

Postfeminism and Health

Critical Psychology and Media Perspectives

SARAH RILEY, ADRIENNE EVANS,
and MARTINE ROBSON



CRITICAL APPROACHES TO HEALTH

POSTFEMINISM AND HEALTH

This groundbreaking book employs a transdisciplinary and poststructuralist methodology to develop the concept of 'postfeminist healthism,' a twenty-first-century understanding of women's physical and mental health formed at the intersections of postfeminist sensibilities, neoliberal constructs of citizenship and the notion of health as an individual responsibility managed through consumption. Postfeminist healthism is used in this book to explore seven topics where postfeminist sensibility has the most impact on women's health: self-help, weight, surgical technologies, sex, pregnancy, responsibilities for others' health and pro-anorexia communities. The book explores the ways in which the desire to be normal and live a good life is tied to expectations of 'normal-perfection' circulated across interpersonal interactions, media representations and expert discourses. It diagnoses postfeminist healthism as unhealthy for both those women who participate in it and those whom it excludes and considers how more positive directions may emerge.

By exploring the under-researched intersection of postfeminism and health studies, this book will be invaluable to researchers and students in psychology, gender and women's studies, health research, media studies and sociology.

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CRITICAL APPROACHES TO HEALTH

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Media Perspectives

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Adrienne Evans

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To Rosalind Gill, an inspiration. And our partners who saw less of us
because we were writing this book.



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SERIES EDITOR PREFACE

Critical Approaches to Health

Introduction

Health is a major issue for people all around the world, and is fundamental to individual wellbeing, personal achievements and satisfaction, as well as to families, communities and societies. It is also embedded in social notions of participation and citizenship. Much has been written about health, from a variety of perspectives and disciplines, but a lot of this writing takes a biomedical and causally positivist approach to health matters, neglecting the historical, social and cultural contexts and environments within which health is experienced, understood and practiced. It is an appropriate time to introduce a new series of books that offer critical, social science perspectives on important health topics.

The *Critical Approaches to Health* series aims to provide new critical writing on health by presenting critical, interdisciplinary, and theoretical writing about health, where matters of health are framed quite broadly. The series will include books that range across important health matters, including general health-related issues (such as gender and media), major social issues for health (such as medicalisation, obesity and palliative care), particular health concerns (such as pain, doctor–patient interaction, health services, and health technologies), particular health problems (such as diabetes, autoimmune disease and medically unexplained illness) or health for specific groups of people (such as the health of migrants, the homeless and the aged) or combinations of these.

The series seeks above all to promote critical thought about health matters. By critical, we mean going beyond the critique of the topic and work in the field, to more general considerations of power and benefit and, in particular, to addressing concerns about whose understandings and interests are upheld and whose are marginalised by the approaches, findings and practices in these various domains

of health. Such critical agendas involve reflections on what constitutes knowledge, how it is created and how it is used. Accordingly, critical approaches consider epistemological and theoretical positioning, as well as issues of methodology and practice, and seek to examine how health is enmeshed within broader social relations and structures. Books within this series take up this challenge and seek to provide new insights and understandings by applying a critical agenda to their topics.

In the current book, *Postfeminism and Health*, Sarah Riley, Adrienne Evans and Martine Robson bring their cross-disciplinary critical perspectives to provide novel ways of understanding women's health at this point in the twenty-first century. They explain and draw on different understandings of postfeminism throughout the book, but position these around their primary conceptualisation of postfeminism as a sensibility. A postfeminist sensibility arises from mainstream media and public discourses that put forward (often inconsistent) notions of ideal femininity, what it means to be a woman and what it means to live well. These discourses offer women understandings which they can use in thinking about their own health and producing their gendered selves. A postfeminist sensibility framework allows the authors to provide a critical consideration of health as a key dimension within the complexities of gender relations and their implications.

Riley, Evans and Robson critically develop the concept of 'postfeminist healthism' by drawing on theoretical ideas arising from the postfeminist sensibility framework, alongside neoliberal constructs of citizenship, and health as an individual responsibility within consumer culture. They then apply this theoretical framework to seven important topics for women's health; self-help, weight, surgical technologies, sex, pregnancy, responsibilities for others' health and pro-ana (anorexia). The authors provide engaging and rigorous analyses of each of these issues, employing relevant transnational and transdisciplinary research and media accounts. Their analyses draw on critical, poststructuralist perspectives that bring the essential issues of subjectivity, discourse and materiality to the fore.

