Health sociology from post-structuralism to the new materialisms

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Abstract

The paper reviews the impact of post-structuralism and postmodern social theory upon health sociology during the past 20 years. It then addresses the emergence of new materialist perspectives, which to an extent build upon insights of post-structuralist concerning power, but mark a turn away from a textual or linguistic focus to address the range of materialities that affect health, illness and health care. I conclude by assessing the impact of these movements for health sociology.

Keywords: post-structuralist, postmodernism, new materialism, social theory

Health sociology and the rise of post-structuralism

My first encounter with post-structuralism was in the late 1970s, reading Michel Foucault's *Madness and Civilization* (1971) during an undergraduate course on psychopathology. It was a powerful and allusive read – if on occasions questionable historically (Armstrong, 1997: 19) – documenting the 'ship of fools' that navigated the rivers of medieval Europe (Foucault, 1971: 8), and the confinement of the insane in the gates of cities to mark status as betwixt-and-between this world and another (ibid: 11). The critical insight, however, had been that contemporary treatment of the mentally ill was not necessarily better than in the past – just different. Read against the then background of the anti-psychiatry movement, in an era when large asylums still dominated mental health care, Foucault's thesis that mental illness and its treatment were historically-contingent and constituted in relation to power and systems of knowledge was radical, persuasive and challenging.

Foucault supplied the route into post-structuralism (or 'constructivism', as it has sometimes been labelled in health sociology) for many sociologists of health and illness in the decade that followed, either through *Madness*, or the later *Birth of the Clinic* (1976). In the latter, he argued that modernity had produced in 'the clinic' a social formation that drew bodies, power and knowledge into a novel configuration, where patients and their diseases could be subjected to a penetrating medical gaze (how strange that word sounded in the '80s, how commonplace today!). The gaze was the means by which illness and the sick were disciplined, not by a top-down coercive power but via a micropolitics of surveillance and archiving, that had the by-product of establishing a modern medical science and a medical profession (Foucault, 1976: 115), as well as the physical spaces of contemporary medicine.

This perspective on health and medicine was consolidated in David Armstrong's (1983) *Political Anatomy of the Body*, which traced incisively the disciplinary workings of power and knowledge in a range of contemporary medical sub-specialities such as child health, psychiatry and general practice. It also hinted toward a Foucauldian analytic of the public health, in which a 'community' gaze took a population rather than an individual as its subject (1983: 111); this assessment of public health medicine was taken up and developed fully in later papers (Armstrong, 1993; 1995; see also Lupton, 1995; Petersen and Lupton, 1996). In the wake of Armstrong's book, a variety of other areas of health and medicine received the Foucault treatment, including nursing (May, 1992), health promotion (Coveney, 1998), the mortuary (Prior, 1988), Nettleton's (1992) analysis of dentistry, and to an extent, my own study of surgery (Fox, 1992).

Alongside this body of work, which concentrated on applying Foucauldian concepts and his archaeological/genealogical method, a number of more general works in the sociology of health addressed broader post-structuralist concerns with embodiment and power. Bryan Turner's *The Body and Society* (1984) and *Medical Power and Social Knowledge* (1987) drew on a range of perspective from Marxist and Weberian sociology to French social theory and feminist materialist writing on the body, while in *Medicine as Culture*, Deborah Lupton (1994) synthesised post-structuralism with social constructionism (of the Berger and Luckmann variety), political economy, cultural studies and feminism. Those attracted to

post-structuralism were also influenced by pathfinder social science texts, notably the Clifford and Marcus (1986) anthropology collection *Writing Culture* and Ann Game's (1991) *Undoing the Social*.

By the time the first issue of *Health* was published in 1997, a substantial body of work pertinent to the social study of health and the body was citing post-structuralist writers, though Foucault was overwhelmingly in the ascendant. My concern when I wrote *Postmodernism, Sociology and Health* (Fox, 1993) had been to extend the application of post-structuralism beyond the narrow confines of Foucauldian concepts such as discourse, the medical gaze, disciplinary power/knowledge and governmentality. In particular, I was keen to explore the work of Derrida, Lyotard and Baudrillard, the post-structuralist feminism of Cixous and Kristeva, and make connections to the materialism of Deleuze and Guattari (of whom more later). These writers had in common the recognition that embodiment and subjectivity were intricately caught up with both power and social constructs, and that power 'acted on actions', rather than being an unitary force, as is the case in structuralist sociology. With their focus upon texts and textuality, post-structuralists rejected sociological conceptions of an over-arching social structure, and sought instead to explore how systems of thought or 'discourses' shaped social action in ways that were historically and culturally contingent, and thereby only ever partial versions of a phenomenon (Fox, 1999: 43).

