DEPARTMENT OF
CHILD STUDIES

CHILDREN, HEALTH AND THE BODY

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WORKING PAPERS ON CHILDHOOD
AND THE STUDY OF CHILDREN
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CHILDREN, HEALTH AND THE BODY

FRIDAY, 26TH APRIL 1996, 9.00 -16.00

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Constructionism, materiality and agency:
how may we think about childhood bodies

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Emotions as mediator in children's embodied daily experience

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The conference will take place at Collegium
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The conference will take place at Collegium, Mjärdevi, Room Delfi. Please contact Anna Ghannadan by 19th April, tel: 28 29 39, fax/address below.
INTRODUCTION - TOWARDS A SOCIOLOGY OF CHILD HEALTH

Berry Mayall

This introduction is to the four papers presented at the conference: Children, Health and the Body. My aim here is to provide briefly some background to the papers, in terms of theory within medical sociology and the sociology of health and healing; and also to introduce some ideas towards the construction of a sociology of child health. I present some notes towards the idea that children, as an important social group, repay study in connection with health and illness, as embodied actors. This is not least because incorporating children into consideration of the sociology of health requires re-thinking the division of labour and intergenerational relationships within it.

Children and sociology

By now there is a considerable body of work outlining the main features of the argument that children are appropriately to be regarded as social actors, members of a social group which in social, political and economic terms is a minority group (eg Qvortrup et al 1994). Compared to other minority groups, children suffer doubly: not only in terms of their powerlessness, but because they are commonly regarded by reason of age\stage as inferior to adults. Their knowledge, cognitive ability and moral sense are called in question, by comparison with adults'. In line with these views, children are regarded as vulnerable and appropriate policies are thought to be those framed in terms of protection and exclusion from adults' worlds (Engelbert 1994). Yet these views rest less on adult knowledge of children's knowledge and more on confusion between the natural biological dependencies of young children and the vulnerabilities socially constructed by adults about children as a group (Lansdown 1994). However, children have had and continue to have low status within mainstream sociology, being regarded, unproblematically, as socialisation projects within the private domain. Sociology has preferred to study the workings of the public order, with the private domain assumed as separate, natural and inferior.
'Socialisation' - a term which appears to have been adopted uncritically and unproblematised by sociologists from developmental psychology - has been used by them to emphasise adult behaviour towards children. It is a curiously disembodied concept, referring to the embedding within children of social rules and norms. It diverts attention from the children as actors, and towards the reproduction of social norms. Mainstream sociology, including the sociology of the body, continues to use this idea as a basis for sidelining children (eg Shilling 1993: Chapter 7). You could say that the disembodying of children - their status as cognitive and moral projects - provides one basis for this neglect.

Medical sociology - structures of thought

One of the tasks of sociology is to relate the biological to the social order; people’s physical being and living is a component of their social being and living (cf Herzlich 1995). Yet, as historians note, sociologists have traditionally bypassed relationships of bodily well-being to social functioning in their explorations of the public domain of work. The founding fathers took little account of health as a pre-condition of the performance of socially ascribed roles (although the impact of work on health was noted, for instance by Marx). A key turning point is identified as the 1940s when streams of work relating to normalcy (partly encouraged by contemplation of Nazi Germany), and to the rise to power of the medical profession coalesced in the work of Parsons (see Gerhardt 1989: Introduction). The focus in Parsons' (1951, 1975) and later allied work in the functionalist tradition was on social roles, deviancy from them through illness or villainy, and the work of the medical and legal professions respectively to restore people to their socially designated and expected productive roles in the public world of work. Medical sociology research built on these foundations and concerns itself mainly with health-related institutions, encounters between medical professionals and 'lay' adults, and the structuring of adults' illness-related behaviour through their 'lay' beliefs.

The concept of deviancy was further refined through the 1960s and 1970s, when, notably, Freidson (1970) pointed to the power of medicine to create and define disease and pathology; and when the symbolic interactionists proposed that society works through the imposition and acceptance of rules, rather than through encouraging psychological motivation to conform; and that those who are deviant are those who have successfully been labelled as deviant from the rules (eg Becker 1963). Goffman (1968a, 1968b 1969) is clearly important in pointing to
bodily action as a component of social interaction; in particular he analyses bodily action as a mediator between self-identity and social identity (1968b). However, it has been argued that he does not provide a clear account of agency, but regards the body as the result of the application and acceptance of other people’s constructions; furthermore interactionist theory has failed to link understanding of micro-interactions to wider social structures (Shilling 1993: 82-8).

In functionalism, the status of the body is as a means to an end within a paradigm emphasising social functioning and deviance from it. In interactionism the body is a component of the negotiation between people through which self-identity and social identity are constructed. However, neither functionalism nor interactionism, it can be argued, are concerned with issues to do with tensions between embodied experience and the structuring of the body through social processes. Both functionalism and interactionism are concerned with people’s (adults) behaviour in relation to social events, institutions, organisations. Furthermore, the sociological focus on deviance has served to emphasise illness (not health).

The questioning by symbolic interactionists of the functionalist paradigm can be seen as a basis for the development in the 1970s of conflictual paradigms to explain illness, in opposition to consensual models. Thus Zola (1972) proposed medicine as an institution of social control, and in complement social rather than biological or psychological factors were stressed as causes of illness. Interactionism and conflictual paradigms provide a point of departure for Foucault’s work. His proposition (1975; 1979) that power is an institutionalised disciplinary apparatus which crosses the public-private divide and reaches into people’s private lives, throws emphasis on health as well as illness, on concepts of normalcy and on people’s everyday behaviour. Indeed his work counters the idea that illness is to be sharply distinguished from health, bodies from minds, the private from the public and the individual from the population. Instead he proposes that we study: normalcy as the key to understanding ideas of health and illness; and the workings of disciplinary control of people’s interlinked bodies and minds. His work points towards shifts in areas for concern and study in terms of the focus, target and method of control; he emphasises shifts in the focus of control - people’s daily living and reproductive behaviour (rather than their illness behaviour); in the target of the psy complex - the population (as well as the individual); and the method of control - away from repression towards the stimulation of desire (through education and the mass media). Debate continues on
the status of the body in Foucault; some commentators (for discussion see eg Turner 1992: 52-4; Shilling 1993: 88) say Foucault sees the body solely as a social construction; he focusses on the mind as the object of the disciplinary apparatus, and the mind is the site within which the body is constructed. Others argue that he draws attention to the lived experience of the body in tension with the constructions to which it is subjected. No doubt Foucault would approve of the view that his work should be subject to many readings.

Foucault’s agendas for study resonate with social trends. People have been taught that optimal health is unobtainable, they live with a continuum of health through illness; all of us could be healthier if the environment or if our behaviour were different. Socio-economic conditions are revealed as constituents of our health status (eg Townsend and Davidson 1982; Doyal 1979). We learn that we live in a society where risks beyond our control menace our health, and that balancing risks is a normal component of everyday decision-making (Beck 1986; Giddens 1991:Chapter 4). The idea of the medicalisation of daily life (eg Zola 1972) pervades our consciousness. Public programmes of health promotion give us similar messages - our health status is in question. Preventive testing, for instance in pregnancy and childhood, and for conditions such as cancer and AIDS, reveals the fragility of our health status.

Foucault’s vision provides useful pointers towards the construction of a sociology of child health. He described the late nineteenth century emergence of a public health concern not just with the environment, but with people’s behaviour; and in particular with women’s health care behaviour, as housewives responsible for children’s and men’s health, and as workers in nurseries and clinics. Within this new public health concern, children were high on the agenda - as a problem: to be overseen and monitored both within public spaces (nursery, clinic and hospital) and at home (Armstrong 1983; 1995). Thus he made visible and problematised interrelationships between the public and the private, and the work of women became an object of enquiry spanning these domains. Children’s bodies and minds become a key focus of attention, emphasising normalcy as a critical issue. All this meant that the status of children as objects of the psy complex, through work on their mothers, could be regarded as problematic; to what extent they themselves enter the division of labour in child care, as agents (Stacey 1980). The visibility of children, through the observations of health, welfare and education agencies, provides a basis for considering their own contributions to their health status, and to the social order both now in their present lives as children, and in their future lives as adults.


Feminism, Foucault and childhood studies

It is not surprising that feminist sociologists have drawn on Foucault’s work in their own analyses of women’s social positioning in Western societies. And their studies also provide points of departure for the construction of a sociology of child health - though children as a topic of study have not been at the forefront of feminist work (however, some progress is discernible in the 1990s).

In the first place, feminists have enlarged on the idea that the relations of ruling - as Dorothy Smith (eg 1988) puts it - act to structure the body. Using the concept of gender, they mount a critique of the natural body as a basis for social inequality (eg Oakley 1972). Similarly, we may argue, the natural body of the child has been regarded as a basis for the designation of children as physically, as well as socially inferior.

Secondly, women have argued against the reification of social life into the public and the private. Women’s work, they argue, spans and thereby destroys this divide. A provisional acceptance of the divide leads to the proposition that a critical feature of women’s work takes place in an intermediate domain, between the public and the private, where paid and unpaid women negotiate the character and status of their health care knowledge (Stacey and Davies 1983; Smith 1988). The case made is that it is specifically women’s work that is characterised by this crossing and blurring of boundaries. We can go on to argue that health care work by children too crosses these boundaries, as they move from home to school and negotiate with the adults who control their daily lives (Mayall 1996).

Thirdly, and following on the second point, women have stressed the critical importance of knowledge and its status in influencing - or structuring - the ability people have to determine their daily lives, and the care they receive and give. Here feminists have stressed the character and value of experiential knowledge in its relationships with professional, public or scientific knowledge (eg Rose 1985, 1994); the argument has ranged from micro-discussion of women’s health care work to critiques of ‘malestream’ moral understanding (eg Grimshaw 1986; Gilligan 1993) and of scientific knowledge (Harding eg 1992). These challenges to the received, natural or incontrovertible status and character of knowledge open up for more general discussion the relativity of knowledge. We are only at the beginnings of thinking about
the character and value of children’s own knowledge; and its status as a basis for the ordering of their lives, and those of adults.

Fourthly, then, feminist work has thrown doubt on the legitimacy of claims by professionals, in health (and I would argue education), to the best, and most appropriate knowledge for ordering health care (and educational) institutions. Scholars challenge the division of labour whereby professional knowledge has priority and primacy. As Margaret Stacey (1980) pointed out, we need to rethink who participates in the division of labour, who does which work for whom. Most health care, she argues, for people in both health and sickness, is done by unpaid women, with the medical profession as minor contributors; yet the status of the work is in inverse relationship to the amount: highly paid and highly regarded doctors at the top and unpaid low status women at the bottom. With our new-found understandings of children as competent actors, we may enquire how the division of labour looks, if we include children.

The focus of women’s work on a continuum of health and illness, including the maintenance, promotion and restoration of health has provided one basis for the argument that ‘medical sociology’ should give place to the ‘sociology of health and healing’ (Stacey 1991). Such a change both reflects and encourages several sets of shifts in thinking. We are learning to focus on health (rather than illness), and on the problematics of what constitutes normal health and of health promotion. The health care work of ordinary people, both in self-care and in the care of others is acquiring somewhat higher status, as compared to medical interventions. The site of health care as a focus of study is shifting from health care institutions to daily life: from medical encounters in clinics to the contexts of everyday life - at home, at work, at school, on the buses, in the environment. These shifts provides routes into considering the daily health-care work of a range of social groups, including children.

Finally, we may note the importance of feminist work on the sociology of the body and emotions. Exploring links between the biological order and the social order has been a newly interesting topic for sociologists since the 1980s (eg Turner 1984, 1992; Shilling 1993); and finding links has been newly problematised. In what senses, they ask, can we say we have bodies, are bodies and do bodies? Freund (eg 1988) has argued for an embodied sociology which recognises the dynamic interpenetration of bodies, mind and society, as well as the structuring of bodies by social forces. Women scholars have been notable for pursuing these
topics through empirical data; they have explored the interplay of theory and women's accounts in their work on the salience of embodied experience in their daily lives: the structuring of their bodies through the social gaze, the requirement to carry out emotion work, including the regulation of their bodily appearance and movement; and the mismatch between the public social order and the character of women's embodied experience (eg Young 1980; Hochschild 1979; 1983; Martin 1989; and see also Connell 1987, 1994). Feminist work explores the dual, but interactive status of the body - as lived experience and as constructed understanding.

Though by all the writers quoted in the above paragraph, children are neglected, yet these new developments in sociological thought provide an important way into thinking about children as a social group: about their embodied experience and learning, in tension with their membership of a minority social group. They, too, like women, inhabit social worlds designed by and for others; children's embodied experience takes place in social worlds ordered in the interest of adult agendas. Children, like everyone else, both experience their bodies in day-to-day living, and experience the social ordering and valuation of their embodied selves. The one experience works on and modifies the other.

Towards a sociology of child health

The many strands of thought constituting work on the sociology of health and healing provide a basis for considering children as social actors engaged in health care work, and as health care projects for adult work. Such considerations should not only help us understand more about the social conditions and positioning of children as a social group; but can also provide us with more general understandings of the social order.

First of all, we may enquire how far traditional sociological approaches help us to understand the position of children, how they are regarded, how they understand their position. For instance, the functionalist view (dating back to antiquity) that we adults are expected to fulfill social roles, unless we can prove ourselves incompetent health-wise, can be recognised as applying to children too. You have to go to school, and work at school, unless you can provide a good, health-related reason. Parsons was speaking to our common understanding and it applies to children too. Deviance from the social role of pupil has to be legitimated through
adult sanction (the teacher's assessment, the mother's letter) and children's own sickness bids are traditionally questioned by school staff on moral grounds - poor motivation (Prout 1986; Mayall 1994). The labelling of children is a well-exposed feature of their social experience, within the home (the terrible twos) and in more public places (learning disabled, disturbed, trouble-makers). Feminism has emphasised children as the objects of women's care and the products of women's work. The surveillance of children, in the interests of public health, is also well documented; they are of critical interest to the psy complex.

However, to elevate children to the status of a social group whose activities are to be considered within a sociology of health and illness requires a concerted programme of work. Again, we can look at the progress of women's studies to help us here. It has been pointed out (Alanen 1992, 1996; Smith 1988, 1991; Oakley 1994) that women's challenge to received sociological 'malestream' knowledge has gone through a series of ordered stages. In the first place a critique has been mounted against existing knowledge. This has led on the development of concepts that allow for the deconstruction of that knowledge, and to the proposals for women-based standpoints towards structures of knowledge. For feminists, the key concept has been gender, as a means of deconstructing the taken-for-granted understandings of the social order and of reconstructing knowledge in the light of that concept.

Childhood studies are in their infancy. You could say we are still at the critique stage. We know little about children's own understandings of their social positioning, and indeed it can be argued that for adults to understand, let alone represent these, is problematic (eg Thorne 1993; Oakley 1994). Some pioneering work has been done here, focussing on children's acquisition and use of knowledge in relation to serious, and critical health-related conditions. Thus Myra Bluebond-Langner (1978) has studied how children acquire knowledge adults wish to conceal from them, about their imminent death from cancer; and more recently (eg 1991) she has studied siblings of children with cystic fibrosis and has related the character and expression of their knowledge to the stages of the disease (rather than to the children's age). Priscilla Alderson (1993) has studied children's consent to surgery in relation to their understandings of its implications, and in relation to issues of children's rights, and their competence to participate in decision-making. Both these writers have shown the importance of knowledge-acquisition and decision-making within the context of personal relationships, rather than as knowledge acquired and moral reasoning conducted in lonely autonomy. In my own work,
focussing on children’s daily lives, I have explored children’s understandings of their social positioning at home and at school - how they understand and deal with the social order controlled by adults and with adults’ ideas of what children and childhood are and should be. Using the insights of structuration theory (Giddens eg 1979) I suggest an interplay between children’s social positioning and their understanding of it, and their health care knowledge and actions (Mayall 1994; 1996).

Understanding the social order from the children’s own standpoint requires not only study of their knowledge but the development of concepts that foster that understanding. These are early days, but there seems to be a convergence on the idea that a key concept in understanding childhood as a social phenomenon is that of generation. (Alanen 1992, 1994; James and Prout 1995; Mayall 1996). Childhood, it is argued, is a relational concept. Children are those whom adults define in their character as non-adults. Children’s lives are structured through their relationships with adults, and through adults’ understandings of what children are, and how their childhoods should be lived. Thus the point that children are set apart as belonging to a separate generation from adults, yet must work towards establishing their identities and social lives through intergenerational relationships becomes key to the establishment of a sociology of childhood.

More specifically within this focus on generation, we may argue for consideration of a number of inter-related issues in relation to children as sociological participants in health care. A starting point is children’s positioning as a minority group within the triangle of children, parents and the state. For instance, we may study access to resources in this context. Children’s access to, for instance economic security, education and health, can be regarded as sited within their dependency on parental socio-economic position, and in tension with the operations of social policies and their agents. Children can be regarded as doubly minor - to parents and to agents of social policies. Within the home, children’s ability to maintain and promote their own health is conditional on the parent-controlled social order, which itself is subject to the demands and pressures of wider social forces (hours of employment, views on child-rearing) (Mayall 1996). Children as schoolchildren spend their days in a teacher-led environment strongly controlled by social policies on education, mediated by parental intervention in respect of children as individuals and as a group. Their positioning within
medical encounters is doubly dependent on parental and medical behaviour (eg Silverman 1987; Aronsson 1991).

Undoubtedly, study of children’s social positioning requires considering intersections of generation with gender. Gender as a force within children’s experience has been studied especially (in the UK) in relation to schooling, where teacher-child and child-child relationships as intersecting structures have been regarded as critical. We know little about gender and generation within homes. However, Brannen et al (1993) studied health-related knowledge and decisions through the accounts of 15-year-olds and their parents. A recent study has explored with younger children (aged 3, 9 and 12), ideas about the home as a place of risk or safety (Mayall et al 1996b). The Nordic One-Parent Study has considered children’s (aged 9-13) accounts of autonomy, integration and decision-making in the context of their relationships with their mothers (Alanen 1992).