The book provides a unique and thoughtful critique of the contemporary gendered social and cultural landscape in Western societies and what this means for women's health, individual subjectivities and everyday practices. It is a very strong addition to the Critical Approaches to Health series.

Antonia Lyons and Kerry Chamberlain
March 2018

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PROLOGUE

The term ‘postfeminist sensibility’ describes a set of ideas about ideal femininity that have been circulating in the media for over ten years. It is a term that helps analysts to recognise how a set of otherwise contradictory notions of femininity come together to form a cohesive way of making sense about what it means to be a woman and to live a good life. These ideas circulate across a range of media, acting as a ‘media address’ that offers a set of understandings through which women can make sense of and produce their own gendered selves.

Understanding postfeminism therefore requires an approach that can examine subjectivity in a highly mediated cultural context, without falling back on simplistic ideas of media influence. In taking this requirement as our starting point, this book offers a novel splicing of critical psychology – itself informed by philosophy, politics, feminist and postcolonial studies to name a few – with media and cultural studies. We have also taken a transnational and transdisciplinary perspective. This is because postfeminist sensibility is embedded across the Anglophone world; many of the examples we give in this book are drawn from the UK, Australia, New Zealand, Canada and the USA – and are relatively interchangeable. This is also true for research in some other European countries, including Scandinavian countries. Postfeminist sensibility is also expanding its reach, informing developments in gender subjectivities and practices in countries such as China, Singapore, India, Russia, Ukraine and Nigeria. Taking a transnational focus allows us to explore the way in which different elements of postfeminist sensibility emerge in different contexts and helps us to develop the intersectional analysis of postfeminist sensibility.

An interdisciplinary perspective also allows us to draw on the diverse work across the social sciences and humanities that is using postfeminist sensibility. This breadth of research demonstrates the importance of postfeminist sensibility as an analytical tool across a range of contexts, disciplines and time frames. But in the main, despite reading across disciplines, researchers have used each other’s work to inform their

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own disciplinary concerns. In this book, we therefore significantly develop the field through our transdisciplinary approach, which facilitates a dialogue that blurs the boundaries between disciplines, an approach we suggest is essential to address the complex issue of health. In so doing, we also address a hitherto neglected dimension of research on postfeminist sensibility, that of its impact on women's health.

To consider the implications of postfeminist sensibility for women's health, we take a poststructuralist approach, predominantly informed by Foucault, but also by the work of Deleuze and Guattari. We also bring together three interrelated bodies of thought on postfeminist sensibility, neoliberal constructs of citizenship and healthism, which we argue intersect in a variety of ways to create the discursive and material assemblage that we call 'postfeminist healthism'. Our interest is in how postfeminist healthism structures the way women may make sense of themselves and are made sense of by others in ways that have direct consequences for their health. We take you through what we mean by postfeminist sensibility, neoliberal constructs of citizenship and healthism to provide context for readers who would like a sense of the literature and debates in which this book is located. We finish the prologue by outlining the rationale and the chapters that follow.

This girl can

A good place to start a discussion of postfeminism is with the Spice Girls pop group. In the mid-1990s, they sang 'I'll tell you what I want' and, in doing, so the Spice Girls epitomised a new, self-assured and self-determined femininity – one that was girly *and* assertive. Meanwhile the television show *Sex and the City* defined femininity in terms of the pleasures of female friendship, consumption and sexual agency and in the 'Hello Boys' Wonderbra advert (1994) model Eva Herzigova looked down joyfully at her pushed-up breasts, inviting men to do the same. Across a range of media then, a confident, sexually assertive femininity was being articulated. This new femininity aligned with a government focus on women that aimed to enhance gender equality and equal opportunities in education and employment. Femininity in postindustrial countries across the globe seemed transformed with women unprecedentedly sexually agentic, confident and publicly active. Academics called this new gendered landscape 'postfeminism' and have since charted its rise into the twenty-first century.