The foundations for a post-structuralist sociological perspective on health and illness were to be found in the literary theories of Roland Barthes and Jacques Derrida. Barthes' concept of *intertextuality* and Derrida's *différance* provided the basis for a radical constructionist epistemology in which language and abstract concepts stood in the way of ever gaining knowledge of the 'real world'. Although concepts supposedly refer to 'real' objects, these can only be signified through symbols (signifiers) such as words or other notations, which are necessarily constituted through reference to other signifiers – for instance, to describe a kidney as a 'bean-shaped' body organ. This chaining of signifiers produces the *intertextual* play of one text upon another, in an endless process of referentiality, and led to Derrida's (1976: 158) statement that 'there is nothing beyond text'. Because signifiers can only refer to other signifiers, definition offers not reality, but a further approximation that, regardless of effort to make it more 'real', is always already deferred and irrecoverable. This is reflected in

Derrida's (1976: 93) neologism *différance*, a term that suggests both difference and deferral, and which thereby established post-structuralism's relativism.

Recognising the impossibility of direct knowledge of reality was important, Derrida argued, because in most cultures, claims to know the truth or *logos* was the means to establish authority, status and control over others. Thus, for example, authority has been invested in knowledge of the holy books of the religion, in concepts such as papal infallibility, or in the 'divine right' of a monarch to rule. Secular laws enshrined the claims of a ruling elite to define right and wrong, and to punish those who breach these edicts. In the post-Enlightenment period of modernity, the proposition that humanity might know the truth of nature, society and polity through the application of reason and scientific method has been the basis for a new secular authority that displaced religion, and led to the emergence of disciplines from biological and physical sciences to psychology, sociology and economics (Fox, 2012a: 12; Rose, 1999). All these claims to know the truth, Derrida argued, were *logocentric* propositions that underpinned the authority of their claimants, and their consequent access to power, resources and domination over others.

For post-structuralists, intertextuality and *différance* established insurmountable barriers to ever knowing authoritatively a world beyond texts; indeed post-structuralism accepted this limit to knowledge and consequently recognised a multiplicity of realities. Critics argued that relativism marked post-structuralism's fatal weakness when applied to social theory, effectively denying any possibility of gaining definitive knowledge of the social world (Lau and Morgan, 2014: 580). Post-structuralist theorists countered that relativism was to be celebrated as a recognition of the context-dependency of knowledge and the perniciousness of power relations underpinning claims to knowledge in modernity (Hassard and Cox, 2013: 1715; Tremain, 2015). By examining the micropolitics of health care, post-structuralism provided a means to link the daily interactions between patients, professionals and technology with wider social and power relations in modern societies, to show how knowledge based upon the biomedical model empowered health professionals' authority over the body, and how the body itself might be understood (Lupton, 2012: 23-24).

The postmodern turn in health sociology

Coinciding with, and partly contingent upon the emergence of post-structuralist critical approaches within the humanities, sciences and social sciences, Lyotard (1984) discerned and proclaimed a 'postmodern condition' affecting both daily life and scholarship in the latter part of the 20th century. This condition was marked by the gradual erosion of the certainties of modernity founded in science, rationalism and humanism by a perfect storm of the information revolution, post-industrialisation, pluralism and academic relativism. Postmodernism has on occasions been treated as a periodisation – as a specific cultural era following modernity (see for example, Clegg, 1990; Cockerham and Wasserman, 2014); it is more generally and usefully defined as a perspective typified by suspicion of those meta-narratives in science, social science and culture that made absolute claims to truth, and by its contrary effort to acknowledge the validity of multiple perspectives (Agger, 1991: 116; Lyotard, 1984: xxiv).

