Current Online First Articles: A Digest

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Following previous digests published here the articles are drawn from ‘Articles in Press’ on the Social Science and Medicine (SSM) website; ‘Early View’ on the Sociology of Health and Illness (SHI) website and ‘Online First ’ on the Health website. Similar to the previous digest (Cavaye 2013) the scene for my selection emerged from the re-occurrence of articles relating to contemporary problems of eating, diet, weight and managing healthy lifestyles.

From Health, Kristensen and Køster (2014) present an interesting investigation into ‘Contextualising eating problems in individual diet counselling’. This article starts from the assumption that individualistic, bio-psycho interventions such as health coaching, diet counselling, and motivational interviewing, do not fully respond to the complex, contextual qualities of eating problems. This position is not unexpected as one of the authors is a narrative therapist and the other an anthropologist working in the sociology of food. Both authors examine narrative practice (White and Epston 1990, White 2007) as a means to contextualise eating problems: "In our work with eating problems, we engage in collaborative mapping of how the client's problem is continually constituted through social interaction and historical context" (Kristensen and Køster 2014 p:4/5). A storytelling strategy, 'externalisation' is used to identify the problems experienced as an external entity, existing outside, independent of the person. This external ‘problem’ is then articulated, reflected on and analysed. This reflective analytical stage is called ‘co-researching’ the problem in the person’s ‘life world’. The authors argue this narrative practice allows the client and the therapist to explore social obligations, relationships, structures and discourses that shape the eating practices and each individual's response. This permits the complex and contextual qualities of an eating disorder to be observed and addressed. The authors do not claim that narrative practice enables the client to challenge the social structures and discourses that shape them. This narrative practice works to change the way the story is told and consequently is seen to offer new opportunities to respond differently to the problem. The authors present their argument systematically, initially discussing the philosophical and psychotherapeutic underpinnings of narrative practice, and then followed by a series of analytical case studies from the clinical setting. This analysis identifies three key contextual themes that frequently frame the person’s story. The first theme, ‘logistic eating problems’, shows how the problem is located within schedules, organisations and social practices of preparing food, and eating food. The second theme ‘social eating problems’ emphasise social relationships where issues of intimacy and trust are contextualised through the mediums of eating and types of food. The last theme focuses on ‘discursive eating problems’ when people locate their self-identities within ideal discourses of gender, body, health and diets. Research evidence from this psychotherapeutic setting depends upon the coherent and robust analysis of case studies. Here the authors present a persuasive and interesting point of view on the success of this phenomenological therapeutic practice, one that fits well with those who seek to prioritise the social within the complexities of health and illness.

The next article from SHI ‘The pursuit of preventative care for chronic illness: turning healthy people into chronic patients close’ (Kreiner and Hunt 2013), explores doctor/patient interaction and the micro processes involved in the medicalization thesis. The
authors present qualitative data from more than 100 clinical observations plus in-depth interviews with 58 primary-care physicians and 70 patients in the US to show how risk indicators transform preventative health to illness management. This builds on previous research that has highlighted new categories of "borderline disease" or "pre-disease" where risk factors become a symptom to be treated. In this study blood pressure and blood glucose results identify specific risks, both determined by evidence and clinical guidance. Evidence from population comparative norms determines acceptable/unacceptable threshold measurements. When this is combined with clinical guidance from improved knowledge of causation and long term implications the parameters of risk are set. The data from consultations and doctors' descriptions demonstrate how high blood pressure or glucose levels test results become targets to be reduced. In turn, this minimises healthy lifestyle discussions and prioritises interventions such as drug treatment to bring measurements within acceptable thresholds. The patient interviews also show how this shift towards treatment rather than prevention is internalised as ‘being a diabetic’ or ‘having an illness’. The authors conclude how aggressive interventions to reduce risk can unintentionally result in illness. The authors end with a compelling warning that if preventative care increasingly shifts towards illness management the well-being of the individual is compromised for the overall maintenance of a healthy population. This powerful warning is sustained and clearly documented by the research data here. It will be interesting to see how this warning influences future research in the UK NHS, where risk factors and population norms are increasingly more prominent in the clinical setting.