A further key issue which may help us to understand children’s viewpoint on their social positioning in relation to adults is their dual status in time (cf Ennew 1994). Children, unlike other social groups, have dual status - as people now, and as projects for the future. Or, if ‘the child is father of the man’, they have a further status, they are now what they will become. As Foucault and others have taught us, children are a critical object of state policy, in the interests of constructing their bodies and minds, through the medium of adult intervention at local level - for instance, mothers at home and teachers at school. The tension for both these sets of people is indicated through studies of their concern for the children’s experience now, for ensuring that they acquire behaviours and knowledge to fit them for the future, and for doing their duty as socialising adults in the service of wider social policies (Newson and Newson 1978; Halldén 1991; Mayall et al 1996a).

If we take a larger view, then conceptualising children as social actors making contributions to the construction of the social order indicates the need to reconsider the division of labour. Feminist thinkers have enlarged the concept of work to include the unpaid (such as caring, household maintenance) as well as the paid. Thus children can be regarded as taking part in maintaining and promoting the social order of the home, through their participation in the health maintenance work of the home (setting tables, cooking, clearing up) and in the making and developing of personal relationships. Similarly, at school they may best be regarded not as
objects of the education system, but as contributors to it, through their work (cf Qvortrup 1985; Oldman 1994). Children may be regarded as participants in, rather than merely as recipients of, the work of constructing their lives and re-forming the social order of home and school. This conceptualisation of children as contributors to the division of labour shifts our understanding of adults' contributions. In particular, the work of women may be regarded as comprising not just the care and education of children, but care and education with them, and in some senses, possibly a partnership, or as Gilligan (1993) puts it, an alliance. Such shifting of social positioning and relationships within and between two minority groups, women and children, must give cause for reconsidering the social position of men and their relationships with children. (In this regard, social policy initiatives to alter fathers' childcare participation provide interesting ground for study.)

Children, health and the body

These notes on the importance of generational issues in the lives of children acquire specific interest in relation to children's embodied experience. There are several related points here. The first, perhaps, is that childhood provides a dramatic case for study. Whilst some people may find it hard to think of adults as embodied actors, it is relatively even clearer that children's bodies are the critical site of their own experience and of adult interpretation and behaviour. Children's bodies constitute the centre of adult attention in their early days and remain critical for their experience and for that of their caretakers in succeeding years. As Sonja Olin-Lauritzen details in her paper, mothers experience a blurring of boundaries between their own and their babies' bodies, they interpret their baby's health status through her bodily expressions of happiness and distress, their concern for their child's normality rests on her bodily activity, growth and development.

In the case of these very young children, too young to act as verbal informants, mothers provide insights into relations between the bodily and the social in babies' experience. Mothers stress that they understand their baby to be healthy, in part because she is happy. And happiness is described in terms of alertness and responsiveness to the physical and social environment surrounding the baby. That is, according to mothers, a baby experiences health as including the capacity to interact positively with the physical environment (touching and looking at things) and with the social environment - her parents' faces, actions and words.
Perhaps we may infer that for the baby physical and social well-being are interlinked and interactive. And, further, the baby’s feeling of well-being, discomfort, pain serves as a bridge or mediator between her embodied self and the social context, because, through the expression of emotion related to physical sensation, the baby links into and participates in constructing the social relationships within which her health will be restored, maintained and promoted.

Secondly, children’s own experience teaches them that they are valued for their bodily appearance and achievements. They have embodied value, they gather, as they hear adults talk above them and to them about their beauty and progress. Children also learn that acquiring socially valued bodies is part of the task of childhood; their identity as children at home and later at school is constructed in part through negotiation with their peers and with adults (James 1993).

Thirdly, children experience, at home but especially at school, tensions between their bodies and minds and how they are valued, a topic discussed here by Bendelow and colleagues. Adults require that children learn to juggle their own evaluation of mind and body. At home, their bodily achievements are valued only some of the time - physical activity in small spaces grates on parental sensibility; their urge to learn meets encouragement but sometimes rebuff from tired parents. At school children are required to subdue their bodies in the interests of the academic curriculum, but at certain points they are asked to develop their bodily skills in formal sports, and are allowed to exercise their bodies in break times. And though they are taught what constitutes a hygienic life-style and a healthy diet, many children are presented (in the UK) with decaying and dirty buildings, poor washing and lavatory facilities and with ‘unhealthy choices’ as well as healthy ones in the school dinner (Mayall et al 1996a).

Finally, childhood provides a site for the study of the role of the emotions as mediators between bodies and minds. As noted above, in their earliest days babies’ emotional expression links their bodies into the social worlds of their mothers’ responses. Yet children’s daily experience at home and at school is also of the requirement to subdue their bodies in the interests of adult timetables and civilising agendas; they are asked to manage their emotions in order to make the space for cognitive work; most crucially of all, perhaps, their cognitive development is inter-related with their emotion - thus it is through their relationships with
adults and other children that they learn about other people’s goals and feelings and about social rules (eg Dunn 1988).

Much work on the body is interested in cultural shapings of the body, in the context of social inequalities (Bourdieu eg 1984). The study of children’s embodied experience in the context of ideas about a sociology of child health is key here, for the structuring of their experience through inequality can readily be demonstrated. The minority status of children is clearly apparent in their oppression as health care actors, a point forcefully demonstrated in Shirley Prendergast’s paper. The diverse and many-sided character of adults’ understandings of children - victim or threat, innocent or ignorant, valued and neglected, and to be enabled or controlled, regulated or civilised - can usefully be countered by children’s own understandings of their social position, as actors.

This set of four papers, presented at the Conference: Children, Health and the Body, presents a range of considerations of issues in the study of childhood. The day began with Alan Prout’s paper; he discussed recent theoretical developments in the sociology of the body, and their usefulness for considering the case of children. The following three papers considered intersections of theory and empirical data; they focussed on studies of children in relation to health, progressing through three ages of childhood. Sonja Olin Lauritzen considered mothers’ accounts of health in their babies, in relation to theories of health and health care. Gill Bendelow took as her starting point the sociology of the emotions and discussed related issues in the embodied experiences of primary school age children. Shirley Prendergast took the case of girls and boys in secondary school to discuss the impact of social structures and group dynamics on young people’s daily experience at school, with particular emphasis on the construction of gendered identities.
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CONSTRUCTIONISM, MATERIALITY AND AGENCY: HOW MIGHT WE THINK ABOUT CHILDHOOD BODIES

Alan Prout

The new social studies of childhood (1) have developed within a broadly social constructionist framework. Whilst this undoubtedly provided a necessary and useful, perhaps even essential, counterpoint to biological reductionism and helped to create a specifically social space within which to think about children and childhood, the time has come to make a re-examination. Whatever its benefits it is now apparent that social constructionism stands in danger of replacing biological reductionism with social or cultural reductionism. When the body is thought of as an effect of social relations or culture, a ‘made-up’ entity, then there is little room for the body as a physical or corporeal entity.

This paper suggests that it is important the sociology of childhood find a way of apprehending the body as a material as well as representational entity. I therefore consider the implications of the recent discussion about social constructionism and the body - discussions which I think have been generally neglected or at least underplayed in the formulation of the new ideas about childhood. This way into the problem is useful because some important issues identified in debates about the body run parallel to those emerging issues in the social study of childhood. The central question is: how might we bring the material body back into accounts of childhood without lapsing into biological reductionism. I want to suggest that this is not possible within a social constructionist framework - although there are elements of it that are valuable - and that to accomplish such a shift requires a rethink of childhood and materiality in wider terms.

The paper has five sections: the first introduces Turner’s distinction between foundationalist and anti-foundationalist accounts of the body; the second shows examples of these in the literature on childhood; the third discusses Shilling’s notion of the body as biologically and socially unfinished, suggesting that this is a useful formulation but one that needs some modifications to be more useful; the fourth calls attention to the sociology of translation as a
framework for discussing childhood; the last makes some observations on body boundaries and distributed agency.

**Foundationalist and anti-foundationalist accounts of the body**

It is now widely agreed that an adequate social theory must account for the body and the part it plays in social relations, despite the tradition of defining the scope of the social sciences in ways that specifically exclude the biological. For example, the concept of socialisation not only tended to place children in a passive relation to culture, the familiar criticism from the new social studies of childhood, but also drew on a notion of culture that was posed in distinction to that of nature. This both limited the field of legitimate expertise of the social sciences in relation to childhood and society but also, and at the same time, left the legitimacy of the biological sciences unchallenged.

This position is unsatisfactory, not least because much of childhood (like social life in general) is performed corporeally, through the interaction of bodily beings. The problem for the social sciences has therefore been to bring the body and society into a different sort of relationship to each other, avoiding on the one hand a collapse into biological reductionism and on the other dissolving the body as a material entity into a set of insubstantial meanings. This turn in social theory has proved difficult, plagued by a tendency to fall into either biological or cultural reductionism. In his reviews of the field Turner (1984, 1992) has suggested that contemporary sociological thinking about the body is divided between what he terms 'foundationalist' and 'anti-foundationalist' approaches. These mirror the twin reductionisms discussed above by making different and contradictory ontological and epistemological assumptions at every level. Whilst Turner argues that both approaches are inadequate in themselves and that some theoretical synthesis or transcendence of them is required, his characterisations make a useful starting point for examining how these different assumptions about the body are present in different analyses of children.

Foundationalists take the view that the body is a real, material entity which is not reducible to the many different frameworks of meaning, such as the anatomical textbook in biomedicine or the chakras of Ayurvedic medicine, in which it is variously represented in human cultures. At its most basic, foundationalists assume that there is something constant (but changing) which
functions independently (or partially so) of the social context within which it is found. The body (and its processes of change) form an entity which is experienced and lived. What is prioritised in this perspective, therefore, is largely phenomenological. The task of sociologists is to document and analyse how the body is experienced and interpreted by different actors in different social and cultural contexts.

Anti-foundationalists, however, are unwilling to make a distinction between the body and its representations. In an extreme form, anti-foundationalists might argue in an entirely idealist fashion: that there is no material body - only our constructions or understandings. Less extreme, but also less coherent and somewhat untheorised is the view that even if the materiality of the body is conceded we only have access to it through discourse of various kinds. It is these discourses, or ways of representing the body, that structure and shape our experience of it and the meanings we give to it. In this view, then, the task of social scientists is to analyse these representations and uncover the social processes through which they are made and have their effects.

**Childhood bodies: the prepared gaze versus the experiential body**

Both foundationalist and anti-foundationalist approaches to the body can be found in the literature on childhood. The work of David Armstrong (1983, 1987) is a prominent example of the latter. In fact Armstrong’s interest in the construction of childhood bodies has intellectual roots rather different from those of the sociology or anthropology of childhood. It derives from the important role that he argues childhood as a cultural construction has played in the constitution of twentieth century medicine. Writing from within medical sociology, his purpose is to undermine the idea that human anatomy underlies or is a secure material context for understanding medicine as a social practice. He strongly contests the claim that there is a biology outside of social life to which we might refer when trying to understand the enterprise of biomedicine. Instead the body is seen as a socially constructed knowledge. He insists, therefore, that at any historical moment the body is to be understood not as an underlying reality but as a form of knowledge shaped by the social circumstances of its construction. Knowledge of the body is, therefore, not to be understood as a more or less accurate representation of some underlying and changing but constant material reality, but as a way of looking and representing which is sustained by and is sustaining of social practices:
What is the nature of the body?...The body is what it is perceived to be; it could be otherwise if perception were different. (1987:66)

The body is a construction, invention, classification or representation that is endlessly reconstructed, reinvented, reclassified and rerepresented. It is from this perspective that Armstrong views the human body and, in particular, the construction of the bodies of children in biomedicine. One of Armstrong’s main concerns has been to trace the development of paediatrics as a distinct medical discipline, at first as a speciality concerned with the diseases of children but later in its attempt to claim a concern with the health and development of children as a whole. The emergence of modern biomedicine in the eighteenth century entailed the creation of an anatomy of pathology which could isolate and place disease within specific sites of the body. At this point there was little concern for the age or stage of development of the patient. Although distinctions between adult and childhood versions of a pathological condition gradually came to be made, these classifications did not form the basis of a distinct medical specialism. That development came about in the early twentieth century and was the result, Armstrong argues, of societal changes in the relationships between children and adults. The establishment of paediatrics at this point turned around a shift from the idea of disease in children to the diseases of children. As childhood came to be thought of as distinct from adulthood, so medicine came to think of children’s disease and children’s bodies as different from adult ones. Childhood bodies were not so much discovered as invented.

Whilst the anti-foundationalist view of children’s bodies has a great deal to say about the role of the professions such as medicine and their role in the creation of frameworks through which the body is understood, it has little to say about the body as an experienced entity. For this we have to turn to those who have placed the lived worlds of childhood more centrally - although the foundationalist assumptions of these accounts are often left implicit. These writers are concerned to enter into the social worlds of particular children or groups of children through the use of ethnographic methods - what Allison James has called the tribal view of children. The two examples I discuss below share this approach, although in rather different circumstances. Both show the body, as Turner puts it, ‘drenched with symbolic significance’ and therefore an important element through which children come to create their identities. Allison James deals with the more commonly experienced contexts of children’s everyday lives,
focusing on how children create and enact categories of significant difference, especially bodily difference at home and in school.

James (1993) notes that bodily differences (of height, weight, etc.) have been employed to create 'the child' as an Othered category in Western cultures. Cultural stereotypes about what constitutes a normally developed body for a child assume, she argues, great importance both for parents and children themselves. Deviations from these normative notions can create intense anxiety. Amongst children themselves, experience of the body, and especially of bodily differences, function as important signifiers for social identity. In her ethnography James noted five aspects of the body that seemed to have particular significance for the children she studied: height, shape, appearance, gender and performance. Each of these acted as a flexible and shifting resource for children's interactions and emergent identities and relationships. Although cultural stereotypes about each of the five features mentioned by James played a role, children did not simply passively absorb them. Rather they actively apprehended and used them in experiencing not only their own body but also its relationship to other bodies and the meanings that were forged upon this. One reason for this was that children have to come to terms not only with their own constantly changing bodies and those of their peers but also with the changing institutional contexts within which meaning is given to these changes. For instance, James reports how in the later stages of nursery school children came to think of themselves as 'big'; their apprehension of the difference between themselves and the children just entering the nursery plus the significance of the impending transition to primary school signalled this identity. But once they had made the transition and were at the outset of their career in primary school, they were catapulted back into being small again. This relativity produced, therefore, a fluidity about the relationships between size and status that produced what James identifies as a typical 'edginess' among children about body meanings. The body became a crucial resource for making and breaking identity precisely because it was unstable.

The importance of the social context within which children experience and interpret bodily difference is also strikingly illustrated by the work of Myra Bluebond-Langner (1991). In her study of a summer camp for North American children with cancer she noted that the unconditional acceptance by their peers was one of the most valued aspects of the experience by the children who took part. Whilst their hair loss and other effects of therapy resulted in these children isolating themselves because of the teasing and stigma characteristic of their
relationships with healthy children in their school or neighbourhood, on the contrary these bodily effects were taken up at the summer camp as signs of a different but shared identity.

The body unfinished

Both foundationalist and anti-foundationalist accounts of childhood bodies were incorporated into the discussions which gave rise to the new social studies of childhood, but the fundamentally different assumptions on which they were based were not really recognised or resolved. It is noteworthy that a current of uneasiness, not to say evasion, always ran through some social constructionist writings about childhood. Interestingly, these often implicit and unresolved reservations were at their most noticeable when it came to childhood bodies. To be self-critical, Allison James and I acknowledged (1990) that the (material) body should be understood as at least a limit or constraint on the possibilities of the social construction of childhood; we posed questions about the extent to which childhood as text could be understood independently of childhood as a stage of biological growth; we enquired about the weight that should be given to each if childhood was to be seen as both social and biological. But no answers were given and the questions remained unrefined. Instead a rather ill-defined social constructionism was allowed to become something of an orthodoxy - as was also the case for studies of the body. The reason for its attraction was much the same in both cases: social constructionism seemed to provide the most secure defence against attempts to read social relations as epiphenomena of nature. And since we wished to see both childhood and the body as part of culture not nature, this seemed a congenial position to take.

The problem is, that as Turner argues, it is not possible to be foundationalist and anti-foundationalist at the same time. Turner’s suggested way out of this problem is methodological eclecticism: that is to say he suggests using both approaches as and when it is appropriate, seeing them as in some way different but complementary. This is clearly inadequate: as he points out, quite different assumptions about the material character of the body are being made. Chris Shilling argues that Turner fails his ambition to synthesise foundationalist and anti-foundationalist approaches because his method is additive rather than relational. Turner attempts to ‘combine foundationalist and anti-foundationalist frameworks without altering any of their basic parameters’ (1993:103). Consequently, Shilling argues, he does not examine the relationships between the body in nature and the body in society.
Shilling attempts a synthesis by another route and in so doing he develops a position that is of great potential for studies of childhood and the body. The essence of his suggestion is that the human body is socially and biologically unfinished at birth. Over the life course it changes through processes that are simultaneously biological and social, although each of these terms is made problematic. Drawing on a very wide range of social theory he suggests two basic elements of a framework. The first, that the mind-body relationship has to be seen in the wider context of the culture-nature relationship, is drawn from both anthropological and feminist analyses. Important among the former is theory of symbol and metaphor developed by Lakoff and by Johnson (see Shilling 1993: 113 for discussion). They argue that there is a close, but not one-to-one, relationship between mind and body as a result of the mind being located in and dependent on bodily mechanisms for the perception of the natural world. We exist, for example, in a world where gravity creates phenomena of motion as ‘up’ or ‘down’ and human thought incorporates, draws on and elaborates this phenomenon. Feminist writers have also, though to different degrees, pointed to irreducible biological differences between the sexes which shape experience differently for men and women. Whilst some feminist analyses tend towards biological reductionism (often with an inversion of male claims to superiority), others look to an interaction between biological and social processes in which natural differences are transformed or distorted into social ones. In these accounts, the body is not only shaped by social relations but also enters into their construction as both a resource and a constraint.

The second, and equally important element of Shilling’s approach, is the suggestion that once we grant the body a biological/physical existence, we can begin to see how it is worked on by society. Some of this work occurs through the symbolic and discursive practices highlighted by social constructionism - the body is represented and classified in various ways. But there are also social practices which are material ones, for example diet, exercise and disciplinary regimes, which materially shape the body. In each case the relationships between the body and society is reciprocal: society works on the body, just as the body works on society.