A postmodern sensibility within the social sciences criticised grand theories or systems of thought, and the truth-seeking aspirations of post-Enlightenment modernists who applied rationalist methodologies, including science, humanism and social scientific realism that made claims to uncover truth (Fox, 1993: 128; Rosenau, 1992: 13). They were suspicious of claims to truth made by scientific disciplines in the physical and biological sciences, in social sciences such as economics and politics, and by professional groupings such as law, medicine and education that grounded their practice in these bodies of scientific knowledge (Goldstein, 1984). This was reflected in a rejection of over-arching social models including Marxism and psychoanalysis, in pessimism about progress through scientific advances, and in critiques of scientific claims about gender, race and sexuality as based in colonialism, racism, heteronormativity and patriarchy (Braidotti, 2013: 37; Rosenau, 1992: 78). It provided the basis for a radical critique of subjects including psychology (Henriques et al, 1998; Rose, 1998) and sociology (Game, 1991; Rosenau, 1992: 105-107) as themselves implicated in the construction of modernity. Doubts over the validity of truth-claims led instead to a willingness to entertain multiple parallel explanations of the social world, and openness to innovative research methodologies that might elicit such disparate accounts (Curt, 1994; Fox, 2003; Lather, 1993; Lyotard, 1984: 60).

A number of writers in the sociology of health explicitly engaged with this postmodern sensibility, including Cheek (2000), Morris (1998) and Fox (1993, 1999). Thus Morris suggested that we should understand health in terms of a biocultural 'postmodern illness' that was no longer to be considered simply as a biological process, but as situated within 'cultural systems that govern the flow of knowledge and power' (1998: 74). For Cheek (2000: 11), postmodern theory was a necessary antidote to the creeping discourse of economic rationalism (neoliberalism) that was infecting both health care and health research at the time. My own objective had been to use post-structuralist and materialist perspectives to explore both social construction and social production, and to set out a critical and progressive ethics and politics of both health care and social research (Fox, 1993: 7-9; 1999: 210), and to shift from the academic register of post-structuralism to a political register that challenged logocentrisms from scientific rationality to patriarchy. In this postmodern project, Lyotard's (1988) notion of the *differend* marked and revealed the violence by which the powerful silenced the powerless; Derridean (1976) *deconstruction* was the basis to undermine systems of privilege such as patriarchy or colonialism, and thereby offer a feminist, postcolonial or queer alternative (Cixous, 1976; Spivak; 1999); Foucault (1970, 1984) revealed genealogies of discourses, governmentalities and technologies of power that underpinned a variety of regimes of truth at different points in human history.

At the same time, postmodern theory required that its proponents turn the spotlight on themselves, to extend this recognition of flux and fluidity to sociological analysis itself and the 'truths' to which sociology might lay claim, and to counter a sociology of health that vied with biomedicine in revealing the 'reality' of health and illness. Whereas modernist methodologies sought objectivity and a means to exclude researcher biases, post-structuralist and postmodern approaches were characterised by reflexivity concerning the production of academic texts (Cheek, 2000: 5; Fox, 1999: 174ff.; Rosenau, 1991: 106-108). Using methods inspired both by Derridean and Foucauldian approaches and by feminist methodologies (Ramazanoglu, 1992), the voice of the researcher or writer became stronger within the research text; analysis was fragmentary and multivocal rather than unifying and systematic; and conceptions of validity and reliability were displaced by emphases on enabling, transgression of established values and power relations, and collapsing barriers between academic theory and social or political action (Curt, 1994; Fox, 2003; Lather, 1993; MacLure, 1996).

There were a number of distinctive consequences for the sociology of health and illness of adopting post-structuralist and postmodern perspective. Unlike interactionist accounts, post-structuralist and postmodern perspectives took issues of power and resistance as a fundamental concern, while unlike structuralist analyses, they considered how power acted at the level of actions and interactions of health professionals, patients and others in health settings. Foucauldian studies of health and illness examined how technologies of power such as observation and record-keeping and the use of health technologies shaped health care institutions and the relations between patients, clients and professionals in clinics, hospitals and the wider community (Arney and Bergen, 1983; Harding, 1997; Nettleton, 1992: 93-96), while the Petersen and Bunton (1997) collection *Foucault, Health and Medicine* explored both theory and a variety of applications.

