1991). This has resulted in a blurring of traditional gendered childrearing

roles and a related tendency to increasingly construct fatherhood in terms of "achieved" as opposed to "ascribed" (see Jensen, 2001).

Ascribed fatherhood refers to a relationship based on a biological tie between father and child, a perspective from which fathers tend to be perceived as emotionally distanced breadwinners whilst mothers are regarded as nurturing carers. Throughout western contemporary societies this traditional model is being replaced by one which increasingly replacing the "father of duty" with the "loving father" (Bertaux and Delcroix, 1992). Although fathering has traditionally received less attention in research compared with mothering (see Cabrera et al., 2000) there is strong evidence to suggest that increased father involvement is significantly related to positive child outcomes (Amato, 1994: Barnett et al. 1992; Fagan and Iglesias, 1999; Floury & Buchanan, 2002 and 2003; Hwang & Lamb, 1997; Youngman et al., 1995). Studies of the effects of father involvement suggest that involved, nurturing fathers are positively associated with the social competence, locus of control, intellectual and empathetic abilities of their children (Amato 1994; Gottfried et al., 1998). One of the main conclusions is that in relation to both resident and non-resident fathers "The more contact with the father the better adjusted their children to be." (Lewis et al., 2002).

(iv) Emotional labour

Feminist theoretical analyses of "the family" have critiqued both the artificial separation of instrumental and expressive tasks in domestic labour, identified in functionalist role theory, and the division between the public and the private that underpins the delivery of many policies and services (Hochsschild, 1989; Olesen). As Bourdieu puts it: "The public vision […] is deeply involved in our vision of domestic things, and our most private behaviours themselves depend on public actions, such as housing policy or, more directly, family policy" (Bourdieu, 1986b: 25). In other words, care and health work in the home and family are both constituted by and constitute gendered social identities, for instance, father, mother, wife and husband. Most of these understandings are implicit and remain unacknowledged, but nevertheless tend to result in the unequal distribution of domestic work between men and women.

Research on gender now routinely argues that femininities and masculinities are performed rather than biologically determined (Butler, 1990; Connell, 1995). Seen from this perspective, gender is a dynamic "performance" that is being enacted within practices of everyday life. Practices include emotionality and emotional labour. In western culture the notion of the "emotional woman" and the "unemotional" man (Lupton, 1998) is a binary that is reinforced by the private public divide. Traditionally, the home is where women have been held responsible for the creation of an emotionally supportive environment in which men received the necessary comfort that enabled them to function effectively in the harsher, rational and emotionally colder environment at work. Identity theorists assert that people seek to construct interactional settings that lead to the confirmation of their identities (Burke & Cast, 1997). It may be that

women perform more food-related tasks because such performances enable them to conform to feminine identities.

Emotionality tends to be culturally associated with femininity and rationality, meaning lack of emotion, is represented as masculine (Brownmiller, 1984). As Brownmiller (1984: 208) puts it, "it is commonly agreed that women are tossed and buffeted on the high seas of emotion, while men have the tough mental fiber, the intellectual muscle, to stay in control". For these and other complex reasons emotional labour, which often remains unacknowledged and under-valued, has traditionally been regarded as "women's work". Not only is emotional labour generally unpaid, it is also associated with taken-for-granted ideas about essentialised femininity which means that, although demanding, it tends to remain invisible. As James (1989: 27) notes "When emotions are thought to be 'irrational' it is hard to associate them with organization, yet managing them requires anticipation, planning, timetabling and trouble-shooting as does other 'work', paid and unpaid." For these reasons some feminists have criticised the negative associations between femininity and emotionality. Others relate emotionality in a positive way with the capacity for empathy and relating to others. Proponents of this perspective tend to put forward values of interdependence as an alternative to the masculinised ontology of the unified and separate self, constructed as individualistic and non-relational in orientation (Ruddick, 1994; Williams, 1998, 2000; Tronto, 1993). Similarly, although from a different ideological perspective, Giddens (1992: 1-2) argues that women are promoting the ideal of the "pure relationship", which is a "relationship of equals" and a "social relationship entered into for its own sake". Giddens (1994) takes the view that people who are emotionally developed are more likely to be effective citizens than those who lack this quality. As men have been cut off from their emotional selves, he views men as less well equipped to fulfil the role of engaged citizenship.

Little research is available examining the emotional components of work in families work and linking this to social scientific understandings of the relationship between gender and the division of domestic labour. One notable exception is provided by Mckie et al. (2004) who have developed the concept of "healthscapes" that allows for the multi-dimensional analysis, including the gendered, temporal and spatial dimensions, of health work within the family and over the lifecourse. This work, which draws on earlier work relating to the notion of "caringscapes" shows how public health policy relies extensively on women's labour, both instrumental and affective, which is largely carried out "invisibly" in the domestic sphere. The theoretical basis of both "caringscapes" and "healthscapes" is that people, normally women, plot ever changing temporal and spatial routes when undertaking care and health work and that their activities are both constituted by and constitute gendered social identities. Public health policy tends to undervalue and under-acknowledge this highly gendered form of work, which is nevertheless complex and demanding. The *Making Healthy Families* studies offers an opportunity to further study the notion of "caring" and "healthscapes," incorporating into this analysis a particular focus on the instrumental and affective work in relation to food. As Charles and Kerr (1988) and Fisher (1991) have previously pointed out, food is far from being an emotionally neutral subject

(v) Myth: making "the hidden" visible

Gender, ethnicity and social class are sociological categories of critical significance for understanding families. As Daly (2003) explains, these are "positive forms" as they are visible to social scientists and constitute an established part of the research tradition. In the sense that are concerned with predictability and variables, they are arguably "postpositivist" (Daly, 2003: 772) in orientation. However, taken alone, they, they cannot present a complete picture of family practices, many aspects of which defy categorisation and are consequently more difficult to perceive. While these elusive aspects of family life, including belief, intuition, myth and folklore, are in some ways more challenging to scrutinise than those more immediately "visible" (Daly, 2003), I would suggest that ecocultural model, with its focus on processes, practices and relationships, constitutes a reasonable starting place.