The next article also from SHI, ‘Sustained multiplicity in every day cholesterol reduction: repertoires and practices in talk about ‘healthy living’, (Will and Weiner 2014) picks up some of the issues expressed in the previous paper. Will and Weiner (2014) compare two datasets from different research projects where both consisted of interview accounts on health activities undertaken to lower cholesterol levels. This leads the authors to analyse the discourses in relation to interpretative repertoires. They focus on the specific terms and narrative constructions used to describe healthy living behaviours such as diet, exercise and weight loss. This analysis reveals the ease in which the participants use three repertoires of health, pleasure and practicalities. They show how the repertoires of health and pleasure coincide. Here contradictions of healthy or pleasurable (unhealthy) activities coexist. This mixing of repertoires begins to portray notions of being ‘ordinary’, neither being a health fanatic or an unhealthy risk taker but a ‘balanced’ person. Most importantly, the authors continue to propose how such repertoires function differently. The health and pleasure repertoires interact in order to justify, moderate and balance actions undertaken. The pragmatic repertoire remains relatively inert. Here discourses portray "what is", actions are perceived as determined by the social context with little room to manoeuvre. The repertoires are also analysed in relation to temporal and spatial determinants to confirm the patterns across different timelines and social contexts. The authors conclude that from this group of active health seekers (to reduce cholesterol levels) there is little evidence of a coherent or dominant healthy discourse. Instead a ‘sustained multiplicity’ take place ‘as people tried out different foods, routines, incorporated products into everyday life and made messy compromises in the spaces of household and beyond’ (Will and Weiner 2014:p.11). Most researchers and practitioners working in health promotion and prevention recognise the complexity of grasping how healthy choices transform into healthy actions. This paper establishes the importance of discourse analysis to approach this complexity in everyday life. As the authors indicate it will be interesting to see further analyses on how interpretative repertoires function to support or challenge the adoption of healthy lifestyles. I would however, like to hear more on the point made at the beginning of the paper regarding "metaphors of balance-the balance of the high wire" that the authors attribute to the work of
Mol (2008). I felt slightly disappointed as this was lost during the discussion of repertoires but perhaps this is for another paper.

I am fortunate that the next paper selected from SSM ‘Maternal Work and Children’s Diet, Activity, and Obesity’, (Dater, Nicosia, and Shier 2014) balances my previous bias towards qualitative methods. Childhood obesity is a major concern in the US. Research has established a link between obesity rates for children and the hours mothers spend in employment. This study aims to examine the mechanisms that link mothers’ working hours to childhood obesity. In order to address the multiple mechanisms that could link mothers’ time at work with childhood obesity the researchers develop particular statistical models to examine specific variables and co-variables. The researchers use a US national dataset on young children in kindergarten. From the datasets information on children in 2004 and 2007 is used to explore links between the children's BMI measurements, diet, physical activity, sedentary behaviour and time for supervised and unsupervised play/activity. The mother's health and ability, income, the hours worked, and the time spent parenting are incorporated into the statistical modelling. Information on parents’ education and income is calculated into two categories of high and low socio economic status (SES). The researchers support the focus on mothers noting how other research continues to indicate mothers as the primary care giver irrespective of the hours spent in paid employment. Correspondingly, there is scant evidence to suggest changes in the working patterns or parental responsibilities of fathers.

From the statistical modelling the researchers conclude that the mothers’ increased number of paid work hours link directly with an increase in their children's unhealthy diets and incidences of obesity. The statistical modelling demonstrates how multiple mechanisms are involved here and the causality of time constraints is not as clear-cut as previously thought. Time constraints when managing children's diets can limit time for food preparation, involve increased use of ready meals, fewer family meals, more unsupervised snacking or increased sedentary activities. While these mechanisms were found in both higher and lower socio economic families a higher income could result in more paid for organised sport activities. A potential benefit diluted at times by increased time spent in sedentary activities. The research concludes that the complexity of the mechanisms that link childhood obesity with mothers paid work requires flexible policies that redress work-family balance across all socio economic groups.

Finally, I find myself unable to leave this space without highlighting SSM’s ‘Introduction to the special issue on structural stigma and health’ (Hatzenbuehler & Link 2014). My selection of these ‘early’ online articles reminds me of the medical sociology legacy I have benefitted from. The renewed academic attention to the concept of structural stigma in this special issue reinforces the importance and relevance of key sociological concepts in contemporary health. Structural stigma is defined as “societal level conditions, cultural norms, and institutional policies that constrain the opportunities, resources and well-being of the stigmatised” (Hatzenbuehler & Link 2014:p2). The introduction to this special issue discusses how the collection of papers applies this working definition across varying methodological approaches, contexts and health issues. I am captured by the authors’ excitement to see how structural stigma will influence our explanations and interventions of health inequalities for the future.
REFERENCES