The theoretical opportunities afforded by these positions were reflected in the pages of *Health* from its outset. In the very first issue of *Health*, Lucy Yardley (1997) used Derridean deconstruction to question the privileging of 'normal' or 'natural' over 'abnormal' or 'unnatural' in medical and rehabilitative discourses on deaf people's communication. This hierarchy served to 'obscure and suppress a variety of pertinent, substantial and sensitive issues concerning our use of language and technology and our relationship with minorities such as deaf people' (ibid: 38). In similar vein, Traynor (2000) invoked Derrida and Kristeva to deconstruct how dualisms such as pure/impure and wisdom/superstition operated within texts advocating an evidence-based approach to healthcare.

Predictably, Foucault has been the most cited of the post-structuralists within the pages of *Health*, appearing in 178 contributions between 1997 and 2015. Nicholls et al (1999) used Foucault's notion of governmentality to examine how a physiotherapy clinic turned a fundamental activity of daily life – breathing – into both an object of concern and the basis for re-making physiotherapy within a neoliberal healthcare. Cervical screening could be understood as a Foucauldian 'technology of the self', Armstrong (2007) argued, concluding that despite an 'official discourse' on screening, reflexivity and embodied practices provided a means for women to resist and take control of their own health, for instance by questioning the validity and objectivity of screening practices. In a more equivocal piece, Daneski et al

(2011) found utility in a Foucauldian genealogy of stroke that explored changes in treatment in terms of the different ways the disease had been spatially conceptualised over time, but pondered the need for a more nuanced and less theorised historical approach.

Beyond post-structuralism: the turn to matter

Though the 'linguistic turn' of post-structuralism/constructivism has been a substantive influence upon the sociology of health and illness during the publication life of *Health*, this has not been uncontested (Hoffman, 2012: 242; Williams, 2006: 9). While the epistemological relativism of post-structuralist and postmodern theory proved a means to reveal the associations between power and knowledge that underpin both medicine (Lupton, 1997) and sociology (Turner, 1987: 16-17), they at same time posed a challenge to address the materiality of well-being, life and death that health sociology has made its object of study. In post-structuralism, texts and textuality became the object of inquiry, while the biological body appeared to recede beyond the analytical purview of the post-structuralist social scientist (Fox, 2012a: 56).

The emergence of an explicit 'sociology of the body' in the 1990s (Featherstone et al, 1991; Fox, 1999; Turner, 1992; Williams and Bendelow, 1998) may be seen retrospectively as a proxy war between constructionist and realist epistemologies, which sought in different ways to make sociological sense of the body and how it might be 'known'. Post-structuralism was accused of ignoring or even denying the 'reality' of the body – a reality which should be revealed through a mix of phenomenology and interactionist sociology; constructionist retorted that body realists had been taken in by propagandists for a taken-for-granted 'body-with-organs' (Deleuze and Guattari, 1988: 158) in the medical and biological sciences. However, for some (including myself), body sociology provided the basis to shift sociological focus from epistemology to ontology (Fox, 2002: 355; Fox and Alldred, 2015), and to centre attention firmly upon materiality; not only the materiality of flesh, but also all the other physical and biological stuff with which bodies come into contact, along with the sociocultural constructs that also affect bodies materially (Coole and Frost, 2010: 6; Fox, 2012a),. This turn to matter within sociology is the focus of the remainder of this paper.

Distinct from both constructionist and realist approaches, the 'new' materialisms that have emerged in recent social science and humanities scholarship are, like post-structuralism, concerned with the workings of power, but focused firmly upon matter and the materiality of social production rather than upon textuality and social construction (Coole and Frost, 2010: 7; Taylor and Ivinson, 2013: 666). Among their radical claims, new materialist theorists have argued that the material world and its contents are not fixed, stable entities, but relational, uneven and contingent (Barad, 1996, Coole and Frost, 2010: 29; Lemke, 2015). They suggest that 'nature' and 'culture' should be treated as contiguous rather than distinct realms, as both the physical and the social have material effects in an ever-changing world (Braidotti, 2013: 3; Haraway, 1997: 209). And they claim that the capacity for 'agency' – the actions that produce the social world – extends beyond human actors to the non-human and inanimate (Braidotti, 2013; DeLanda, 2006; Latour, 2005).