There are, however, several uses of the term 'postfeminism' (Gill, 2007a, 2017b). We outline these uses before engaging more deeply with 'postfeminist sensibility', the approach we find most useful for thinking about our contemporary gendered landscape.

For some analysts, postfeminism describes an era after feminist politics. In this use of the term, the undeniable gains of feminism for women and for society at large, including managed fertility, equal opportunities in the workplace and more equitable, negotiated romantic relationships, means that there are few issues left for feminists to challenge. Thus, despite the continuation of some feminist activism, including new forms of 'fourth wave' or 'digital feminism' (Cochrane, 2013;

Gill, 2017a; Keller, 2012), for those defining postfeminism as an era, feminism is located as a valuable historical notion, but a spent force in today's context; a position McRobbie (2004) described as being consigned to 'a retirement home in an unfashionable rundown holiday resort' (p. 512).

Others use the term 'postfeminism' to describe a backlash against feminism (e.g. Faludi, 1991). In this backlash, feminism is represented to the public as both ludicrous and dangerous, as seen in the figures of bra-burning women, women who refuse to shave their legs or armpits and angry man-hating 'femi-nazi' lesbians. From this perspective, there is little to be gained from identifying as feminist. Young women in this new postfeminist world should make the most of the gains of the feminist movement, while recognising that traditional gender roles are more likely to lead to their happiness and fulfilment.

A further use of the term 'postfeminism' is in defining a new theoretical movement. This use of the term takes its cue from the development of ideas captured under the term 'post' that offer new ways of conceptualising the self, including postmodernism, poststructuralism and post-humanism. A key theorist here is Judith Butler, whose work on the performativity of gender (1990) proposed that gender is not something one is, as an essential characteristic of the self. Instead, she conceptualised gender as a performance, created through a complex combination of interactive historical traces that produce an experience of the self that is fluid, partial and performative. As a theoretical moment in the story that feminism tells of its own history, such accounts of gender have been understood as postfeminist in that they appear to refuse the essentialism of earlier feminisms (Gill, 2007c; see Hemmings, 2011 for a critique).

At various points in this book we draw on these different understandings of postfeminism. We see them as useful in highlighting, for example, the way that feminism is often understood as having had its heyday or being a dangerous ideology of a minority of crazy, anti-capitalist and misanthropic women. But our main analytic for conceptualising postfeminism is in line with work that identifies postfeminism as a sensibility, which we outline below.

Rosalind Gill's (2007c) seminal paper on postfeminist media culture defined postfeminism as a sensibility made up of a set of interrelated themes articulated in Anglo-American media. One theme was an understanding that femininity was produced through appearance work, so that femininity was constructed as a bodily practice and the body as the locus of women's success and identity. Gill argued that although media representations of this body work were produced through discourses of choice, pleasure and empowerment, postfeminist sensibility had a disciplinary function, tying women into concerns around heterosexual attractiveness and appearance.

Gill (2007c) argued that understanding femininity as a set of bodily practices was facilitated by a makeover paradigm that constructed the body as in need of constant transformation. A postfeminist sensibility thus required women to engage in self-surveillance and self-monitoring, so as to identify areas that needed improvement. Gill and other analysts were also critical of this transformation imperative.

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Ringrose and Walkerdine (2008), for example, identified a form of aggression in a range of television programmes that examined women's clothing choices (e.g. *What Not To Wear*), since they encouraged female viewers to scrutinise and judge other women's appearance. Another significant concern regarding postfeminist sensibility was that the emphasis on individual transformation masked the ways that cultural, classed, sexualised, racialised and embodied aspects of contemporary feminine ideals marginalised those who were not white, slim, middle class, able bodied and heterosexual (Craig, 2006; Evans, Riley and Shankar, 2010; Gill 2009a, 2011; Skeggs, 2005; Tate, 2007). And that this marginalisation occurred on a global scale through fashion magazines, like *Grazia*, *Vogue* and *Marie Claire*, whose similar formats articulated a postfeminist sensibility that minimised diversity and difference to women across a range of countries (Butler, 2013; Chen, 2009; Evans and Riley, 2016; Gill, 2007b; Gwynne, 2013; Lazar, 2011; McRobbie, 2009; Press, 2011).