It is strange, to my mind at least, that in developing this idea of the body as socially and biologically unfinished, Shilling pays little attention to childhood. I think it is true to say that children per se appear in relation to only two substantive topics: Norbert Elias’s account of the ‘civilising process’, that is the long-term historical trend towards individuals practising internalised control and restraint over forms of behaviour concerned with bodily functions such
as eating, copulating and defecating; and Bourdieu's account of the transmission of class habitus. But from the point of view of the new social studies of childhood, both Elias and Bourdieu are deficient in their assumptions about childhood socialisation. Both treat children as passively and gradually accreting or accumulating embodied dispositions in the transition to full sociality in adulthood. There is little sense that children actively appropriate and transform as well as absorb. Nor is there a sense that childhood and growing up are full of reversals, transformations and inversion rather than being a progression to an ever closer copy of adulthood. In short, what is missing is a sense of childhood as a being as well as a becoming: childhood as staged, performed and experienced in its own terms in the present as well as those of adult society and the future. But once this notion is allowed, it opens up the possibility that childhood itself might be thought of as exhibiting difference at the level of bodily conduct. As Prendergast points out:

The issue of embodiment as a cultural process surfaces most poignantly at key points in the life cycle: the trajectory of the body is given symbolic and moral value: bodily forms are paradigmatic of social transition... Each stage requires that we adjust to and attend to our body, or that of others, in an appropriate and special way. (1992:1)

We have here the possibility that childhood is created through, even perhaps requires, certain kinds of bodily performance.

This is the direction taken by Toren (1993) and Christensen (1993, 1994). Developing a position broadly similar to Shilling, but owing perhaps more to Merleau-Ponty, Toren views children as growing and developing within a historically and socially situated body. Mind, she argues, develops in specific social, cultural and historical circumstances that shape it not just as consciousness but also as body, even at the level of the nervous system. Unlike Shilling, she stresses the creative activity of children who inhabit a world that stands in paradoxical relationship to the adult one and is not to be taken as an incomplete or faulty version of it. Christensen takes this point further by showing that children might be expressing bodily experiences in ways quite different from their adult caretakers, such as teachers. In her ethnography of Danish primary school children and their actions and relationships during episodes of sickness and minor accidents, she focuses on how the children gave help to others.
She noticed how teachers and other adults saw children as complaining too much about minor cuts, grazes and bruises acquired during the course of the school day. In response the adults tried to teach the children to make less fuss, sometimes by telling them so and sometimes by ignoring their complaints. Observation of the children showed that they often drew attention to bodily experiences in very dramatic ways, often with the request from others to ‘Look!’ For the children, however, this demand was not one for medical attention or first aid or even help - as adults tended to interpret it. Rather the children were drawing on a wider practice, engaged in during all kinds of games, play and other activities, of asking others to share their experience of the body. In her interactions with the children, she, as an adult, came to learn the culturally appropriate response was not to reprimand the child for over-dramatising, or even give them help, but simply and without fuss to share in the act of looking.

The body translated

So, to summarise the argument so far: social constructionism is inadequate as a theoretical framework for understanding either childhood or the body. Its strengths are that in relation to both it guards against biological reductionism and highlights the importance of representation in their social constitution. These strengths are, however, beset by some crucial inadequacies; because social constructionism underplays or denies the body as a material entity it cannot account for: the body as a resource in the construction of social relations, meanings and experiences; the body as a means and resource for agency, action and interaction; or the body as a site for socialisation and embodiment. Shilling’s notion of the body as socially and biologically unfinished is a useful way of recuperating these possibilities without collapsing into either biological reductionism and whilst retaining a place for practices of representation. But Shilling does not pay enough attention to children as agents or to childhood as being rather than becoming.

But if the encounter between the sociologies of the body and childhood shows social constructionism is inadequate, then what sort of theoretical constructionism might prove more robust? One approach to this question is to be found by moving beyond the relationships between body and society and instead locating it within that between nature and culture - of which the body-society relationship might be thought just one instance. To explore this
possibility I want now to discuss how childhood bodies might be thought about in terms of what is sometimes called the sociology of translation.

Developed within the social study of science and technology (see, for example, Latour and Woolgar 1986, and Latour 1993), but having implications far beyond it, the sociology of translation is concerned with the material from which social life is produced and the processes by which these are ordered and patterned. It has much in common with forms of sociological analysis which emphasise the relational, constructed and processual character of social life: semiotics, social constructionism, symbolic interactionism and Foucauldian concerns with panoptical surveillance and the exercise of power. At the same time, it is quite distinct in one crucial and radical respect: it rejects the assumption that society is constructed through human action and meaning alone. It is therefore constructivist - but in a radically generalised way; and materialist, but in a way which places the material in relation to the other elements that constitute society. In fact 'society' is seen as produced in and through patterned networks of heterogeneous materials; it is made up through a wide variety of shifting associations (and dissociations) between human and non-human entities. Indeed, so ubiquitous are associations between humans and the rest of the material world that all entities are to be seen as hybrids - what Latour (1993) has termed 'quasi-objects' and 'quasi-subjects' - where the boundary between the human and the non-human is shifting, negotiated and empirical.

Social life cannot, therefore, be reduced either to the 'purely' human or to the 'purely' animal, vegetable, mineral, technical, artefactual, abstract... As a general rule (but subject always to detailed empirical examination) we can say that none of these entities alone determines the ordering that results from their combination. Sociological approaches which try to make one kind of entity do all the explanatory work result in some form of reductionism (biological, technological, cultural ...) . In this view, then, childhoods, like all social relations, are constructed not only from human minds and their interactions, not only from human bodies and their interactions, but through an unending mutually constituting interaction of a vast array of material and non-material resources. Bodies and minds are to be included - but alongside aspects of the natural and material environment, including their orchestration and hybridisation into artefacts of many different types. All of these are to be seen as a priori equal or symmetrical actants in the creation of society - or more properly 'the networks of the social'.
In short, this approach would place childhood in relation to not only symbolic but also material culture. What produces childhood is not simply the biological event, not only the phenomenology of bodily experience, not merely structures of symbolic meaning - although all of these are important - but also the patterns of material ordering through which, as Latour puts it, society is made durable. Examining childhood is a matter of tracing through the means, the materials and practices of its construction. ‘Translation’ is the process by which these heterogeneous entities mutually enrol, constitute and order each other.

A brilliant and highly pertinent example of this approach is found in the work of Bernard Place (1994). He shows how different approaches to the body might be integrated, by looking at an instance when the bodies of children are intensively combined with medical technologies. The ethnographic location he chose was the modern hospital, specifically a paediatric intensive care unit. He points out that in this particular location the human body is perforated, cannulated, intubated and catheterised before being connected to sets of technological artefacts which enable detailed examination of the functioning of the heart, kidneys, brains, lungs and other organs. Such artefacts generate sets of symbols (traces, numbers and images) which are manipulated by the doctors and nurses. Changes in these symbols are understood to relate to changes of similar magnitude occurring within the corporeal body:

In the process of connection to these artefacts the body is, in the situated vocabulary of the intensive care unit ‘sorted out’. Literally it is ‘sorted’ (the disordered body is ordered) ‘out’ (the internal body is externalised). At the same time the boundary of the body is extended and circumscribed by both corporeal (human) and non-corporeal (technological) elements. The body is, in this sense, ‘technomorphic’, revisable by connection to technological artefacts.

In this setting, the nurses and doctors, as well as the parents and child patients, are concerned to maintain the integrity of the body. But what is the body in these circumstances? Is it enclosed by the skin or is it bounded by the technologies that treat and monitor it?

On the basis of his participant observation, Place makes a distinction between what he calls ‘child data’ (what is happening within the corporeal body) and ‘data child’ (the visible manifestation of that corporeality through its connection to the surrounding technological
The coincidence of the two cannot be taken for granted and he argues that the conditions whereby they are held together are accomplished minute by minute; the work of the intensive care unit entails maintaining an association between 'child data' and 'data child'.

Place's insights give a fresh perspective on Turner's central divide between foundational and non-foundational views: the body and representations of it are not necessarily mutually exclusive. Rather the 'child data' and the 'data child' mutually explicate each other, so that at least in this setting one is unthinkable without the other.

One does not determine the other, with the necessary implication of prior and post status. They are conjoined, mutually explicating only when juxtaposed. When the two forms do separate, one becomes a set of meaningless symbols, the other a disordered mass of flesh and blood.

It may be that this presents a useful way of conceptualising the different versions of the body that permeate the sociology of childhood. Different notions of childhood might be seen as the product of such translations, that is to say different, usually unstable, orderings of heterogeneous elements. Different children in different circumstances may be associated with different material resources - producing not 'the child' but many different local versions of children. Similarly the large-scale phenomenon we indicate through the notion of childhood might be thought of as heterogeneously constructed. What elements, we might ask, have gone into its construction, how are they ordered and held together, what resistances had to be overcome in the process and how is it being made into a large-scale phenomenon or given local variation?

**Boundary bodies and distributed agency**

One consequence of this approach is that the boundaries between the human body and other entities become much more blurred than is normally thought to be the case. The body is seen as having extensions of all types. By combining with and enrolling each other, children, adults, animals, plants and devices create hybrid entities which are more than the sum of their parts. This serves to remind us that the intensive care unit may be one of the unhappiest but is far from the only place in which we encounter children's bodies in some sort of combination with
material artefacts. I would go so far as to say that we never do anything else. Everywhere we look, children are associated with a huge variety of artefacts - bicycles, computers, toys, spectacles and so on.

The very commonplaceness of these associations normalises them and makes us forgetful of their importance. Whilst we might notice that children's culture is populated by all sorts of quite explicit hybrids - Mutant Ninja Turtles and Biker Mice from Mars, to give just two examples - the everyday hybridity of a child with a wrist watch, a pencil or a TV set merges into the background and we fail to notice its possible significance. But the combinations which children make with material artefacts have a crucial bearing on their capacity for agency. It is my impression that when advocates of the new social studies of childhood talked about children as social actors, we assumed agency to be essentially embodied. We had in mind the bounded capsules of children being counted in as actors in social processes. From this point of view, what we urged was quite a limited reform in the structure of attention of social research; count children as social was our injunction.

But in the distributed view of agency, the capacity to act is an attribute of connectedness. It arises from a relationship and is not to be found at a point - whether that be a bounded body or a discrete machine. Rather agency is created through their combination and distributed between them. Just as the form of the body is revisable in these connections, so is the capacity for agency.

It is necessary, therefore, that in order to understand how children can be social actors, we examine the boundaries of children's bodies and how these are experienced, constructed and shifted by the translations of adults, children, nature and technology. The issue then becomes not whether there exists a foundational body as distinct from social constructions - because this could be taken for granted - but rather the discussion would centre around different claims to 'speak for' this body, to translate it and enrol it in the service of social action. We could then begin to ask what translations empower children and which do not. As social analysts we would then be able to give a certain symmetry to the claims of Armstrong's paediatricians and James's playfully serious school children.
Note 1

I use the term ‘new social studies of childhood’ to indicate those approaches emerging in the 1980s which urged that childhood be included in accounts of society and children understood as social actors, shaping as well as shaped by social relations. It was centred on the work in sociology (exemplified in writings by James and Prout, Jenks and Qvortrup) but now extends beyond that into an interdisciplinary concern: ‘new social studies’.

Annex

I offer the following headings as a summary of some of the questions raised or implied in this paper:
Dimensions for the Study of Childhood and the Body:

Localities?
What are the different localities (schools, hospitals, households and families etc) within which children’s bodies are worked upon? How are these localities connected and how are large-scale phenomena generated? How does a locality and its connections shape the work which is done?

Material and Symbolic Work on Bodies?
What are the varieties of material and symbolic work done on children’s bodies and by whom: representing and making them visible; regulating, controlling and disciplining them; forming identities, habituses and internalised body maps?

Work Done By and With Bodies?
How are children’s bodies enrolled in the shaping of social relations- of age, gender, ability, ethnicity?

Interactive and Communicative Processes?
How do adults and children, male and female (and their various possible combinations) negotiate and construct the body as a resource and as a constraint?
Boundaries, Combinations and Agency?

How are the boundaries of children's bodies experienced, constructed and shifted in the translations of adults, children, nature and technology? What are the modes of agency achieved by children through their alliances and combinations?
References


MOTHERS' ACCOUNTS OF HEALTH IN THEIR BABIES

Sonja Olin Lauritzen

Introduction

The focus of this paper is mothers' understandings of health in their young babies. My point of departure is a broader interest in lay and professional health ideas and how these ideas are communicated and constructed in different social arenas. Here, I will present a close-up of mothers' accounts of health in their young babies, drawing on a study I carried out in Stockholm and London in 1992-94, and I will concentrate on the character of these accounts and what the mothers say about health and threats to the health of their babies.

This piece of research has its background in a study I carried out earlier on interaction between parents of young children and health professionals in child health care clinics here in Sweden. My observations of how parents are intensively confronted with medical health ideas and ideologies, which are communicated explicitly as well as implicitly within the routines of the health services (Olin Lauritzen 1990, 1993), generated questions about how parents are influenced by these encounters with professional discourses on the child, and how they actually make sense of health in their young children within the context of their everyday lives.

Accounts of health

First some preliminaries about accounts of health. Studies of lay ideas of health and illness reveal that people seem to draw on a range of co-existing ideas of the character and causes of health as well as illness, rather than a coherent system of explanations (Herzlich 1973,
Pierret 1993, Stainton Rogers 1991) and that these understandings of health also vary across social groups and across the life-cycle (Williams 1983, Lupton 1994).

As Claudine Herzlich demonstrated in her influential study in 1973, and others after her, health ideas seem to vary along several dimensions, such as health as an absence of illness, as a resource in the individual or health as an equilibrium, or as a balance in the individual - and that people seem to understand health in relation to a double frame of reference, the bodily and the social. In studies of adult health, the social refers to activities in the social world and the individual's capacity to fulfil his or her regular social roles or duties. At the same time, the health or illness clearly exists in the body of the individual. In her everyday life, the individual observes and reflects on signs and symptoms of her body cognitively as well as emotionally, and communicates her reactions and understandings within her social network. In this sense, bodily experiences are embedded in a social context (Radley 1994). One could thus raise questions about how this applies to understandings of health in young children.

One approach to the study of people's notions of health and illness, and how these are constructed and elaborated in the context of their everyday lives, is to explore their accounts of their 'lived' experiences of health and illness. People's accounts of health and illness can be seen as "chains of cause", in the sense that what people say about health and illness is given structure by their need to strive for some experiential coherence in their accounts. Radley (1993:5) points out that 'expressed beliefs about health and illness are not merely sampled from a pre-existing system of shared thought, but are articulated accounts that serve more than one purpose. One of these purposes is the search for meaning, the need to render suffering and uncertainty tangible and, at least, subject to anticipation if not to prediction.'

Stories told in everyday life as well as in institutional settings typically involve accounts, and these are always "accounts of" aspects of life, and as such they involve knowledge and understanding as well as people's explanations of events and experiences. Accounts are in this sense both depicting and explaining (Stainton Rogers 1991).
So, if people draw on a range of health ideas, and these ideas also vary across stages in the life-cycle, it is of interest to see how child health is understood in relation to the bodily and the social - and I will look at this from mothers' perspectives; that is, how mothers live with and reflect on health in their children.

**Maternal perspectives on child health**

A focus on mothers' accounts of child health means that health is explored, not in relation to the individual herself, but in relation to the child as another person. An analysis of such accounts can tell us something about how child health is depicted, explained and contextualised by the mothers. As Allison James (1993) argues in relation to studies of childhood, parents' accounts of their children offer a perspective on childhood which derives from personal experience, but these accounts are at the same time social constructions, contextualised by the parents' belonging to a particular class, a particular locality and a particular cultural context.

The particular part of the life-cycle which is chosen in this study, is the very first months of the child's life, when health and normalcy is constituted in the new born baby as a 'new' human being. This period has some special features, of importance for the exploration of health ideas.

As I have mentioned, this first constitution of the baby's health and normalcy takes place in several arenas; within the private domain of the family and the social network of the parents and within the public, medical, discourse of the health care services.

Another feature of interest in this period is the special bodily experiences in the early mother and baby relationship. Health in the baby is understood within a close interpersonal relationship. The baby has until very recently been part of the mother's body, and the bodily closeness between mother and baby is extreme, particularly through breast feeding, to the extent that bodily borders may be blurred.
Also, the baby cannot express itself in other ways than through signals which have to be interpreted by the mother. It is thus reasonable to see mothers' notions of health in their babies in the context of the particular characteristics of this period of life: the immaturity and dependency of the baby, the modes of communication between the baby and the mother and the process of transition to motherhood.

However, neither the close interpersonal relationship between mother and baby, nor the immaturity or dependency of the baby can be regarded as 'given' phenomena. As Prout and James (1990) argue in their discussion of how "childhood" is socially constructed and reconstructed, "the immaturity of children is a biological fact of life but the way in which this immaturity is understood and made meaningful is a fact of culture" (1990:7).

Given these special features of this very early period of life, I wanted to look at how health in young babies is understood. In the study I carried out in 1992-94, I explored mothers' understandings of health in their babies, and what their accounts reveal about the process of making sense of the health of the baby, how health and illness in the baby is contextualised by the mother and also how the mothers draw on notions of children and health that are culturally available to them.

The study

To establish contact with mothers with young babies, I contacted three local child health care clinics in the Stockholm area located in areas with different population structures, to obtain some variation in the socio-economic and educational backgrounds of the parents. The health visitors agreed to introduce me to mothers of new babies, and I told them I preferably wanted to see "ordinary" first time parents with babies between three and five weeks of age, not to interfere with the very first vulnerable weeks of family life but still to start seeing them while the baby was "new" and before the medical assessment were made.

My approach was to follow a limited number of mothers, with repeated contacts over some time, to allow for an in-depth analysis of their accounts. The process of contacting mothers carried on until twenty mothers agreed to see me. One mother dropped out after first having
given her consent, as she was also participating in another project, on breast-feeding. During the field-work, fathers would occasionally be present and in some cases took part in the conversation (in one immigrant family the father participated all the time).

Of the nineteen participating mothers, fourteen had a first baby and five a second baby (with a first child under three years). The mothers were between 21 and 36 years old. Two of them were single, living on their own with the baby, the rest were living together with the father of the child. Two mothers were of non-Swedish origin.