The new materialisms encompass a dizzying array of perspectives, from actor-network theory, biophilosophy, feminist and queer theory, non-representational theory, posthumanism, quantum physics and Spinozist affect theory. While actor-network theorists such as John Law and Bruno Latour have long been features on the sociological landscape, the other new materialist theorists that have been significant within health sociology over the past 20 years have been the philosopher Gilles Deleuze and his collaborator, the psychoanalyst and activist Félix Guattari. I can claim a small part in introducing these writers to health sociologists – in 1993 I placed DeleuzoGuattarian discussions of embodiment, power and resistance at the theoretical heart of my book on postmodernism and health (Fox, 1993), and many of my subsequent outputs used their work as inspiration (Fox, 1999, 2002, 2011, 2012a, 2012b).

Deleuze and Guattari's relational ontology provided health sociology with a radical material conception of health, illness and embodiment, defined by what a body can *do*, rather than what it is. The body is no longer regarded as an independent entity, but as situated within a network of biological, psychological, cultural, economic and abstract relations to other bodies, objects, technologies, ideas and social organisations. These relations affect and are affected by others in the assemblage (an interaction that Deleuze and Guattari called simply, an 'affect' (Deleuze, 1988: 101). These affects specify or 'territorialise' (Deleuze and

Guattari, 1988: 88-89) the limits of a body capabilities – what it can do, feel and desire. Changing or extending these relations offers possibilities for enhancing body capacities (for example, to improve the quality of life of someone with a chronic illness or opportunities for sexual expression in people with physical impairments), and may enable new identity-positions, such as 'expert patient' or 'resisting health consumer' (Fox and Ward, 2006). Deleuze and Guattari (1984) applied this model of embodiment to mental health, while others have explored topics including anorexia (Buchanan, 1997), drug use (Duff, 2007; Oksanen, 2013), chronic illness (Danholt, 2013), human development (Duff, 2010), ageing (Fox, 2005), and sexual health (Potts, 2004), as well as health and illness more generally (Duff, 2014; Fox, 2012a).

The utility of a DeleuzoGuattarian perspective for health sociology can be explicated most simply via the ideas of an 'ill-health assemblage' and a 'health assemblage' (Fox, 2011). An ill-health assemblage is constituted from the myriad physical, psychological and social relations, and the affects that surround a body during an episode of ill-health. At its simplest, we could imagine an assemblage comprising simply a body and a disease. However, for an adult human, many other psychosocial and cultural relations will contribute, and we can conjecture an ill-health assemblage such as:

organ – disease – doctor – biomedicine – health technology – work – family responsibilities – family members/friends – carers

Ill-health is shaped by the capacities and limits of the 'sickening-body' (Fox, 2011: 365) produced by the affective interactions between these relations, which thereby materially link biology, psychology, emotions, cultural contexts and social formations. So, for example, Potts (2004: 22) described an impotence treatment-assemblage that included a male body, a penis, doctors, Viagra (or other pharmaceuticals) and the person's partner: the affects in this assemblage constituted a Viagra-body with certain sexual and non-sexual capacities that limited what the man's and his partner's bodies could do. An ill-health-assemblage is not fixed: it will shift and fluctuate over time, dependent on the affective forces that draw relations into assemblage. Hence, for every episode of ill health, there will many relations and affects unique to the setting, circumstances, past experiences and other aspects of illness:

people's differing responses to illness and to health care are explained by the idiosyncrasies of their own particular ill-health assemblage.

If there is an ill-health assemblage and a sickening-body, is there also a health-assemblage, and a becoming-healthy body? We might simply conjecture a health-assemblage in which disease and the paraphernalia of medicine and care played no part. However, the insight to be gleaned from a DeleuzoGuattarian understanding of health and illness is that it is the capacities and limits of what a body can do that determines whether it is 'healthy' or 'sick'. As Buchanan (1997: 82) points out, Deleuze adapted the term 'health' from Nietzsche to connote 'the actual measurable capacity of a body to form new relations', along with an assessment of whether these new relations in turn produce new bodily capacities or close down existing ones. While for Deleuze this articulation went far beyond the conventional understanding of 'health' and 'illness', it also supplies a formulation that can be used to establish a new materialist sociology of health. Explicitly, 'health' is not just an absence of 'ill-health' relations (as suggested in the biomedical model), but the opposite – the proliferation of a body's capacities to affect and be affected (Fox, 2011: 366). Furthermore, given that 'bodies' are relational, it follows that health is 'a relational achievement ... the effect of bodies acting together in force and sympathy' (Duff, 2014: 185). It is influenced by