Gill (2007b) also argued that postfeminist sensibility involved a shift from sexual objectification to sexual subjectification, where women's sexual appearance was represented as evidence of an agentic, self-knowing, sassy sexuality and a key source of women's empowerment. Within a postfeminist sensibility, practices once considered sexist and objectifying – wearing high heels or participating in porn for example – were represented as choiceful, empowered acts. The concept of sexual subjectification highlighted how the expectation to produce oneself into a highly polished, hyper-sexy form of femininity was constructed as women doing it for themselves, who in 'having it all' were no longer tied to a humourless feminist critique but could laugh at the ironic, retro-sexism of contemporary media landscapes.

Gill's postfeminist sensibility tied into McRobbie's (2004, 2009) argument that postfeminism involved a simultaneous drawing on and refutation of feminism; for example the way the language of empowerment was used to justify sexual subjectification. Thus, an important aspect of postfeminist sensibility was the way that feminist ideas were articulated (e.g. that women's empowerment is important), while feminism as the means towards this empowerment was rejected, often in favour of individual and consumer-oriented choices. Paradoxically however, the discourse of individual choice was often tied to a discourse of biological essentialism. For example, postfeminist media often articulated notions of the 'good life' as one that oriented around traditional gendered roles of heterosexual attractiveness, marriage, pregnancy and 'domestic bliss' and constructed women's desires for these aspects of a good life as both freely chosen *and* driven by their biological femininity.

Gill and others also discussed how the language of choice in postfeminism connected postfeminist sensibility to ideas of 'choiceful' citizens, which were central to countries organised around neoliberal capitalism. Traditional notions of femininity as flexible and emotionally oriented were also used to advance a case that women were ideally suited to emerging service and consumer-oriented economies. This tying of postfeminist sensibility and traditional femininity with neoliberal economics and constructions of citizenship created a celebration of women as the new citizens of the millennium (Evans and Riley, 2014; Gill, 2007c, 2008a; Harris, 2004; McRobbie, 2009; also see our discussion on neoliberalism below).

Over a decade on from Gill's (2007c) original formation, postfeminist sensibility continues to circulate within and across various media, offering a set of understandings for women, and in particular young women, to make sense of themselves. But it is no longer only a media address. Postfeminist sensibility has spilt into everyday sense making, structuring how women feel about themselves, how they interact with other women and men, and how others respond to them. As such, the postfeminist gaze is no longer restricted to the micro-aggressions of the makeover show, but can form part of everyday interactions that create an anxious, judgemental culture (Riley, Evans and Mackiewicz, 2016).

Postfeminist sensibility has expanded in other ways too. The transformational makeover paradigm, once focused on the body, now extends into the psychological. This 'psychologising' of postfeminism can be seen, for example, in recent prescriptions for self-love and self-care and the steady shift away from the previous decade's 'bitchy' tone in women's media. For example, magazine articles that derided women for having too much cellulite, deodorant marks, body hair, tan lines, and so on, have been replaced by articles calling on women to feel comfortable in their bodies and to take care of ourselves. Borrowing from Ahmed (2010), we see this call to self-positive feelings operating as a 'promise of happiness'.

In her book *The Promise of Happiness*, Ahmed (2010) suggested that the things culturally understood as making us happy are things that both support the status quo (e.g. marriage, family) and are located in the future. For example, girls are told their wedding day *will be* the 'happiest day of their life', while women are told that one day (with the application of this technique or technology) they *will* look better, feel healthier or more confident in their bodies. This future orientation can be seen in the new psychological language of postfeminism in which, as Gill and Elias (2014) argue, calls to 'celebrate your curves' or 'awaken your incredible' come with the assumption that these are not emotions or attitudes that women *already* have about their bodies. These positive, feel-good messages assume that women feel bad about themselves, and so normalise a body negativity and a need to work on the self for improved body image. They also construct work on the body and the self as the mechanisms through which health and happiness are achieved.