After having carried out the field work in Stockholm, I had the opportunity to add a cross-cultural component to the project by doing a similar though smaller piece of field-work in London. The purpose was not to carry out a comparative study in a traditional sense, but to add social and cultural variation to the project and to be able to draw on cultural contrasts in the process of analysis of parents' understandings of child health.

Ten mothers were contacted in a similar way at two inner-London health clinics, and I saw these mothers twice for interviews in their homes (except one mother whom I interviewed once at the clinic). Just as in the Stockholm sample, there was variation in the parents' socio-economic, educational and ethnic backgrounds, and the mothers were predominantly first-time mothers within the same age-range as the Swedish mothers. However, I am not going to address the cross-cultural issues or differences between the Swedish and British mothers. Here, I am going to focus on some similarities across these samples.

What I am concerned with here is accounts of child health. The accounts presented here are derived from mothers. The mothers speak about their own experiences as mothers. However, they occasionally also speak about themselves together with the father of the child, as parents, or reflect on parents' situations or responsibilities in a more general sense. This means that the word parent appears in the text, though the focus of the analysis is consistently on mothers' accounts. The quotations in the following sections are from British mothers, to bypass difficulties in translations of spoken language, but they are chosen to illuminate themes which runs through the entire material.
Interviewing mothers

Interviewing mothers of young babies about health makes it necessary to take several methodological and ethical issues into consideration. For ethical reasons, I gave great attention to the information and consent procedure, and to adapting the process of data collection to the individual family. The first months with a new baby is a vulnerable and unpredictable period of family life. I also stressed that I would see the mothers when it fitted in with their family lives, in their homes or at the clinic at their choice. I therefore accepted a variation in number and schedule of contacts. I saw most Stockholm families four to five times within a time-span of up to six months, but some of them just twice owing to the family leaving the Stockholm area. Most of the interviews took place at home, but sometimes also during a mother's visit to the clinic.

In the interviews, I used an informal and unstructured approach to encourage the mothers to talk freely (Mishler 1986). So, the mothers' accounts are constructed within their conversations with me, a researcher but also a mother however belonging to an older generation, and a foreigner to the British parents. Most interviews took place in the 'natural setting' of the families' homes; this often meant a visit over a couple of hours where conversation with a tape-recorder switched on every now and then was interrupted by looking at, caring for and feeding the baby as well as tea drinking, phone calls, visits by neighbours or other people. This of course gave me a more vivid image of these mothers' lives. At the same time, care had to be taken to cope with the closeness and intimacy of the situation.

The fact that the baby was physically at the centre of the interview situation added another dimension to the interviewing. Typically, the mother would every now and then interrupt her talking to look at the baby and make comments on what she saw. 'Look at him now, why is he kicking his legs like that?' The baby was talked about, in terms of the mother's experience of her baby in retrospect, and was also a participator in the situation and subject to the mother's immediate reactions and comments.
As the purpose was to explore the mothers' understanding of health and her ideas of what was 'health' and 'not health', I was concerned not to introduce biomedical, or other research categories of health and illness into the conversations. At the same time, I had to describe my field of interest to the mothers, and we both had to draw on some commonsense understandings of child health to be able to develop the conversation through the interviews.

This is a dilemma which has been discussed by Sarah Cunningham-Burley (1990) in relation to her study of mothers' perceptions of illness in their children. She concludes that 'shared meanings and commonsense knowledge form the basis for successful research interviews, irrespective of how oriented the interviewer is towards the perspective of the respondent' (1990:89).

What I did was to introduce my general interest in mothers' own experiences and understandings of health in their children, and then to start off by asking the mother to tell me how her baby had been ever since he or she was born, in order to stimulate longer narratives of the mothers' lives with their babies. From there, I could pick up on issues introduced by the mother, relating to the ways she describes her baby as healthy or not healthy, or to her own worries, and ask the mother to elaborate on these issues.

As health, to a large extent, is a taken-for-granted phenomenon, and some mothers seemed slightly worried that they didn't have anything interesting to tell me - the child was fine and nothing in particular had happened - I followed the approach developed by other researchers in the exploration of everyday family life (Backett 1990, Halldén 1992). I asked the mothers to describe concrete everyday situations, such as the baby's sleeping and feeding and the routines of their day-to-day lives, and stressed that I was interested in her point of view and her concerns about her baby, however minor.

In the analysis of the transcribed interviews, I focused on how the mothers depicted their babies in terms of the baby being healthy or not healthy, how they explained different conditions in the babies, and how they accounted for their own assessments and processes of seeking information and help when needed.
Threats to the health of the baby

What particular images of health and illness are presented through the accounts of these mothers? In their accounts of the health of their babies, the mothers are typically moving between descriptions of the child's competence or capacity, and various threats to the health of the child.

He was very healthy and very happy, he had awful chicken pox as you know... that put him back a little.. but he's been very good and because I’ve been breastfeeding him.. I think that helps enormously with his immune system and keeping him healthy, so no, he’s been very good luckily..

The competence of the child is talked of in terms of what the child can do, the awareness and responsiveness of the child and also how the child initiates social interaction or activities. Most of all, the mothers talk about a wide range of minor or major threats to the health and development of the child, threats that they have experienced with their baby and threats that they reflect on or worry about. These threats range from health hazards, such as infections and children's diseases, to issues of the baby's well-being in day-to-day life. The accounts of threats to the baby's health are typically constructed as chains of arguments about what could, or could not, happen to the baby - what the mothers worry about and what they do not worry about. In this sense, the accounts of threats revolve around images of health.

Here, I will take my point of departure in how the mothers describe these threats to the health of their babies and will focus on some major themes of threats that emerge across the cases, which I will describe here as: threats of abnormality, threats to the survival of the baby, threats to the thriving and well-being of the baby and finally threats from illnesses. I will explore each of these themes of threat in terms of how the mother observes signs of threat in the baby, how she accounts for the character and genesis of the threat, the process of mothers' assessment of the threat and also accounts of consultations or information given by the child health services or other social agents.
Threats of abnormalities

Worrying that something could be "wrong" with the baby is a theme running through the mothers' accounts, particularly in relation to the period of pregnancy and birth, and is often accompanied by the claim that all mothers have such worries. The way these worries are dealt with in the interviews ranges from simply referring in passing to problems that luckily do not exist to engaging in more elaborate explorations of what could be wrong with the baby. The word "lucky" is used frequently when the mothers talk about their children being healthy and say that there is really no reason why anything should be wrong. To my first question about how her baby has been since his birth, Anna replies as follows:

Healthwise he has been very, very well. I was worried as a first-time mother that there would be something wrong with my baby, even before he was born, and again in the first two weeks after he was born. Perhaps because I am a doctor I was continually watching for signs of illness or some sort of malformation or something, but he has been absolutely perfect so far, touch wood.

In talking about the worries during and after pregnancy, Anna mentions a variety of things that could be wrong with the baby. 'Oh, I thought he might have anything from Down's syndrome to, you know, a missing limb.' Abnormalities occasionally occur, you just don't know when. She also relates her worries to her age. 'When you get to your thirties, people start whispering about Down's syndrome and all these things that can happen as you get older.'

Anna claims that her worries came to an end when the baby was born and she could see for herself that he was fine. On the other hand, she returns to her worries throughout the interviews. She worries that her baby is too thin, or rather that he is too tall, which could be a sign of abnormality. Anna says she does not talk about these worries at the child health clinic. She just asks the health visitor to measure the baby so that she can see for herself. So, first Anna tells me that the baby is very well, then she goes on to talk about her various worries, and finally she concludes that he is fine after all, a pattern which is typical of how the mothers talk about the health of their babies.
Throughout the cases, the threats of abnormality are typically depicted as something that could happen to the baby or something that could be wrong with the baby. When the mothers speak of the causes of what could be wrong with the baby, their explanations range from quite vague expressions of something that could happen to a baby unless you are 'lucky', to more specific influences such as a genetic factor that runs in the family, the mother's age, the mother's past or present illness, or the influence of drugs or other factors on the pregnancy. The mothers describe how they observed the growth of the fetus and the scans. The fact that the scans were 'normal' is used as an argument not to worry. 'I was worried at first, but the scan was fine.' Typically, the mothers talk about how they felt reassured when the baby was born and they could see for themselves that the baby was fine and looked normal.

However, the process of assessment goes on, and less articulated worries surface in comments and questions about the physical appearance of the baby. Body movements: 'Why does she move just one leg like that?' and body positions or asymmetries: 'Why is one eye opening more slowly than the other?' - are taken as possible indicators of something being wrong with the baby. These worries are often commented on by the mothers as being irrational or stupid, or as examples of the kind of worries that all mothers have, which can be seen as a way to normalise the worries and thus reduce the threat.

When talking about their worries, mothers refer to what they have heard from others or what they think about hereditary or environmental influences on the fetus, things they heard or read about or picked up from the media. The mothers say that they do not talk about these threats to the health of the baby with the health professionals. On the other hand, it can sometimes be seen that the parents check on their worries by having the baby declared 'normal' by the professionals, or by asking questions about specific behaviour or the way the baby looks. The parents thus seem to draw on their own reflections and imaginations concerning things that could be wrong. The way the accounts are structured indicate that the mothers oscillate between arguments for and against their worries - from depicting the baby as being fine, to exploring the worries they still have, to presenting arguments why there is no reason to worry after all.
Threats to the survival of the baby

The survival of the baby is a powerful theme, particularly in accounts of the birth and the very first weeks of the child's life. Many mothers literally speak of the survival of their baby. This could of course be related to threats of something being wrong with the baby, but the threats to the survival of the baby are linked to the ultimate responsibility parents have, around the clock, for the health and well-being of their babies. In her accounts, Mary explores several facets of the threats to the survival of her baby:

She sort of survived the traumatic delivery... she just would not come out basically, she was just hanging in there... and she got distressed and I was a bit distressed... so the bonding moment was a bit lost....but at least she was out and alive.

The paediatrician very quickly came up to her to tell her that the baby was fine, 'almost too quickly for my liking'. Mary tells me in a joking manner that the doctor said she was 'fine, a lovely baby, bla, bla, bla.' Then the midwife took over and decided that the baby needed heat treatment. Mary observes signs and reactions in her baby. She also observes the work of the professionals, but she does not leave the responsibility to them. She keeps a critical stance and refers to her own observations of the baby.

Another threat to the survival of the baby that Mary also talks about is cot death. 'A lot of other mothers I know of dash over and check their babies' breathing all the time.' Mary tells me that she does not think that she herself 'panics' so much, but she was alerted to the risk of cot death at the ante-natal class and through the media, and there has been a lot on television. 'So, everyone talks about cot death and what one should do.'

You can't prevent it.. but you're supposed to eliminate the risk for cot death... I mean, I'm sure there has been cases of when the mothers and fathers have been doing exactly the right things themselves, and it still happens, for whatever reason... they don't know, do they, it's still a mystery.
Mary tells me that the rate of cot death has gone down by something like half since parents were taught that the ideal room temperature for babies is around eighteen degrees and that they should be laid to sleep on their backs, with only cotton blankets because it is possible to breath through them. And absolutely no smoking anywhere near the baby. But, she says, you can't control the babies really.

Anything can happen to children...you have a perfectly healthy child one minute and then anything can happen the next, you never know, that's the main thing.

Another facet of the threats to survival is the ‘frightening’ experiences of the very first period of the child's life. Mary talks about new babies as being very small, helpless, and completely dependent on their parents. This makes the parents their only link to the world around them. Mary comments that babies cannot protect themselves, the parents have to work their limbs, hold their heads and be an extension of all their functions. In this context, she talks of her fear that she could actually harm her baby if she did not do the right things, ‘...it must be the size and they're so helpless and I think you know that if you make a mistake, it's all down to you.'

Through the accounts of these threats to survival, the baby is depicted as unpredictable, as if the capacity for surviving could change at any time. Cot death is mentioned spontaneously in most of the cases. The threats to survival are again rather vague or unspecific, ‘anything’ could happen. What the mothers do is to observe their newborn babies closely, their breathing, temperature, eye contact, body movements and reactions. ‘If he didn't look like he was breathing I used to shake him..terrible.' It is as if the mothers are trying to ‘read’ their babies, who have not yet developed the capacity to communicate even very basic states. ‘He's trapped within his own little world and was desperately trying to communicate.. and I find that worrying.' The mothers try to support the survival of their baby by staying very close so as to be able to interpret the baby's signals of the baby. The image conveyed by the mothers is that not only are the children helpless and lonely in relation to the threats to survival, the mothers are also lonely and vulnerable as they are exposed to their own ability to function as an extension of their baby.
In their accounts the mothers are not exploring the genesis of the threat or the reasons for their worries to any great extent. It is of course easy to see links to worries about something being wrong with the baby, but it seems to be much broader than that - the child could simply stop breathing or lack the spirit to go on living and there is also the possibility that the parents fail to understand the baby's signals or needs properly. In the accounts, the consultations with health professionals are of only minor importance, with the exception of the mothers' experiences of the delivery clinics. But even here, the mothers observe their babies closely, and do not rely completely on professional assessments. The mothers' sources of information and the ideas they reflect on rather seem to come mostly from a wide range of media, from public debates, and from what other people say.

**Threats to the baby's thriving**

To get food into the baby, to make the baby thrive, is an issue much talked about and elaborated by the mothers. Threats to the baby's thriving can of course be related to notions of survival, but the baby's thriving also clearly involves the mothers' efforts and conduct when it comes to the feeding and the everyday care of the babies. When Rosie's baby was five weeks, she noticed that he was not feeding properly off the breast:

> The most significant thing that happened was that the feeding began to not go well. He was just not feeding properly off the breast, and was just getting lazy and falling asleep and started being a bit fretful and I wasn't too worried until I took him to the clinic and he hadn't actually put any weight on... so the two things combined I decided I would have to change what I did.

Rosie was not very worried until she took the baby to the clinic and saw that he had lost an ounce in a week. She says she knows this is not very much, but still, the fact that he had not put on weight confirmed her feeling that things were not well, and she was quite convinced that she had to do something. It was a kind of a crisis at the time, she says, and she had to find a way to get food into him, rather than doing what others considered to be the best way to do it. 'He's a baby and he needs food regularly, and if he doesn't get it he's going to start suffering, so there wasn't any time for experimentation.'
For a couple of weeks Rosie tried out various ways of combining breast-feeding and formula. She reflects on the advice given by the professionals and says, 'There is all the theory in the world, and that's fine, but unless it's practically working for you it's not fine.' She continues to look at how much he is eating, and to assess how her baby is feeding and growing. After some time she finds a solution of her own, expressing breast-milk and topping it off with formula. The fact that he put on weight the following week proved to her that these changes were necessary and seemed to be working. Rosie concludes, 'He's still getting the breast milk which is the important part, so I'm quite pleased that that's worked out', and the baby seems to be 'quite happy now so that's good.'

Across the cases, the threats to the baby's thriving are discussed as maternal worries about the growth of the baby as well as problems in the baby. The mothers reflect on the size and the growth of their babies, and frequently compare this to other babies, or to the standards of the child health clinic. 'I know that's ridiculous because all babies are different, but I thought my God.. this baby is fifteen pounds and John is barely nine.' Throughout the cases, feeding, vomiting, stomach problems and colic constitute a set of inter-related, day-to-day issues about how to get food, the right food, into the baby - and how to make the baby keep the food. 'Obviously he couldn't keep his food down and he used to be quite distressed after the burp.. he used to look quite sad trying to keep it down but it was just like forced out.' They observe how the food enters and leaves the body of the baby and the baby's bodily reactions, such as how the food comes out of the body, the baby's facial expressions, its crying, kicking its legs, body tension - and finally they observe if the baby seems to be happy.

When the mothers understand that the baby has problems in this process, their typical pattern of response is that first they listen to advice from others - professionals, family and friends. Then they try out the various pieces of advice, step by step. The feeding schedule, type of formula, combinations of breast-milk and formula are tested, and the mothers make their assessments to see what works for their baby. This can be seen as a process, where the mother continuously observes and evaluates the amount of feed taken by the baby, the stools of the baby, the body position while feeding and other reactions in the baby. The feeding and growth issues are frequently discussed with the health professionals,
particularly the health visitors, and are obviously understood by the mothers to be part of the task of child health care services. However, throughout the cases the mothers describe themselves as being in charge. The mother listens to advice and consults different people, but she is the one who is actively and continuously assessing what works for her child.

The child is depicted as an immature and vulnerable being, not quite ready to cope with the process of taking the right amount of food and retaining it. The mothers refer to this immature condition as a way of understanding the problems of getting the food into the baby, and thus as ultimately causing the threats to the baby’s thriving. At the same time, the mother herself is deeply involved here. The threats to the baby's thriving could also be attributed to how well she, the mother, copes with the feeding. However, in a few cases the baby is described as being strong-willed - wanting or not wanting feed, ‘making herself sick’, liking or not liking particular brands of formula. In these cases, the baby is to a greater extent depicted as being in control of its bodily processes.

Threats from illnesses

Everyday illnesses and children’s illnesses are observed closely by the mothers, but talked about as being trivial as long as the child does not seem to be affected in a more general sense. ‘He was a little snuffy, but he didn’t suffer and he didn’t go off his feeds, and the next day he was fine.’ The health of the child is frequently compared with the health of other children who were more affected or became more ill. ‘Luckily he hasn’t had anything more dreadful like my friend’s baby who had a chest infection that was treated with antibiotics which caused diarrhoea and caused him to go off his food.’ Illness episodes that are experienced as more severe or scaring are often described in detail by the mothers, as in Kathy’s case:

He had awful chicken pox that put him back a little...(..), he was covered, his face, his skull, his chest, his legs, his ears, everything, a real bad case, and it was terrible... his hand was enormous, it had blown up completely, one of his little spots was infectious... and I was just totally distraught... and his temperature was appalling that day.
Kathy says that the temperature was the worst thing: 'They can go into severe convulsions if their temperature is kept high, I think in some cases it can cause brain damage... so I think that was the first priority.' What she talks about at length, however, is how the child might be feeling, 'of course with the high temperature he was crying and he was very uncomfortable and feverish and he probably had headaches as well.' She describes how her ill baby looks, how he reacts, and how she herself imagines he must be feeling. The treatments given by the health professionals are talked about primarily in terms of the discomforts to the baby. He was given oral injections of antibiotics, 'which he hated because they taste disgustingly and camoline lotion on his skin which he hated.'