> ... refracted and resisted relations, biological capabilities or cultural mind-sets, alliances with friends or health workers, struggles for control over treatment or conditions of living. Health is neither an absolute ... to be aspired towards, nor an idealised outcome of 'mind-over-matter'. It is a process of becoming by (the body), of rallying relations, resisting physical or social territorialisation, and experimenting with what is, and what it might become (Fox, 2002: 360).

This Deleuzian model of health, embodiment and what a body can do has been applied with increasing frequency in the pages of *Health* since 1997. By exploring the relations that bodies have – an approach that Deleuze called 'ethology' (Duff 2010: 625) – a person's health identity can be explored empirically (Fox and Ward, 2006). Duff (2010: 629) argues that this kind of ethological approach may be used more widely, to explore human development from cradle to grave, in the 'five developmental domains of social, cognitive,

emotional, material and moral development'. Development over the life course can be seen as a gradual enhancement of a body's 'force of existing' or power of acting (ibid: 630). For Prasad (2015: 139), the material interactions between bodies and technologies during stem cell therapies can break bodies free from narrow territorialisations as 'patients', and carry them on a de-territorialising 'line of flight' into new possibilities, while Fox (2012b) suggested that engagement in the arts or other creative pastimes could be 'good for health' as they enhanced what a body can do. Danholt (2013) makes the case for this kind of perspective on chronic illnesses such as diabetes, arguing that

> I may have a chronic condition, but the exact way in which this chronic condition unfolds and affects my life is not a settled matter. In fact, I might come to care for my condition as an event that transformed my life in a manner that I appreciate (2013: 388).

Conclusions: material futures?

In this review I have looked back on two theoretical threads that have influenced health sociology in general and the papers published in *Health* since 1997. The 'linguistic turn' of post-structuralism was already an established force at that time within our sub-discipline, and in the years since post-structuralist and postmodern approaches to health, illness and medicine have been applied to explore the intimate associations between embodiment, power, knowledge and identity in health and healthcare. Unlike structuralist analyses, post-structuralism's concern has been concerned not with 'top-down' conceptions of power but with the micropolitics of how power acts upon the actions and interactions of health professionals, patients and others in health settings. Studies have explored the discourses that linked knowledgeabilities to these micropolitics, and opened up new approaches to analysing texts and accounts of all sorts, to reveal how power both constrains and enables action (Alldred and Fox, 2015: 202).

The turn to matter in the arts, humanities and social sciences is now impacting on health sociology, as social theorists seek a way beyond the epistemological arguments between 'constructionists' and 'realists' (Barad, 1996: 165; van der Tuin and Dolphijn, 2010), by shifting the ontological goalposts that have led to that impasse. New materialism's relational

and ‘flat’ ontology (in common with post-structuralism) eschews any notions of social structures, systems or mechanisms that can ‘explain’ social action and interactions. Instead it explores the world and human lives by exploring how natural and cultural relations assemble, the forces (affects) between them and the capacities these affects produce.

Proponents argue that this ontology provides the means not only to move beyond textuality, but, critically to enable a clear understanding of resistance as well as power. Applied to health and healthcare, new materialist perspectives have addressed the materiality of bodies as they engage with other material (natural and cultural) relations. While this reveals the forces that impinge on bodies, resistance is not only a possibility, it is an inevitability, as physical and biological, psychological and emotional, social and cultural relations provide opportunities for new capacities. Health is the body’s capacities to affect and be affected, and thus its *resistance* to forces of territorialisation that limit these capacities. It is a process of becoming, of rallying capacities, resisting physical or social territorialisation, and experimenting with what is, and what might become. Perhaps this may also be the role for the journal *Health,* as it documents and articulates health sociology scholarship into the future.

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