Much of family life is based on inherited traditions and practices that form a backdrop to family life of taken-for granted assumptions (Geertz, 1973). As Patton (1999: 339) argues "myths that have survived and have been passed from generation to generation are inherently normative … [and] provide a basis for interpreting highly particularistic life events, experiences and histories." Although presented as factual accounts of real lives, family myths are social constructions. As such, they do not merely reflect identities but constitute them and are therefore political processes that create stories of characters, culture, events and relationships against a background of cultural processes, values and experiences (La Rossa, 1995). Often family myths depict idealised versions of the past. Gillis (1996) has written that everybody lives in two families: the one of everyday life and the one they live by. The latter are largely created through myth and ritual and tend to be a romanticised version based of family life in the past. While largely utopian, they nevertheless have an important role to play, often acting as blueprints that point the way forward in the everyday disorder of life.

While the manner in which labour interweaves into daily schedules has been demonstrated in time diary research (Geshuny, 1995) to date little attention has been paid to the larger picture of caring work, or specifically food-related practices within families across timescales larger than one day. By incorporating the notion of family myths into an investigation of family practices, the focus is no longer on the here and now but includes "stories" over much longer time. People may, for instance, "inherit" a pre-given assumption that coronary heart disease is an essential component of their family legacy, although how they respond will differ widely (Hunt et al., 2000). Urry (1990: 170) writes of "imaginary co-presences" within families, that is the continuing influences of people who may be either physically distant or even dead. Similarly, Davison et al., (1992: 682 cited in Emslie et al., 2001: 206) identify the high incidence of "Uncle Norman" myths: "The fat Uncle Norman figure who… survived into healthy old age, despite extremely heavy smoking and drinking." "Uncle Norman" is often contrasted with a slim clean-living person who unexpectedly succumbed to a heart attack despite being the "last person you'd expect to have a coronary." Myths are constructed through

interweaving and dynamic narratives and developed over time. Linking the past to the present, myths highlight the role of the past in shaping the present, an influence that may easily be overlooked or underplayed in the future orientation of the "do-it-yourself" biography of the reflexive agent (Beck, 1992), discussed below.

(vi) Reflexivity in families: from modernist to postmodern models

Whereas in Government rhetoric, diverse family forms are linked to the abandonment of traditional morality, others contest this perspective (Morgan, 1999; Silva and Smart, 1999) arguing that families remain a crucial relational entity which continues to operate within the moral realm of care and care giving. However, the boundaries defining care are more fluid. Instead of dividing people into pre-determined categories such as "the self-sufficient worker", "the dependent carer", "the recipient of care", a focus on practices within families recognises that each person may be find themselves in all of these roles during the course of a lifetime (Sevenhuijsen, 1998; Tronto, 1993). In relation to this study (*Making Healthy Families*) it may also be considered the extent to which different family members assume different roles within families either at different times or possibly more or less simultaneously. Silva and Smart (1998) suggest that gendered understandings of family practices, for instance, should also include those done by men when they absent themselves from the family.

The variety of roles that individual family members may assume within a family is a particularly important consideration in the context of a late modern society. The model of labour based on Fordist principles (husband in full-time employment and woman in charge of reproductive work) is being superseded by a greater diversity of employment types that are often casualised, part-time and temporary. Nowadays gendered roles may be negotiated in more complex ways. As Morgan (1998) points out "either or", associated as it is with the scientific rationalism and modernism, tends to stress structures, categories and classifications. If "either or" is replaced by "and" it can point towards greater fluidity and openness. The emphasis on "and" also recognises that one particular analysis of a set of "family practices" does not preclude other interpretations.

In *Risk Society* Beck (1992) considers what he terms "reflexive modernization" which, he argues, is characterised by increasing concerns in relation to numerous risks to life and health. While many of the risks are global and therefore beyond the scope of individual agency, perhaps somewhat ironically individuals are being exhorted to take greater personal responsibility for their health by making reflexive choices and constantly monitoring their own practices in terms of risks and opportunities. Lupton (1995) points out that the risk discourse has often assumed a universal experience and has been neglectful of socio-economic and structural inequalities.

This shift towards "the do-it- yourself biography" (Beck, 1992: 135) and the "negotiated provisional family" (Beck, 1992: 129) owes less to tradition or moral pressures than to the individualised expectations and aspirations of family members. Gillis (1997) discusses the temporal dimensions between family and reflexive modernisation. Whereas the traditional family was constituted through practices and understandings based in the past (tradition) and sought to predict and shape the future through children and hoped for developments, reflexive modernisation questions many aspects of the past and longer sees the future as necessarily following an already decided trajectory. The resulting growing diversity and absence of clear temporal trajectories within families, which is generally constructed in Government rhetoric as a threat to the moral fibre of society, has been interpreted by others as encouraging people to invest more in inter-personal relationships in the family. In other words in a world in which the individual is seen as the central reference point (Beck, 1992), families are becoming more important in providing the support necessary for the constitution of personal autonomy (Lupton, 1996; Silva and Smart, 1999).

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