Kathy tells me that on one occasion when her baby's temperature was very high, she said to him, 'John, we are going to sort this problem out today.' The baby is suffering and she decides that something has to be done. Kathy stresses that it is very important for mothers to be very strong and to use their own intuition and judgement. In this case, not only did the child have chicken pox but also, according to the mother, a reaction to the treatment prescribed by the doctor. In the following excerpt, the mother's line of reasoning is demonstrated:

The maternity nurse came and was giving him Kalpol and the doctor came again and gave him antibiotics and the following day I noticed his stools were very green and runny and he wasn't feeding properly... and I said this isn't right, five minutes into the feed he would start screaming, and I thought this isn't colic... he was totally in distress and his legs were kicking... and I thought no, no, no, there's something else that's wrong here, and I phoned my doctor again and he said, I don't think it's something else, I think it's just a reaction to the antibiotics... and I said no, he's in pain, he isn't feeding properly... so I spoke to the health visitor and said I am not happy about this at all.

This mother makes an assessment of her baby in terms of how he is feeding and his more general state of being happy or unhappy, and she describes the process of consulting professionals as something she actively handles herself.
Across the accounts of the children’s illnesses, the mothers’ point of departure is their own observations of the child. Whether the baby is feeding or not, and its reactions when feeding, seem to have a central role in these observations. Also, the mothers describe the child’s general state in terms of how alert or ‘floppy’ the child is, or how happy or unhappy it is. The fact that babies cannot say what is wrong with them runs through the mothers’ accounts, as does their more emotional, empathic reactions to the baby, they feel so sorry for the baby: ‘poor little thing’. The progress of the illness is described, and they elaborate on how they decide that the illness has become serious and that something must be done about it.

Everyday infectious illnesses are also discussed in terms of how parents can, and whether they should, protect the baby from germs. On the one hand, very young babies should be protected because illness is very hard on them, and breast-feeding is frequently mentioned as a way of making the baby more resistant to illnesses. On the other hand, babies shouldn’t be overprotected; ‘You can’t keep them locked inside all the time.’ One mother draws far-reaching conclusions: ‘It is exactly the sort of child who gets bullied who’s been kept indoors by their mothers all the time.’ Also, there are limits to how much they can be protected: ‘The child will lick the floor anyway, they pick up the germs and you just have to let it happen.’ Children catch different things, sometimes quite evidently from other family members, sometimes from germs or illnesses going around in the area at the time. The number of cases of chicken pox in the local area was attributed to the weather by one mother. ‘When it gets warmer and cold again and then warm again, it brings all this sort of thing out.’

Mothers elaborate on the process of decision-making and the consultations with the health professionals and other people. They describe a chain of assessments and actions taken. Typically, several professionals are consulted, and the mothers describe how they react to the different pieces of professional diagnostic reasoning and advice. Throughout it all, the mother describes herself as being in charge, trying one thing after the other, not giving up even if it is all very tiring and she feels miserable. Again, the image is one of a parent who has to give her all to the baby, however demanding this might be.
Notions of child health

So, how is child health accounted for by mothers during this first period of their child's life? The threats of abnormality and the threats to the survival of the baby are depicted as the most worrying threats, but the genesis of these threats seems to be vague, and they are not subject to active measures taken by the mothers. Threats to the baby's thriving and threats from illness range from the trivial to the severe. These threats are more clearly related to different causes, such as the feed, the immaturity of the baby's body, germs or other environmental influences. Also, the mothers give elaborate descriptions of the measures they take and their frequent consultations with health professionals.

Across all these threats, the mother's accounts have the character of a step-by-step process of reasoning in which the point of departure is her observations of her baby. The mother's description of her child revolves around some recurrent observations; observations of the child's bodily features, its happiness and its process of feeding. This description is followed by reasoning about what would be best for the baby, what the mother has already done and what could be done. Typically, in the process of assessment, the mother returns again and again to her observations. These not only describe conditions in the baby, but are interspersed with accounts of her own efforts to do everything she can to support her baby.

The bodily features of the baby are described in terms of everything that should be there, for example all the limbs and proper breathing, and everything that should not be there such as irregular body movements, body asymmetries, odd facial expressions, high temperature, and a range of various skin rashes or spots - all of which are accounted for in great detail. The mother accounts for these observations as if she were trying to 'read' and interpret signs of well-being, illness or other deviances in the child.

How well the baby is feeding is also used by the mothers as a basic indicator of health. If the child does not take feed, this is regarded as a sign that something is amiss. The baby has a problem and the mother has to find out what it is because it is her responsibility to get the food into the baby. The growth of the baby, according to the mother's own perceptions or according to the growth chart, is also observed and in some cases vital to the mother's
assessment of the health of her baby. However, the feeding in itself seems to be more generally and regularly observed.

The happiness of the baby is continuously referred to by the mothers as the ultimate argument in the assessments of their baby's health. Typical of the stories told about threats to the health of the baby, is that the happiness of the baby is the mother's point of departure for judging if the baby is healthy or not. The happiness of the baby is also referred to when the mother finally concludes that the child is well after all. If the child looks happy, is not crying, smiles, makes noises, is responsive in a dialogue with the mother, then the child is fine. Particularly in those instances in which they are not satisfied with the health professionals, the mothers draw on their observations of the baby's happiness as an argument for carrying on and trying to find a solution on their own.

One could say that within these dimensions - the bodily features, feeding, and happiness of the baby - the mother looks at signs of well-being or signs of illness or deviance. However, the mothers very rarely describe these signs locating their observations to bodily organs in a biomedical sense. Rather, the threats to the health of the baby are described as coming more unspecifically from inside the child, something that is just there, or also as coming from the outside, such as from the environment or the way the baby is being cared for.

The images that emerge in these mothers' accounts can tentatively be described in three basic notions of child health. These are notions derived from the analysis of the mothers' accounts, notions which the mothers draw on in different ways in different situations in the process of assessing and understanding the health of their babies:

- Health in the child as something that is given, or not given, to you. As a mother you are lucky or unlucky. This notion of health refers to something existing in the child as a physical or mental resource.

- Health in the child as something extremely vulnerable, which has to be constantly worked on by the mothers. This notion of health is related to images of the child as immature and unpredictable and to the parental task to be an extension of the child.
- Health in the child as a taken-for-granted resource, related to images of the child as wilful and strong. Health is assumed to simply be there, until illness or deviance is proved. The child is depicted as being capable of coping with attacks from the environment and of working out a balance on its own. (This is however less frequent in the mothers' accounts and perhaps less reflected on.)

Discussion

To conclude, if we return to the double frame of reference, the bodily and the social, the close and detailed observation of the child's bodily appearance and bodily reactions seems to be of vital importance in the mothers' assessments of child health. Shilling (1993) has pointed at the increasing difficulty in contemporary Western societies of maintaining the view of the 'body as given', and that what is emerging in our time are powerful images of the body as 'unfinished', as something to be worked on. In the dominant notion of health found in this study, i.e. of child health as something that is vulnerable and has to be worked on, the baby is certainly bodily 'unfinished', but this is in a different sense from what we find in notions of adult health. The unfinished character of health in the baby could perhaps be discussed in terms of a more existential dimension - the baby's capacity for living and communicating basic states of well-being.

In studies of mothers' accounts of health in slightly older children (Mayall and Foster 1989, Cunningham-Burley 1990) we find that mothers do indeed assess health and illness in their children on the basis of the child's behaviour, and related to what the mothers sees as her unique knowledge of her own children. The recognition of illness is grounded in observations of behavioural changes in the child, such as eating and sleeping patterns, instead of or in addition to physical symptoms. Illness in the child is assessed within the frame of the mothers' concepts of normality, that is what they expect from their children given their age and individuality.

One could argue that the mothers of young babies are in an early phase of developing their knowledge of their own child and thus of what can be expected from the child. The apparently contradictory character of the accounts - on the one hand they are worried, on
the other hand there is no reason to worry - suggests that the mothers in many ways still don't know their babies, and that they are in the process of trying to understand reactions and signals in their babies. Mothers carry the the variety of concerns with them all the time. This could indicate that elements that seem to be contradictory in understandings of health (Billig et al 1988, Radley and Billig 1996) surface more clearly in this very early phase of the life-cycle.

Also of interest here is that the mothers, across the cases, depict themselves as taking responsibility for the assessments of their babies - in short, as being in charge. In their accounts of how they seek help when the baby is not well, the mothers comment on the competence and experience of the different professionals, and how they themselves turn to different people depending on what kind of problem or question they have, and how they themselves initiate this process. The mothers thus seem to see themselves, and present themselves, as being ultimately responsible for the process of overseeing the health of their babies.

In the same vein, the mothers talk about how they have to carry on and do 'everything' in their power, particularly when the baby is seriously ill or unhappy. They describe how they just have to carry on and care for the child at all times, even when they are extremely exhausted themselves. This seems to be a mode of implicitly evaluating their own conduct in the process of accounting for the health of the child. The mothers' accounts of how they make assessments of their baby's health are here intertwined with their presentations of themselves as being responsible, determined, and devoted mothers who do not leave the decisions to others - as 'worthy' parents.
References


EMOTIONS AS MEDIATORS OF CHILDREN’S HEALTH AT HOME AND SCHOOL

Gillian Bendelow, Simon Williams and Berry Mayall (1)

Introduction

Emotions lie at the juncture of a number of classical and contemporary debates in sociology including the micro/macro, positivism/anti-positivism, quantitative/qualitative, prediction/description, managing versus accounting for emotions, and biosocial versus social constructionist perspectives. Indeed, as writers such as Scheper-Hughes and Lock (1987) argue, emotions form the mediatrix between the individual, social and political body; unified through the concept of the 'mindful body'. The central proposition explored in this paper is that emotions mediate between the social order and the body; that they construct how we feel about our bodies. Bodily experience is conditioned by, or modified by the social environment - which itself may be more or less modifiable in response to how we feel about our embodied experience.

The dominance of rationality in Western social and scientific thought - what Bordo (1986) has appositely termed the 'Cartesian masculinization of thought' - has led to the relative neglect or dismissal of emotions as 'irrational', private, inner sensations which have been tied, historically, to women's 'dangerous desires' and 'hysterical bodies'. Historically, and even to the present day, emotions are seen to be the very antithesis of the detached scientific mind and its quest for 'objectivity', 'truth' and 'wisdom'. Indeed, as Jaggar (1989: 145) notes, within the Western philosophical tradition from Plato to the present day, emotions, with few notable exceptions, have usually been considered potentially subversive of knowledge; a view in which 'reason rather than emotions has been regarded as the indispensable faculty for acquiring knowledge' (see also Seidler 1994 on this point and the links between reason and masculinity). Thus in Plato's scheme of imagery, emotions such as anger or curiosity were seen as irrational urges
(galloping horses) that must always be harnessed and controlled by reason (the charioteer) (Jaggar 1989: 145).

For Descartes, the mind is entirely distinct from the body, in other words, he conceptualised the famous 'Cartesian dualism' in which there is a bifurcation of mind and matter, subject and object, observer and observed. The body, for Descartes, is analogous to a machine made up of flesh and bones. Within this scheme of imagery, the body, devoid of a soul, can function like a machine and is subject to mechanical and mathematical laws (Turner 1992). The end result of the dualistic legacies is that, as with the body more generally, emotions have tended to enjoy a rather ethereal existence. Feminist epistemological critiques of science and knowledge have highlighted the elevation of rational masculinist 'public' knowledge over emotional and bodily 'ways of knowing' which are regarded as essentially those of women, and by association through the private domestic sphere, of children (Smith 1987, Martin 1989).

These ideas fit closely with what we know of children's experiences (though this is not very fully researched yet); and they provide a framework within which to discuss these experiences further. Studying the embodied experiences of children is an important but neglected enterprise; and this neglect comprises one branch of the general sociological neglect of children. The case of children, bodies and emotions is interesting sociologically not least because children's experiential learning so clearly spans the bodily and the cognitive, and this is in part because the work women do in controlling, enabling, civilising and regulating children's bodies requires them to take account of links between children's bodies and their minds.

In the first section of this paper we outline a theoretical position which demonstrates how emotions and embodiment are inextricably linked, and, in turn, we use this framework to consider children's experiences at home and at school.

The embodiment of emotions

Considerable attention has been devoted to gender analysis in the study of emotions, as well as the political economy of emotions (Kemper 1990a: 3-23). Here, central questions include how we relate micro-interactional processes of emotion management to broader social structural issues of order and conflict; whether or not emotions can be isolated, defined, observed and
understood as 'things' in themselves or as 'social constructs'; whether we can circumscribe a distinct, autonomous realm of emotions as 'measurable' phenomena, or whether, instead, emotions are to be seen as cultural phenomena, embedded in beliefs, symbols and language, which in turn are inextricably linked to social and cultural processes. More broadly, a related question concerns whether emotions are culturally specific or universal in nature (McCarthy 1989: 51-2).

Regarding the micro/macro debate, for example, Collins (1990) presents a compelling argument that many of the central processes of macro-sociology (i.e. social order, stratification, conflict) ultimately rest on the much neglected micro-foundation of emotions. For Collins, in classic Goffmanesque, Durkheimian style, social order and solidarity ultimately rest on moral commitments which emerge in the course of 'interaction rituals' and emotional exchanges at the micro level. Conflict, too, rests on an emotional foundation, involving as it does the mobilisation of sentiments of anger toward carriers of opposing social values and interests. Solidarity and conflict perspectives are therefore joined in Collins' micro-macro analysis of stratification (Kemper 1990).

Similarly, concerning the positivism/anti-positivism debate, writers such as Kemper (1990a) frequently seek patterns of covariance between social structures and interaction patterns, on the one hand, and the emotions that are hypothesised to ensue, on the other. In this respect, the central thrust of Kemper's position seems to be that emotional outcomes of interaction can be predicted on the basis of a model which centres on the social dimensions of power and status: 'Power and status interactions directly produce emotions' (1990: 11, 207-237). Furthermore, what these approaches share in common is an emphasis on the physiological as well as the social, cognitive and expressive aspects of emotion, in order to pursue what is seen to be a more 'complete' theory of emotions (Kemper 1990:11). In contrast, other writers such as Hochschild (1979, 1983) and Denzin (1984) stress a mainly qualitative approach. Here more attention is devoted to issues such as the self, emotion management, description rather than prediction, a view of emotion as an on-going structure of lived (bodily) experience: the antithesis of positivistic investigation.

However, perhaps the most pertinent debate for our purposes concerns the biological/social divide: an issue which makes the body a central focus of attention. As Kemper (1990: 20)
notes, within the sociology of emotions, the confrontation of the biological and the social is both more focused and more heated than in most sociological subfields. In this respect, whilst few sociologists of emotions would dispute the 'physiological substrate' of emotions, the central question concerns just how important it is (Kemper 1990: 20). At present, as McCarthy (1989: 52) argues, it is not unfair to say that many leading sociologists of emotions, in varying degrees and with different emphases, 'continue to focus on the cognitive and interpretive features of emotional experience and behaviour in contrast to psychological or physiological features of human emotion'.

At a general level, approaches to emotions can be conceptualised on a continuum ranging from the 'organismic' at one end to the 'social constructionist' at the other, with 'interactionist' approaches, as the term implies, somewhere in between. Organismic models of emotions include the work of Darwin, Freud and James. For example, Darwin's theory of emotion is a theory of gesture but, rather than questioning whether emotions are universal or culturally specific, his own general conclusion was to emphasise that they were innate - as indeed have other more recent writers since Darwin's time such as Ekman (1982). As Hochschild (1983: 208) notes, what is missing from these accounts is any conception of emotion as subjective and a more subtle and sophisticated notion of how social and cultural factors impinge on emotional experience and expression.

Freud's approach to emotions, in contrast, is somewhat more difficult to characterise, since it moved through various differing stages. In his early writing he viewed affect as dammed-up libido, emphasising tension and anxiety. Here, affect was simply viewed as the manifestation of (repressed) instinct. At the turn of the century, however, Freud came to view affect as a concomitant of drive, whilst, by 1923 in The Ego and the Id, he stressed instead the mediatory role of the ego between id (drive) and conscious expression: 'Affects were now seen as signals of impending danger (from inside or outside) and as an impetus for action' (Hochschild 1983: 208). Unlike Darwin, however, Freud singled out one particular emotion as the model for all others, namely, anxiety. Moreover, in contrast to Darwin, the meaning of a feeling (i.e. the ideational representation of affect) for Freud was crucial, albeit often at an unconscious level. Like Darwin, however, Freud had 'little to say about how cultural rules might (through the superego) apply to the ego's operations (emotion work) on id (feelings)' (Hochschild 1983: 210).
If, for Darwin, emotion is an instinctual gesture with an archaic, evolutionary heritage, and if, at least for the early Freud, emotion (affect) is the manifestation of dammed-up libido, for James in contrast, emotion is the brain's conscious reaction to instinctual visceral change. James, in other words, equates emotion with bodily change and visceral feeling. On this there seemed to some slight disagreement between James - for whom emotion is conscious feeling and bodily change together - and Lange - for whom emotion is bodily change and feeling secondary - but not enough to prevent the two being referred to together as the James-Lange theory of emotion (1922); a theory which was subsequently discredited by Cannon's (1927) experimental work in which the total separation of the viscera and central nervous system was not found to alter emotional behaviour.

Given these limitations, and the absence of noteworthy differences in the visceral accompaniments of feelings such as fear and anger (Gerth and Mills 1964), psychologists sought to differentiate between emotions according to cognitive factors and thereby laid the basis for social psychology. In other words, this suggested the need to 'go beyond' the organism and the physical environment in order to account for human emotion (Gerth and Mills 1964: 52-53). As Hochschild (1983: 211) notes, whilst 'going beyond' does not mean ignoring the importance of physiology in human emotion, 'it does mean working with a more intricate model than organismic theorists propose of how social and cognitive influences join physiological ones'.

In contrast to organismic theories, social constructionist approaches, as the name implies, stress the primarily social as opposed to the biological nature of emotions. In doing so, they too fall foul of the temptation to overstretch their explanatory frameworks (i.e. the other extreme of the organic-social spectrum). As in (medical) sociology more generally, 'social constructionist' approaches to emotion house a variety of differing theoretical perspectives. Nonetheless, what they do all share in common, in varying degrees, is an emphasis on the socially and culturally faceted nature of emotions as 'emergent' phenomena. In doing so, however, they tend to neglect, or explain away the 'organic moorings' of emotion as at best peripheral, and at worst irrelevant to the sociological enterprise.

From this viewpoint, contra organismic theories, emotions cannot be studied mechanistically, as in specificity theory. Whilst emotions may be accompanied by physiological changes, their
existence is not explained in these terms. Indeed, some emotions, it is argued, such as pride and jealousy, seem to have no specific biochemical 'substrate' at all. Emotions are therefore seen to vary socially and cross-culturally in terms of their meaning, experience and expression. As such, with the possible exception of so-called primary emotions such as anger and fear, they are social and cultural constructions. According to this line of reasoning, sociologists should not therefore focus on 'physiological details' until the varieties of emotions, their meaning, functions and relationship to the broader social, moral and ritual order, as well as other aspects of emotional life, have been thoroughly investigated (Harre 1986).

Leading exponents of this social constructionist view include writers such as McCarthy (1989), Harre (1986) and Jackson (1993) who, from differing vantage points, each seek to elaborate the social or public nature of emotions. Thus McCarthy (1989), for example, seeks to develop what she terms an autonomous (Meadian) sociological perspective on mind, self and emotion as 'emergent' properties: one which will not concede to the psychologist or physiologist exclusive or even primary rights to the domain of emotions. Here the focus is on the fact that, whilst functionally related to the organism, emotions can neither be reduced to nor explained by the organism. Rather, emotions are part of the conscious relations, actions and experiences of selves. Seen in these terms 'Emotions are not "inside" bodies, but rather actions we place in our world...feelings are social...constituted and sustained by group processes...irreducible to the bodily organism and to the particular individual who feels them' (McCarthy 1989: 57). More generally, social constructionist approaches to emotions view human feelings as capable of considerable historical and cultural variation and elaboration.

In a more Wittgensteinian vein, Harre (1986, 1991), argues that the study of emotions involves a focus on a certain kind of social act within a broader moral and cultural order. From this viewpoint, there is no such thing as 'an emotion', rather there are only various ways of acting and feeling emotionally, of displaying one's judgements, attitudes and opinions 'dramatically' in certain appropriate bodily ways (Harre 1991: 142). As this suggests, emotions for Harre are, and indeed always have been, the bodily enactments of mainly moral judgements and attitudes, albeit judgements without premises (i.e. judgements which, in large part, are devoid of conscious ratiocination).
More recently, Jackson (1993) has extended this social constructionist position to the cultural meaning of love as a neglected emotion in sociological discourse. Building on the arguments that feelings are subject to social management—a process which is involved in the very creation of feeling, that our sense of what emotions are is culturally and historically variable (Lutz 1982, 1989, Rosaldo 1984, Stearns 1994), and that there are complex linguistic and other social pre-conditions for the existence of human emotions (Jaggar 1989), Jackson goes on to argue for an approach to love which similarly regards 'the emotion itself as just as much cultural as the conventions which surround it, but which still takes seriously the subjective experience of love' (1993: 202).

These issues, in turn, key into broader poststructuralist and postmodernist critiques of the Cartesian rationalist project (and subject); ones which abandon any notion of a core abiding subjectivity and instead choose to celebrate the body through notions of desire, emotions, the affective life, and corporeal intimacies (Turner 1992). As suggested above however, the problem with these social constructionist and postmodern approaches, is that they end up 'de-centring' the body itself, which simply becomes a textual product; the result of the endless play of inscription and reinscription on the 'nomadic' body ('without-organs'?)(Fox 1993). As a consequence, the imperialistic tendencies of social constructionists mean that their explanatory frames of reference become 'over-stretched' and the body becomes as 'elusive' as ever (Radley 1995). Indeed, as Freund (1990: 455) rightly argues, a 'pure' constructionist perspective in the sociology of emotions 'ignores biological process and presents a disembodied view of human emotions...The relationship between body and emotions are not resolved by ignoring the body's relevance or by viewing emotions simply as cognitive products.

It is in this sense that interactionist approaches, in our view, represent a significant step forward in the sociological study of emotions, sitting as they do in the analytical space between organismic and social constructionist accounts. Again, as with the previous two approaches, a variety of different theoretical perspectives are housed under this general rubric. Nonetheless, they all share a common approach to emotions which seeks to interlock biological and social factors in a dynamic rather than reductionist, monocausal way. For example, Wentworth and Ryan argue that the most penetrating inquiry into the ontology of emotions can no longer be framed as an either nature or nurture question. Instead, they propose that 'the reality of emotion is the interaction of the biophysical, personal and the social. Only in combining can
these elements manifest and retain the distinct properties of the compound that is human emotion (1990: 3).

In seeking to develop this position further they argue that each of these three environments is in some sense social, the latter two in an obvious sense, the former in an interactive sense. As they stress, our biology is not constant, rather it is influenced within one generation and over the long haul of evolution by a variety of noninheritable experiences. Following on from this, innate emotions may be seen as unsophisticated analogues of their later culturally constituted transformations. Moreover, as Wentworth and Ryan stress, whilst the biophysical, personal and social realms of emotions form a synthesis, the particular influence of each on the resultant synthesis (and therefore on experienced and expressed emotions) is a product of biographical, situational and cultural factors and contingencies (1994: 4).

Perhaps the most well known and successful 'interactionist' approach to emotions, however, is made in the work of Hochschild. For Hochschild, emotion is not only a biologically given sense, but also our most important one in signifying 'danger' on the template of prior expectations. Like other senses, emotion is the means through which we know the social world and our relation to it; as such it is crucial for the survival of human beings in group life. Yet as Hochschild also points out, emotion is unique among the senses in being related not only to action but also to cognition (Hochschild 1983: 219).

In adopting this stance, Hochschild joins three theoretical currents in order to theorise emotions. Drawing on Dewey, Gerth and Mills (1964) and Goffman (1959), within the interactionist tradition, she explores what gets 'done' to emotions and how feelings are permeable to what gets done to them. From the organismic tradition, Hochschild is able to posit a sense of what is there, impermeable, to be 'done to' (i.e. a biologically given sense, which in turn, is related to an orientation to action); and through Freud's work on the 'signal' function of feelings, she is able to circle back from the organismic to the interactionist tradition, by tracing the way in which social factors influence what we expect and thus what these feelings actually 'signify' (Hochschild 1983: 222). For Hochschild, emotion is 'bodily co-operation with an image, a thought, a memory - a co-operation of which the individual is aware' (1979: 551).
From this starting point, Hochschild (1979, 1983) goes on to outline her own 'emotion management' perspective; a perspective which allows her to inspect the relationship between emotional experience, emotion management, feeling rules and ideology. As she explains, feeling rules are the side of ideology which deals with emotions and feelings. Emotion management, in contrast, is the type of work it takes to cope with these feeling rules. In this respect, as she argues, 'meaning-making' jobs, which tend to be more common in the middle-class, put more of a premium on the individual's capacity to do emotion work. In this way, each class psychologically reproduces the class structure.

In their differing ways, all these approaches to emotions raise deeper philosophical and ontological questions concerning the problematic status of human embodiment as simultaneously both nature and culture. As Denzin (1984) argues, emotions are embodied experiences; ones which radiate through the body as a structure of on-going lived experience and centrally involve self-feelings which constitute the inner core of emotionality. As a consequence, 'emotion's body', considered as a totality, becomes: 'a moving, feeling complex of sensible feelings, feelings of the lived body, intentional value feelings, and feelings of the self and moral person' (1984: 128). Moreover, as Denzin insists, for individuals to understand their own lived emotions, they must experience them socially and reflectively. It is here, according to Denzin, at the intersection between emotions as embodied experiences, their socially faceted nature, and their links with feelings of selfhood and personal identity, that a sociological perspective and understanding of emotions can most fruitfully be forged; it is emotions which link personal troubles to public issues of social structure (Mills 1959). As Freund argues, the Durkheimian legacy that 'social facts' are not reducible to 'biological facts', together with a predominant focus on the rational actor and other unresolved tensions concerning mind-body-society relationships, haunt the sociological landscape; issues which, he suggests, are most apparent in the sociology of emotions and the sociology of health and illness (1990: 453).

Despite the recent explosion of interest in the body and society (Featherstone et al. 1991, Turner 1984, 1992, Shilling 1993, Grosz 1994), much still remains to be done to 'bring the body back in', in ways which not only satisfactorily resolve the tensions and dilemmas between the biological and the social, nature and culture, reason and emotion, but also avoid the pitfalls of previous crude socio-biological explanations. To date, much of the sociological discussion has been about bodies (i.e. issues of regulation, representation, restraint etc.) rather from
bodies (i.e. a more phenomenological emphasis on the body as a structure of on-going lived experience).

Generally, a number of contemporary social trends and movements are beginning to pose a significant challenge to seemingly 'settled' and 'ossified' conceptual forms in the social science traditions. As a consequence existing networks of conceptual oppositions such as mind/body, culture/nature, society/biology, reason/emotion, object/subject, human/animal, meaning/cause, are beginning to be seen as 'intellectual obstacles' in the way of meeting these challenges. Having sketched the outlines of these broader debates within the sociology of emotions, together with our own particular position within them, it is to their relevance to children's embodied daily lives that we now turn.

**Emotions in children's daily lives**

This section of the paper draws on consideration of data collected in a small-scale qualitative study of children's daily lives at home and primary school (Mayall 1994, 1996) and on a larger study of the status of children's health in primary school, where data were collected through a national survey and in six schools with 264 children aged 6 and 10 (Mayall et al 1996).

Like adults, children are also most appropriately to be regarded as social actors, people who are socially inclined from the outset. The sociality of young children, their wish and ability to participate in constructing, maintaining and modifying the social order, is a theme eagerly elaborated by those who live with them - their parents (e.g. Mayall 1996: especially Chapter 4). This experiential knowledge, acquired by parents on the job, runs counter to the more commonly received view, that it is principally through adult effort that children become social beings. However, developmental research is also studying these issues with a focus on younger and younger children; for instance, Judy Dunn (1988) has described children's social understanding in the second year of life, arguing that emotional and motivational factors drive forward their understanding of and participation in family social life.

As a social group children are also the object of intense and prolonged concern by adults, including not only parents, but what has been called the psy complex (e.g. Donzelot 1980) - the agents of the welfare state. For parents, living with this young member of the family provides
them with new experiences of the social order of a ‘family’; but these experiences and the understandings that this is a person one lives with who contributes to the emotional, physical and moral order of the home, are balanced by the requirement to prepare children, to make them fit to join wider social worlds (eg Hallidén 1991). The preparatory focus of this work - by parents and agents of the welfare services - shows itself in the work of civilising children into the social and moral mores of the wider social group (cf Elias 1978); and some versions of this work on children can be described as regulatory (controlling and modifying their bodies and minds) in the interests of specific agendas (eg the school curriculum). At certain times and places, and notably within the school setting, as well as in leisure centres, children may find it legitimate to participate in the enterprise of constructing their bodies: moulding their bodies to fit socially sanctioned shapes and skills (for discussion in the context of Australian physical education, see Kirk and Tinning 1994). These three kinds of activity on the body: civilising, regulating and constructing: constitute interlinked themes in adult behaviour and children’s experience. Children’s agency looks more severely constricted than that of most adult groups; and children themselves identify adult control as a determining factor in their daily lives.

In the discussion of emotion as a mediating force between social worlds and the body, two critical points can be made in relation to children. These points are particularly important in considering children’s participation in child-adult transactions (compared to adult-adult transactions) because adults are able to control children’s participation, actions, their knowledge and their apprehension of themselves. Furthermore, the more limited experience and knowledge of (young) children serves as a barrier to their engagement in social interactions where adults so desire.

The first point concerns generational proximity: how far the two social groups children and adults seem to be in tension or conflict and how far in harmony. At one extreme, the generations may look - or be experienced as - separate, firm, congealed, and standing face-to-face or in opposition to each other, to the extent that the child cannot take part in the constructing of the social order. At the other extreme, children and adults may seem to be engaged in a joint enterprise, in harmony, with similar goals, and with a comfortable and comforting emotional reinforcement by each to each of their satisfaction with the enterprise and the social relationships embedded in it and strengthened through it. (This idea may be compared to that of James and Prout (1995) who identify families as a social group with
stronger or weaker possibilities for distinctive views and behaviour within that social hierarchy.) Here we are particularly concerned with relationships between groups, their nearness or proximity in terms of interests. And we are concerned, in considering action from children’s point of view, with how far the separation or inter-section of the two groups - children and adults - allows for children to participate in constructing the social order. An example is where two parents are talking about some aspect of life of which the child has little knowledge; she is excluded from ability to participate.

The above proposition includes the idea that child-adult relationships are not fixed but dependent on social factors, such as the immediate situation, goals, numbers of persons present and so on. As such this proposition has to be seen in the context of wider arguments concerning the separation of adult from child worlds. For instance, Angelika Engelbert (1994) argues that childhood is a period of exclusion from and protection from adult social worlds; Judith Ennew, discussing the social conditions within which child sexual abuse has become a noted feature of our societies, refers to ‘a rigid hierarchy creating distance between adults and children (Ennew 1986: 17). On the other hand, changes towards more individualised careers, the pace of social change, and children’s rights issues have been identified as factors leading to more respectful and equal relationships between children and parents (Buchner et al 1995). It is pertinent to note here a distinction between social and psychological distance. It can readily be argued and demonstrated that the social worlds of children are in important respects sharply differentiated from those of adults, by pointing to institutions (such as schools), prohibitions (from entering pubs or from driving), child-oriented services (phone-ins, films and TV programmes). It can also be demonstrated that until they have acquired certain socially approved controls over their emotions and bodies, children are consigned to social distance from adults. However, in terms of psychological proximity or distance, one may suggest that there is wide variation relating to both individual child-adult relationships and social contexts.

Between a given child and parent, a joint enterprise or an adult-controlled enterprise provide, at varying times and places, varying contexts for the psychological proximity between them. Broadly, too, we go on to argue, the home encompasses and promotes greater psychological proximity between children and adults, than does the school.

The second point concerns adult models of children and childhood: what children are, how childhood should be lived, and how, since childhood is a relational concept, adults and children
should behave to each other, across the generations. These understandings structure how homes, schools, health and welfare agencies operate (Alanen 1994). Most crucially, because of the authority and control adults exercise over all aspects of children’s lives, adult models not only importantly affect children’s experience, knowledge and identity; they can be regarded as critical in constructing the personhood of children (Hockey and James 1993). These models serve to present children with, for instance, a series of institutions they must attend - preschools and schools. They encourage the development of certain sorts of bodies, for instance disciplined or athletic bodies. The idea that childhood should be a garden of innocence where children are happy, and the Piagetian notion of play as children’s proper work, provide a complex of ideas that condition the assignment of children to the company of their toys, and the separation of children’s time-use from that of adults: while adults carry out household maintenance work, children are meant to play. The requirement that children be happy can lead adults to protect them from knowledge that might sadden them, such as the death of a relative, or the cruelty people enact towards each other. As Peter Freund (eg 1988) has suggested, at the extreme, social controls in the form of the social organisation of time, space and human motion, have an impact on the vitality and muscular and skeletal structure of the body. In the context of social understandings of proper gendered bodies, girls learn not to develop their muscles, if they are to be socially acceptable; and to restrict their bodily movements within smaller spaces than boys do (Young 1980). As has been emphasised earlier, people, especially in their relationships with their superiors, are required to control and organise their emotions (emotion work) and to use these controls to organise bodily movement in ways approved by their superiors and by more general social legitimation (Hochschild 1979). In particular this can be seen to be so with children, because of their social and political dependency.

Children’s embodied experience at home and school

These two structures: generational proximity and adult understandings of children and childhood, contextualise children’s learning and feeling, not least about their bodies, in the social worlds of home and school. In general, the home seems to provide more opportunity for closeness, for generational proximity. Essentially, the home is the accepted place where attention to the individual may and should have priority; it is the first and foremost site of holistic health care. Women’s health care work, relating to the physical, emotional and
cognitive character of their children - and of their men - is commonly regarded as their central
work (Graham 1984). In this context, therefore, children are likely to experience close
attention to their emotions, bodies and minds. Furthermore, the understanding that emotional
and physical factors are inextricably interlinked in determining health status is also part of the
experiential knowledge of mothers, or of those who care for children continuously. For
instance a mother told of an occasion when her two-year-old son 'went off his food; in her
view this was probably related to the fact that he did not like her recent attempts to toilet-train
him; her cure was to offer more affection, to provide favourite foods and to play down the
toilet-training. Her account also illustrates her acceptance of ideas affecting child
development, which themselves stress emotion as a factor in learning. As Judy Dunn (1988)
suggests, the emotional closeness of child with parent - sharing the same experiences and
concerns - mediates children's participation in the social life of the family. These opportunities
for closeness will be offered at points in time and place where adult enterprises and priorities
do not take precedence. For instance, as Newson and Newson found (1970: 257), mothers
reported that children's wishes took lower precedence than adult and household priorities in
the morning, when everybody had to be organised for the day; it was in the evening, and
especially towards bedtime, that parents responded to what they identified as children's needs
for comfort and ritual. At the supermarket, in public, mothers may require different behaviour
from that accepted at home, in private.

Clearly, children's experiences of school will reflect a somewhat different set of conditions.
Children report sharp social separation between the group of children and the group of adults.
And adults, whether teachers or non-teachers, behave in ways that suggest their close
identification with the formal remit of the school. Essentially, here the cognitive is
distinguished from and takes precedence over the emotional and physical. Whilst teachers at
the outset of their careers may want to mother the children (cf Burgess and Carter 1992), their
work remit demands they maintain physical and emotional distance from the children and treat
them equably and even-handedly (King 1989). The demands of the formal agenda and of the
social order lead to tension between these demands and teachers’ affection and concern for
individual children. Children too are reported as hoping initially for replication of a mother’s
complex set of functions - some of them do tend to call me Mum, said one teacher. But they
quickly learn that their emotional support comes mainly from other children, rather than from adulst. As suggested below, the division of labour for the care of children favours the
separation of the cognitive, as priority, from the emotional and the bodily, although both children and teachers may over-step these boundaries on occasion.

Adult models of children thus differ: the mother, or caring parent, has learned a holistic knowledge of intersections between the physical, emotional and cognitive; whilst the teacher, in line with training and remit, stresses the cognitive child and the child as developmental project. Children’s own ability to participate in the construction and reconstruction of the social order will, in response, be broadly different in the two settings, the first conditioned by close relationships and responsive models; the second by more separated child-adult relationships and by more fixed models of how childhood - during the school day- should be spent.

This very brief sketch of these two arenas (based on children’s and adults’ accounts) is proposed as a basis for more detailed consideration of how emotion mediates between these social orders and children’s embodied experience. A brief comparison of story-time at home and school may serve to illustrate the points made so far.

At home, just before bedtime, two children climb onto their mother’s knee. Her arms are round them and she holds in front of the three a book. The children hold their teddies and are drinking their milk. She reads the story, and the children point out and name details of the pictures.

At nursery school, at the end of the session, a class of children sit on the carpet, arms folded and facing the teacher. One child (on a rota basis) sits on the teacher’s knee. Others claim - unsuccessfully - that it is their turn, and instead move closer to her; two children move closer to me, and lean against my knee. The teacher holds the book up so the children can see the pictures. She reads the story and asks the children questions. Two of the children get up and walk away.

In some ways these two events are similar. The adult exercises control; she aims to quieten children down, to prepare them respectively for going to bed and for going home. In both cases, there is a cognitive element: the story gives an opportunity for thinking, discussing and
increasing vocabulary and knowledge. In both cases the adult responds to children's wish to be physically close to her. However, story-time at home provides an archetypical instance of intricately interlinked attention to the physical, emotional and bodily. The emotional mediates the control element. Story-time at school subordinates bodily comfort to control, in the interests of the cognitive. The children must sit still, and not touch each other. The teacher cannot satisfy all the children's requests for the emotional comfort offered by close physical proximity - and school encourages children to leave their favourite objects (such as teddies) at home. And she maintains a cognitive focus: she asks the children questions designed to ensure they have understood the story and to reinforce their knowledge of colours, shapes and sizes. She emphasises the didactic over the children's own response to the story and pictures.

Perhaps the most striking feature of children's own accounts, and those of their mothers, is that children desire to participate in the activities they see around them. We suggest that the home enables their participation more than the school, and is consequently provides a more satisfying emotional environment. The home maintenance activities mothers and children describe include, bringing home the shopping, unpacking it, cleaning the house, setting tables, preparing meals. Children also engage in the construction of social relationships in the family and locally. Through these activities, we suggest, children feel themselves to be actors with a part to play in collaboration with adults in constructing the social order. To the extent that their participation is accepted, the social order endorses children's feeling that through their actions they collaborate with the household enterprise.

At pre-school and primary school the line between adult and child interests is clearly apparent to children. They perceive teachers and the other adults as those who act to implement the official remit of the school, and are in positions of authority over the children. Faced with this powerful, separate social group, children put great emphasis on child social groups as a source of interest and comfort. Teachers themselves emphasise their task of training the children to behave acceptably within the social norms of the school (Hartley 1987), though these are commonly implicit as well as explicit norms (Waksler 1991). Within this frame, children indicate that they put high value on activity and achievement; though they cannot, in the main, participate in constructing the social order, within certain activities they can exercise limited control over a component of the day. Children express delight in learning, achieving, finishing a project. Playtime, though a highly structured time and place, menaced by bullying, offers
children some scope to form their own social groupings, devise their own entertainment, and construct individual and group identities.

Put very generally, adult and child social worlds are in tension at school, the social order of the school is formally fixed and children have little chance to take part in its modification. These factors may explain in part why people do not recall their schooldays as subjectively important: they are not experienced as participative.

Within the social order of the two arenas, children acquire knowledge of how their bodies are valued, by adults, and, in turn, how they feel about their bodies. The bodily character of children is a marker of their status, their positioning within childhood (Hockey and James 1993: Chapter 3), a positioning marked by orderly progress through life at home, to nursery, to infant and junior school. Children’s experience at home is of parental praise for their embodied beauty, achievements and progress. In their pre-school years, children’s many achievements in terms of bodily skills and management receive praise for a whole range of parental reasons: delighted affection; concern that their child is normal; relief that their child is taking on some aspects of self-care; pleasure that domestic life is less dominated by the physical - the mess that babies create and parents clear up. Children thereby learn that their developing control over their bodily movements may justifiably encourage them to feel proud of their bodies. And their bodily control constitutes a contribution to how the day is organised. As they learn, for instance, to go to the toilet on their own, brush their teeth, climb up and down stairs, ride a trike, family activities and routines also change in response.

These points extend to the more specific ‘work’ of managing emotions. Learning not to hit people, to take turns, and to defer to adult agendas provides children with knowledge of what constitutes acceptable embodied modes of being within the social order of the family - and as they meet other children and other adults, in wider social spheres too. Home therefore encourages children to feel happy in their bodies, to value bodily and emotional achievements, and to understand how these both link in with and contribute to the social order.

The school presents a different set of orientations to children’s bodies. High valuation of their bodies is allocated to discrete times and places at school. The infant (5-7 years) and junior (7-11 years) regimes present interesting contrasts in this respect, for, apart from break-times,
infant children may play at will in the classroom after finishing short pieces of ‘academic’ work; and some of this play includes running about, and devising competitions of physical prowess. But for junior children physical activity is limited to formal physical exercise sessions; during class-time, the body is to be controlled in the interests of cognitive achievement: in literacy, numeracy and so on.

Illness provides specific and dramatic instances in which to consider children’s management of their bodies at home and school. Mothers’ socially assigned responsibility for the health care of family members, in health and illness, extends to children even when they are in the care of others. Children’s accounts of illness episodes at home endorse the picture of home as health care arena. For instance, one boy writes as follows:

I remember when I was seven I was really ill. I think I was ill for a week. I had to lie in my Mum’s bed all day. It wasn’t boring at all really. Mum was with me most of the time. When Mum wasn’t with me, my sister or my brother Bill was there. Bill did anything for me so I took advantage of that. I didn’t change much except for the fact that I couldn’t walk because I was so weak in the legs. I got a lot of attention and presents. This week I was ill was a school week and I liked that fact because instead of working I’m lying in bed watching TV. The only pain I felt was in my head and in my stomach.

At home the care they get comprises attention to their physical and emotional condition, in one package. The primary school presents children with a complex lay health care system, which, though it varies between schools, is essentially based on the add-on character of women’s work: they add caring to their paid remit. But, teachers and other staff are busy workers, with responsibility for delivering the formal curriculum and with many children on their hands. Some children reported that teachers did not listen, or respond, or were suspicious of their sickness bid (cf Prout 1986), or suggested the child carry on ‘till we see how you go’. Children’s satisfaction with the care they received at school was linked to the arrival of a parent (usually the mother) to take over. Some children reported not seeking help at school, and saving up their pains until they got home (Mayall et al 1996).
The onset of illness provides a clear case where children's ability to manage their body - to respond to its signals, is structured by the interlocking forces outlined earlier. Sharp separation between adult and child groups, in terms of their interests, and the adult view of how childhood should be lived at school, backed by the formal remit of school, constitute a firm framework, within which sickness bids are likely to be questioned. So children face mind-body dualism; their embodied experience has lower priority than their cognitive activity; they are required to carry out emotion work on their bodies to suit the social order.

Discussion

Children take their embodied selves, daily, across the private and public divide and in so doing encounter a range of adult-determined social structures. It is suggested that children are likely to feel more comfortable in their bodies at home than at school, and that this is because, in general, the home is the health care centre: mothers both prioritise health care, and recognise interlinkages of body and emotion. Furthermore at home, children are encouraged to value their bodily achievements and to participate through embodied emotion work, in constructing the social order of the home.

Understanding of children's emotional and bodily experiences may be helped by considering goals and behaviour under the three headings of civilising, regulating and constructing (Mayall 1996: Chapter 5). Civilising children can be seen as a central remit of the home - encouraging and enabling children to manage their bodies so that they may participate in the social order of both the home and wider social arenas. It is critical to success that this is a joint enterprise where, with shared interests, children participate in a relatively equal relationship with their parents. By contrast, the school encourages children's belief that their physicality is a problem; their bodies are less valuable than their minds. Their bodies must be regulated in the interests of school and societal agendas. Relatively, regulation is a top-down enterprise.

Yet cross-cutting these themes is a third counterbalancing one: the construction of children's bodies. Children's physical energy may be admired by parents but it is often in conflict with the limited space at home; they have to learn and enact a restricted and controlled body. Given current UK traffic policy and public fears about stranger danger, children have decreasing opportunities (except at expensive leisure centres) for structuring their bodies through physical
exercise. However, at school, in specific times and places, children's bodies are valued as the site for constructing socially valued physical skills, through sports and games. Children report pleasure in the activities and achievements available, which allow them to value bodily skills and the construction of culturally acceptable bodies. School provides the main arena, both in formal sports and through the social experience of the playground, where groups of children themselves construct their vision of the embodied self.

Children’s construction of embodied identity, as suggested in this paper, takes place not only in child-adult negotiations; the child group is an important site too. Not only is children’s identity constructed through the social group of children (James 1993), but children offer comfort and support to each other, and, more generally, they construct the solidarity of the group vis-a-vis the adult groups. For instance, children’s recognition of another child’s distress, expressed needs for help, feelings of alienation or oppression, or of pleasure in achievement, can constitute ratification of that child’s evaluation of her embodied experience. The recognition can also confirm the joint interests of children in an adult-ordered world. Children’s caring work for and with each other takes place at home (eg Dunn 1984), but perhaps it is especially valuable at school (cf Christensen 1993), where adult caring is less reliable.

Implicit in the discussions in this paper are tensions between children’s time and adult time; and how children experience their day in the context of these tensions can be considered in relation to the axes of generational proximity and adult models of adulthood and childhood. From their first days, children are encouraged and then required to fit their behaviour to adult time-ordered norms current in the household and more widely. At school, adult time- interests structure the school day, week, term and year; indeed time can be seen as organised in adult interests (eg Oldman 1994). For children’s sense of wellbeing, therefore, it is critical that they feel themselves to be contributors to the adult enterprise, rather than merely subject to it. Thus the proximity of adult to child interests, and the extent to which adults regard child participation as appropriate will serve to structure how comfortable children feel in their embodied experience through the day.

The time present and the time future of children is also at issue. Broadly, the remit of the home pays attention to the expressed bodily and emotional needs of people now, as well as to the civilising - future-oriented remit. The school, broadly, puts greater emphasis on children’s time
future - school is preparation for adult life - a point children themselves understand. Children are positioned at the intersections of important adult social values: that people must engage in emotional and bodily management which has to suit these values and that ensuring children carry out these remits is a central adult responsibility, in two main arenas, the home and the school. For the quality of children's emotional contentment in embodied living, much depends on how far adults accept their personhood and their contributions to the structuring of the social order.

NOTE. This paper is based on work by Gillian Bendelow and Simon Williams in connection with their forthcoming book (Emotions in Social Life: Social Theories and Contemporary Issues) and on work by Gillian Bendelow and Berry Mayall on intersections of health and education in children's daily lives.
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‘THROWING LIKE A GIRL... BUT CATCHING LIKE A BOY’: SOME THOUGHTS ON GENDER AND EVERY-DAY EMBODIMENT IN SECONDARY SCHOOL

Shirley Prendergast

Prologue

I have always been fascinated by the fact that, with no apparent effort, we all know how girls and boys should look and behave and quite instinctively we ourselves come to do it. The German feminist photographer Marianne Wex captures this aspect of our experience wonderfully. She photographed women and men as they sat outside on park benches where the women kept their legs crossed and arms close to their bodies, while men stretched out in all directions. Wex then photographed what happened when she asked both young women and young men to sit 'like a girl' and then to 'sit like a boy'. These images show that young men and women not only replicated the archetypal sitting styles of their own sex, but they could also very accurately mimic those of the other sex too (Wex 1979).

These aspects of what Bourdieu (1976) has called 'embodied memory' are very powerful. For example, when I was a child the head teacher in my own primary school loved cricket. Our playground extended into the field that was also the village cricket ground and, directed by him, we often played cricket as part of organised sport at school. I vividly recall how he made no concessions to our size or our age: we played on the same grass wicket, with the same kind of hard, red leather ball with stitched seams used at matches. He trained us well: I was pretty good at batting and I loved catching the ball when it was thrown high or very hard, and rarely dropped it. On the other hand I was absolutely hopeless at throwing: I just couldn't flick the ball with my wrist; I was awkward, ungainly; my arm almost jumped out of its socket; I threw myself with the ball and it went wildly in unexpected directions. Exasperated, he would say: 'Shirley: you throw like a girl!'
I've hated cricket and most sport since then, it brings back a sense of boredom and inevitable failure. You can imagine my amazement and pleasure when I discovered the famous essay by Iris Marion Young (1989) after which the title of this paper is named. Reading it reminded me of many unarticulated feelings I had at that age: a shameful sense that my body was in some way wrong, 'disloyal' to be skilled in one respect and incompetent in another; a disbelief that only boys were naturally good at cricket; a stubborn determination and pride in proving adults wrong; a sense of injustice: was it fair that the road to the teacher's regard was to overcome the things that might belong to me as a girl? Was it fair that this regard was denied me because the bodies of girls were, in some utterly incomprehensible way different from the bodies of boys?

In fact these not-quite taken for granted actions and feelings about everyday living and how they come about, touch on some of the most interesting and complex issues in philosophy and the social sciences: are these kinds of embodied knowledge learned or natural? What is our conscious understanding of and control over them of them? What is the significance of collective interpretations of embodiment within social contexts of power and value? To what degree do we have individual agency within these frameworks? These are fascinating and complex questions. They are also questions that remain persistently abstract. One either does fieldwork or discusses theory. In this paper, difficult and messy though it is, I hope to bring the two a little closer together.

**Learning embodied/gendered rules**

This paper explores aspects of the ordering and regulation of bodily experience in school. Because embodiment and gender are so bound up together I want to argue that these forms of social learning are very powerful. They help to explain not just how we learn gender, but how we live it, experience ourselves to feel, to be gendered at a very deep level (Freund 1988, 1990). The ordering and regulation of bodily experience in school is significant in a number of respects. As Shilling (1993) has pointed out, it is of the human condition that the body is profoundly unfinished at birth; for a substantial period of the life-course therefore, in childhood and adolescence, the body is developing, potential, 'becoming'. School shapes children's first experience of public, social values and rules about embodiment outside of the family at this time. Young people have no choice as to this experience, they must be at school over this time and they are relatively powerless while they are there (Qvortrup et al 1994).
Because of this, schools offer powerful models of ordering and regulation over periods of transformation and change. Our first experiences of bodily transformation and regulation are usually inaccessible to us: we go from newborn to baby, from baby to toddler, and toddler to child mostly before language, and usually in the privacy of the family. Freud's theory of the unconscious rests upon an understanding of what embodied rules are at this time and how they are enforced. In later childhood and adolescence bodily transformations are more visible, public and, through school, more subject to collective, social regulation.

However, transformation and regulation is also more contradictory. Puberty is not generally celebrated in our society, and is spoken about as though it were a unitary concept, the same for girls and boys (Simmons and Blythe 1988). While the body becomes more adult and sexual, young people are increasingly in a situation of prolonged social and economic dependence on parents and the state (Mac an Ghaill 1994). Further, if physical size is central to child/adult relations, particularly within power relations and discipline in school and at home, we may expect changes as embodiment becomes more equal (Phillips, 1993). As examples of the ways in which our culture creates gender through bodily regulation and control in the formal and informal curriculum of school, I want to describe two pieces of research on adolescence which I have done in the school setting over the last few years. The first was completed in 1993; I looked at the ways in which schools could influence the experience of menstruation for girls (Prendergast 1994 1996). The second, more recent study on masculinity in school, which is still being written up, explored group formations and meaning of height and physical size for boys (Prendergast and Forrest, forthcoming).

Housekeeping the body: girls and menstruation in school

As Emily Martin (1989) has written, how strange that a key and continuing event in many women's lives, the onset of menarche and the experience of menstruation, which can have huge implications for women's general health and well-being throughout the lifecourse, has been so generally ignored in research. Certainly it is my experience that menstruation, for all our apparent openness about the body and sexual issues, is still something that it is not quite right to talk about, let alone make the subject of an academic study. Investigating the material realities of the body is even more taboo
(McKeever 1984; Lappin 1982). In 1989, with some trepidation, I set out to do both of these things.

While it is difficult enough for many adult women to discuss menstruation openly, I discovered that for young women the difficulties could be multiplied a hundred times. Even now, in the late twentieth century, many had still not been told about menstruation in advance of it happening and many could not and did not talk about it to their mothers. Young women frequently experienced the same serious negative menstrual effects as older women, but without the commonsense practical knowledge and confidence that adult women have built up over the years. Each girl it seemed must make her own 'menstrual maps' of this unfamiliar territory on her own (Grosz 1990). Even more worryingly, I discovered that the situation in schools, far from offering girls support, often made matters very much worse. This happened in three ways: through inadequate educational provision, through a sexist informal curriculum and through appalling practical provision. Some brief examples:

1. A lack of appropriate educational provision that was realistic, practical and sympathetically related to girls age and needs:

* information 'too little too late'
* provision concentrated on biological information and ignored social and emotional aspects
* no 'spiral curriculum' which addressed different needs at different ages
* information not connected to school provision
* effects on health, lessons, sport and exams not considered
* teaching often in mixed-sex classes where girls felt embarrassed and unable to speak

2. An informal curriculum that allowed boys free reign in sexist language and behaviour in and out of the classroom:

* appalling catalogue of boys behaviour in and out of class
* teasing and physical harassment
* tipping out bags and displaying towels and tampons round the school
* use of language, sexual imagery suggesting that girls bodies were dirty and polluted
3. A lack of material and practical facilities at school. Because of this girls were not able to cope with menstruation in a civilised and dignified fashion:

* no reliable soap, toilet paper
* door locks broken, inadequate disposal bins
* toilets dirty and flooded
* no emergency supplies of towels or tampons in toilet so have to queue at secretaries office
* toilets locked in lesson time and crowded at break
* not allowed to go to the toilet in lesson time
* no facilities if feeling unwell
* no painkillers allowed in school

Girls and embodiment: 'loss of control, the domination of the male gaze and constant need to regulate the self'.

Briefly, I want to reflect on the implications of these events for girls’ sense of self. A powerful theme in girls’ accounts about menstruation in school was that of loss of control at the most intimate and seemingly personal and unique level. Each month the body appeared to draw girls into a time of doubtful agency, breaching boundaries. Leaking, staining, flooding, what should be kept hidden might become exposed, inside-outside, private-public. This might be expressed as: loss of temporal control (when would it come, would it be late) loss of practical control (can't stop leaking, pain, bleeding) loss of emotional control (can't stop crying, feeling angry or depressed) loss of social control (can't do the things I usually do, cope with embarrassment, teasing, shame).

Not only had girls lost control but they most graphically expressed their experience of the onset of menarche and menstruation, a phenomenological sense of the self as being 'hit', 'landed', 'clobbered', 'knocked out', 'shattered' (Buystendjik 1974). The events that girls describe in school: embarrassment, shame, defensive body postures, watchfulness, secrecy and anxiety: add up to some overall sense of attack or assault on their taken-for-granted everyday sense of self. It was also clear from girls’ accounts that by early puberty menstruation provided young teenage boys with powerful ammunition: judgement of the female sexual body as polluted (Askew and Ross 1988). While we are familiar with the ways in which women must produce their bodies, via makeup, hair and
clothes, for the judgement of men, these stories were about the ways in which the body must also be repressed, guarded and contained so that its secrets could not be known. They imagined their bodies partly through the eyes of men. Fear of exposure to male gaze must be set against the top-shelf soft porn magazines that circulate among many boys today in school (Holland et al 1991).

Girls in school described how they must keep a mental list of practical tasks, be constantly watchful and on their guard in order to keep menstruation hidden. This included not only watchfulness of the body, constant monitoring to forestall accidents such as staining their clothes, but also watchfulness of bags and possessions and of their own and others’ actions. The combined effect of these kinds of watchfulnesses, both in producing and repressing the body, might be summarised more abstractly as housekeeping or ‘regulating the self (Martin 1989):

**Menstruation as a model for learning to regulate the 'feminine' self**

*to regulate emotions including depression, anger and anxiety  
*to regulate responses like embarrassment, shame  
*to regulate the expression of physical discomfort, including sometimes severe pain.  
*to regulate body movement, posture and clothes so as to maintain secrecy  
*to make clean, comfortable and invisible those body processes seen as publicly unacceptable  
*to plan ahead and be prepared for both cyclical and daily events and bodily changes

We can sum this up as 'loss of control, the domination of the male gaze and constant need to regulate the self'. For young women (perhaps all women) menstrual experience must be constantly present in their thoughts in order that it remains invisible to the outside world. In this fashion the body must be constantly kept in mind. This an exhausting and negative use of energy which contributes to no positive benefit to the self. Clearly these effects are not natural, biological correlates of menstrual experience, but are socially given. As we have seen, conditions in school made it inevitable that most girls would encounter some or all of these experiences.

As you might imagine, this research raised as many questions as it answered. Within the same school, the same classroom, girls and boys seem to be learning very different things about the body, about control, strength, aggression, sexuality and power. I could see how school influenced girls’
sense of embodied self, but what about the boys, how was it they came to behave as they did and what were the processes at work that shaped their sense of themselves?

**Boys, embodiment and group processes.**

In 1993-4 I worked with a colleague with boys and girls in four secondary schools (Note 1). Together we explored what it means to be a boy in school today (Prendergast and Forrest, forthcoming). One of our most immediate perceptions of boys in school was their clustering in often rowdy groups and their incessant and mobile energy. In 1993, looking down onto a paved school playground of Priory school, seething with young people between about 11 and 15, panic sets in. How can I record this: what is going on, what on earth does it all mean?

**Boys at play**

Gradually I see that in the centre of the space it is mostly boys, using tin cans and screwed up bags as footballs, leaping, shoving, rarely still. Around the edges of the space, sitting with their backs to the wall are the girls, giving each other elaborate hairstyles. A band of small boys, some barely four feet tall, have commandeered a patch of worn grass where they wrestle and tumble together. I focus attention on just one corner. A boy crosses rapidly from left to right on a pair of crutches. Two big boys chase a small boy, turn him upside down and carry him round with his legs waving. I glimpse the crutches again, from right to left, but this time it is a different boy, who leapfrogs some concrete bollards with them. The big boys push the small boy headfirst into a large bushy shrub. The crutches cross a third time, now it is a girl. The sky gets dark. The pupils run towards a covered way, the only shelter on this side of school.

As in other studies, we found many cases where boys physically occupied the major spaces in school buildings, classrooms and playgrounds, literally leaving girls at the margins. Boys held the active centre of the playground, tripped each other up, pushing each other to the limits of teasing and aggressive behaviour. Real fights were sudden and often serious.

**Displaying the body**

One day it suddenly struck my colleague and myself that it was only the smaller boys at Priory who wore the red school jumpers. All the bigger boys, even in coldest weather, wore shirts with the
sleeves rolled up, carefully loosened ties. For boys, as the body develops and matures, more of it can be displayed. Big boys, even if they did not use it, carried with them a seemingly automatic potential to dominate by virtue of their size. There was some evidence that a powerful status might accrue to a big boy who did not dominate in this way: a kind of 'gentle giant' who came into being because of the very physical qualities that he eschewed. This is in sharp contrast with girls, for whom the maturing body seems to be something to be kept guarded or hidden. Big girls would be at risk of being called slags if they displayed their bodies in equally visible and provocative ways.

**Learning masculinity.**

One lunchtime I was approached by a group of first years aged 11 to 12 who begged me to make a tape recording of them. Sitting round the table were about 10 boys and girls, looking alert and proud to be taped. The boys were amazingly tiny, and in most cases amazingly scruffy and dirty, compared to the girls. I began just by asking them what their first year of school had been like. Almost no further questions were necessary. An extraordinary flood of stories and experiences followed. Suddenly Will, a small but very thick-set little boy, said that he couldn't wait for next year to start; then there would be all the new ones to boss around. The boys explained that the older boys bullied first years, taking their money and sweets, making them run errands, pushing them about, sometimes using physical violence. There was nothing that they could do, Will said, 'You have just got to take it. You can't go to teachers or nothing. But next year it's your turn'. The boys explained that if a first year boy had a bigger brother, or he was known from primary school, or he was specially big, he might not get beaten up. Will's honesty was an important key to understanding much else happening in school. Earlier in interviews we had heard how older boys in years 9, 10 and 11 might threaten to beat a younger boy up unless they in their turn hit someone else. Even more serious, boys described how some male teachers perpetuated violence, pushing and punching them, using aggressive and humiliating language.

**Denying feelings**

During our time at Harrington school, the first year pupils, aged 11-12 years, went to visit a local primary school to tell those who would be moving up that year what it was like in 'big' school. Each pupil talked to a small group of the primary pupils. In two of the groups the primary boys behaved
badly. They said that Harrington was useless, it was a dump, nobody would go there. It was violent and full of wallies. They laughed at Barry and Patricia (the Harrington group leaders) and wouldn't listen to what they said. Afterwards Barry threw his information folder over a hedge. As we walked home the girls initiated an extended and indignant conversation with Patricia, while Barry walking with the boys was so angry, upset and humiliated that he cried. I stopped to talk to Barry, usually a confident and tough boy in class, but he was seething with angry feelings and refused.

As we got to the long, rough grass in front of school, Barry said, Do you like cats Miss? He asked me to come and look at something in the grass. It was a dead cat, with half its stomach exposed. He looked at me and said, 'It's lovely, it's like liver. I think I will have it for breakfast.' He kicked the cat, and ran off with a smile on his face.

Boys, embodiment and group processes: 'controlling space, the shame of smallness, masculine hierarchies, being hard and passing anger on'

Boy's stories of school are much concerned with the use of space. They are also about the implications of size in relation to embedded hierarchies of superiority and control and metaphors of hardness. Our findings suggest that boys are less inclined than girls to talk about feelings, rather using space and objects to actively express and 'pass on' their emotions. For boys, school offers sites of drama and scale, where group relations overwhelm individual responses. As one boy told us, 'In groups boys do things they would never do on their own.' From what we see and what boys say, group processes are charged by explicit forms of embodiment which prioritise energy, action and size (Mac an Ghaill 1994; Canaan 1989). The spaces of school, playgrounds, classrooms are a little like theatres, where embodied action takes the stage (Schechner and Appel 1990). Of course this reaches its epitome in the drama of formal, organised sport. Like the army, English education has always utilised sport as a way of disciplining and controlling young men, exploiting at the same time the tension and excitement inherent in competitive team games (Messner 1987).

However it is more accurate to say that informally space is dominated by bigger boys who set the terms and conditions in which others may join them. This includes not just girls but also smaller boys. For boys, immature bodies seem to carry some special charge of risk or danger in comparison
to one’s own age group: time and time again smaller boys reported bullying because they were small.

Size, particularly height, operates for boys to distinguish both categories of age, older, younger and also categories of the person, mature and immature (Simmons and Blythe 1988). These processes have different implications which constitute a powerful form of learning. For a boy to take his place in a second year group, learning the rules from fifth year boys for example, even if we do not like the rules, has a orderly, ritualised quality akin to the age grade systems that we find in West Africa (La Fontaine 1985). The system applied to those of the same age (big twelve year olds over small twelve year olds) is more divisive and more brutal. It means that power does not come only from ascribed characteristics which are fair, but also from those that are unfair and arbitrary. Small boys are not just physically immature but judged as immature in all other ways too. They must accept their lower place in the order of things.

This hedging of bets, off-loading of violence, acts like a web which catches even those who wish to have no part in it. For first year boys, straight from being biggest in primary school, this is an almost intolerable return to being smallest and weakest in the masculine hierarchy. Hierarchical and oppositional patterning of power is of course also endlessly circular and self-perpetuating in school. It operates almost as a closed system, independent and to one side of, but clearly integrated with and complementary to the ways in which boys physicality also dominates girls.

I would also suggest that there is an intimate relationship between masculine embodiment and the emotions. (Prendergast and Forrest, forthcoming) Boys are so often in school extending energy into things, throwing and kicking sticks and balls, slamming doors, grabbing coats, hiding books, stealing bags. For example, for Barry the shame he had experienced during the visit to the primary school was almost unbearable. To be seen crying, and to feel my sympathy in front of other boys, was even more unbearable. While the girls talked about their feelings, Barry didn’t. He threw away his folder, kicked the cat, turned his feelings into physical action and passed them on (to me). In this fashion of course, Barry also regained control of the situation, and appeared happy and unconcerned the next day.
Barry's response is typical of what boys described as 'being hard'. This can be seen in the names that boys called one another throughout the study. **Pejorative names** included: 'shortie, low-life, sad, wasted, softie, sad, bottoms, wimp and weed'. **Positive names** included: 'hardnut, king, superior, big and mighty, normal boy, well 'ard, strut'. In this sense group language, as Johnson (1987) notes, is immensely revealing, giving priority to those masculine embodiments that are big, protect the self, present an impermeable surface to the world and cannot be 'touched' by emotions.

**Childhood, gender and embodiment: school as a mediating structure?**

Acknowledging the body is not only to plunge the researcher into the minutiae of everyday lived experience as we have seen, but is also profoundly challenging of some of the basic assumptions in the social sciences. Bryan Turner has written of this dilemma in *Regulating Bodies* (1992). However, while Turner suggests that we 'put the body back into social life and social life back into the body' he fails to acknowledge the factors and processes that mediate between the two. He does not give us examples of what these factors are or how they mediate between the terms and structures of social rules and social existence and us as embodied social actors. My work on gender and schooling suggests that school is a mediating structure of this kind, one of the key **social contexts** in which young people live, work and spend their time: after all, we can't be nowhere, we are always somewhere, in some place (Elder et al 1993). School and the rules and procedures of school, both formal and informal, is a critical site of mediation where the social interacts with the individual. To see this it is useful to summarise some of the ways in which formal and informal aspects of school have an impact on pupils at adolescence:

First, it seems that gender and gendered embodiment may both be shaped by and shape use of formal and informal space in school: that adolescent boys are establishing or increasing their control and command over public space, while girls learn to feel more comfortable out of the public gaze, to inhabit corners and more secluded spaces in the world.

Second, boys are more actively using their bodies than girls. As girls stay out of the large public spaces of school, so too they are much more limited in their use and freedom of the body in a personal sense. Girls often give up games at puberty, and do not move so openly or spontaneously. Wex (1979) has shown how this is represented in the carefully arranged ways in which girls and
women sit, make themselves small. As Iris Marion Young has noted, women rarely even use that intimate space, the circle delineated by the outstretched limbs, while most men, most of the time are reaching far beyond it. Young women, she suggests, learn to live their bodies as objects, the intention of another subject, than as a 'living manifestation of action and intention' of their own (1989: 155).

Third, forms of masculinity appear to be predicated on embodied power relations which include oppressive behaviours from boys to girls and from boys to other boys. This depends very much on unfair characteristics, such as size, over which boys have little control. For boys to be small compared to their peers is in some respects a worrying thing.

Fourth, girls tend to learn internalised, self-monitoring forms of bodily regulation that are often based on being observed, on presentation, passivity and sometimes shame. These forms of regulation mean that girls are much more self-conscious about their bodies, always thinking of them, always doing something about them: always 'on their mind'.

Fifth, boys give priority to embodiments that are impervious, hard. They learn physical ways of coping with emotions: boys literally pass emotions on, get rid of them. Boys shove and fight. In contrast girls talk.

Here we can begin to see how structural forms and rules of school might operate at a crucial time of transformation and change in young people’s lives. In this interaction gender is both re-affirmed and re-made as bodies develop and change. This brings me to my final point. Current interest in childhood has to date generally ignored issues of both gender and embodiment, particularly gender. This appears to have happened because of an overriding primary concern to first 'make children visible', to identify and legitimise childhood as a meaningful category in theoretical and empirical work (Qvortrup et al 1994, James and Prout 1990). Having established childhood in this fashion, without distraction, then the notion of more complex, differentiated childhoods may be allowed to come into focus.

I would argue that this attempt is misguided for the following reasons. First, gender is all-pervasive: to speak about childhood as though it can be separated from gendered experience is to lose crucial
evidence which deepens and broadens our understanding. Empirical research done on this assumption will repeat mistakes of early sociology. It is a fallacy to think that gender can be added to theory: it is itself part and parcel of the development of it. Second, gender is bound up with embodiment, most particularly for children. In talking about embodied gender, following the phenomenologists, I would make no distinction between the body and mind or body and 'self' (Olesen 1992; Johnson 1987; Freund 1990). For children as for adults, the body/mind is the self, it is only through this embodied self that the world can be apprehended. As Csordas (1990) notes, the experience of embodiment is at the heart of collectivity, and it is through this embodied collectivity that culture exists.

Innumerable findings outline the ways in which gendered, embodied definitions are fundamental to the constitution of identity and selfhood in Western societies, the formal and informal ways in which these are shaped for babies, children and young people within family, institutional and public settings, and in the ways in which children and young people shape and use these for themselves. In Western cultures socialisation, the process of development and incorporation into a culture, is delivered via gender: we are a girl or a boy from the moment we are born. Gender, like embodiment, is not a static category, it is active, something that we do all the time, and which therefore is constantly being reaffirmed and remade (Connell 1987). Connell's description is helpful because it suggests that we not only gender/embody ourselves, but that we all of us make gender/embodiment more widely, for each other. In using space as a performative aspect of masculinity a proper femininity also comes to be defined; in excluding boys from 'emotion work' girls throw boys back onto other resources. Because of this each sex knows a great about the other, hence Marianne Wex's photographs. We are girls and women in relation to boys and men: each acts as reference point, as 'other'.

However, childhood, like gender is profoundly influenced by social relations which invest healthy, mature (male) adulthood as the ideal attainment. As Hockey and James (1993) point out within this model we are either 'growing up' towards or falling away from this ideal into the 'second childhood' of old age. Being male or female, large or small, tall or short, strong or weak profoundly shapes how others see and respond to us. Relatively the child is almost always conceived of as small and weak compared to those adults who have responsibility and power over them, girls as smaller and weaker than boys and young boys as smaller and weaker than older boys.


My own experience testifies how powerful these embodied forms of learning are: even today I still do 'catch like a boy and throw like a girl'. This is not to say that anything is preordained. In playing cricket I reached that point where the body offers us the ground of infinite possibility drawn over by the mappings of a cultural biology on which we act as gendered individuals 'endlessly becoming'. This is the paradox of embodiment. If we want to discuss it we must, as Merleau-Ponty (1988) has said about philosophy, possess 'inseparably the taste for evidence and the feeling for ambiguity'.

NOTE. In the UK, the common pattern is that children attend primary school from age 5 (Years 1 to 6). They move to secondary school at age 11 (Years 7 to 14). Compulsory schooling ends at 16. Those who stay in the education system, either remain at secondary school or go to a sixth form college.

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Linköping University hosts an interdisciplinary Institute of Advanced Study known as the Institute of Tema Research. The Institute of Tema Research is divided into five separate departments, each of which administers its own graduate program, and each of which conducts interdisciplinary research on specific, though broadly defined, problem areas, or "themes" (tema in Swedish, hence the name of the Institute). The five departments which compose the Institute of Tema Research are: the Department of Child Studies (Tema B), the Department of Health and Society (Tema H), the Department of Communication Studies (Tema K), the Department of Technology and Social Change (Tema T), and the Department of Water and Environmental Studies (Tema V).

The Department of Child Studies was founded in 1988 to provide a research and learning environment geared toward the theoretical and empirical study of both children and the social and cultural discourses that define what children are and endow them with specific capacities, problems, and subjectivities. A specific target of research is the processes through which understandings of 'normal' children and a 'normal' childhood are constituted, and the roles that children and others play in reinforcing or contesting those understandings. The various research projects carried out at the department focus on understanding the ways in which children interpret their lives, how they communicate with others, and how they produce and/or understand literature, language, mass media and art. Research also documents and analyses the historical processes and patterns of socialization that structure the ways in which childhood and children can be conceived and enacted in various times, places and contexts.

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