As Gill and Elias (2014; also see Gill 2017b) suggest, the psychologisation of postfeminism deepens expectations of self-improvement and self-transformation. As well as working on the body through exercise, diet and beauty products, women also have to work on and transform their minds. For example, Dove's 'My Beauty, My Say' campaign features several different women who have overcome perceptions about their appearance. The women include an androgynous model, an attractive lawyer and a plus-size fashion blogger, who are all presented as having the resilience to be 'who they truly are' and define beauty in their own terms. In a culture where women are judged and scrutinised for their appearance and where their ability to attain the 'good life' is read as a measure of their psychology, such advertising taps into very real, emotional body- and self- dissatisfaction that many women experience. Tapping into women's emotions creates a media address that speaks directly to,

and hooks on to, women's desires and anxieties. We argue that such an interpellation creates powerful subjective effects.

There is now a growing recognition of the ways cultural discourses 'get inside' and come to feel truly part of our own 'authentic' selves. Media discourses do not remain within the media, as static messages, nor are they simply taken up wholesale. Complex processes underlie the formation of subjectivity. For many young women, postfeminist sensibility contributes to these processes by providing important building blocks which they may take up, resist, reappropriate or otherwise negotiate in their production of subjectivity. For example, in our own research, we have explored the way postfeminism structures accounts of women's sense making of sexiness (Evans and Riley, 2014; Evans, Riley and Shankar 2010), how and why women look at each other (Riley, Evans and Mackiewicz, 2016) and the role of celebrity culture on women's appearance concerns (Evans and Riley, 2013). Other work exploring the complexity of young women's engagement with postfeminist media has shown, for example, the way that pre-teen and tween popular culture is a key resource for girls and young women in developing accounts of themselves as media savvy (Jackson, Vares and Gill, 2012). Similarly, Ringrose (2013) and Renold and Ringrose (2011) explored the complex and contradictory ways that postfeminist sensibility informed gendered practices in educational contexts. For example, Renold and Ringrose (2011) showed how female teenagers at school may playfully take up the language of 'slut', but only in particular contexts that reduce the potential stigma of this term, for example, being in the sole company of girls and in a heterosexual relationship.

In complex ways then, postfeminist sensibility structures how women make sense of themselves and also how they make sense of others and how those others make sense of them. Postfeminism facilitates an understanding that women are empowered by working on themselves to meet cultural ideals. This understanding now works across a range of different aspects of life, extending the reach of postfeminism into employment, education and motherhood as well as the body, sexuality, psychology and emotion. Postfeminist sensibility has become common sense (Gill, 2017a, 2017b). There is now a normative expectation for women to be confident, sexually agentic and efficacious and successful in their life plans for public roles, paid employment, intimate relationships and embodied health. In the words of a recent UK public health campaign to get adult women exercising, this girl can.

The 'girlification' of adult womanhood in the language of Sport England's campaign (this *girl* can), demonstrates another emerging element of contemporary postfeminist sensibility, in which femininity becomes associated with girlishness and girlish pleasures. Such 'girlification' of adult womanhood shows how women's participation in public life comes with certain caveats or limits to full participation, as well as masking the aesthetic labour that goes into hyperfeminine appearances (Lazar, 2011). Drawing on Riviere's (1929/1986) concept of the masquerade, McRobbie (2009) argued that within a postfeminist sensibility, women in (previously masculine) professions must wear a mask of femininity so that they can

appear non-threatening. For a more contemporary example, consider the deliberately courted media attention on UK Prime Minister Theresa May's 'kitten heel' shoes when she took office. With the extension and diffusion of postfeminist sensibility, many women now also have to wear this mask of femininity outside their professional employment, so that the opportunity to participate in a range of public and private settings requires the maintenance of an image that is unthreatening through its femininity.

What makes participating in the postfeminist masquerade worth it is the promise of achieving a certain 'good life', involving a successful career, disposable income, domestic bliss and flawless appearance. This promise normalises perfection, when perfection is, by definition, almost impossible to attain and requires significant resources of time and money to work towards (Elias, Gill and Scharff 2016; Evans and Riley, 2013; McRobbie, 2015). It is also devastating when it is achieved, underpinned as it is by 'female vulnerability, fragility, uncertainty and deep anxiety, indeed panic, about the possible forfeiting of male desire through coming forward as a woman' (McRobbie, 2009, p. 67). Put another way, the work done to maintain this hyperfeminine unthreatening image makes women *unhealthy*. As we show in this book, within a postfeminist sensibility, what we value as healthy and happy can paradoxically create the context for a range of health concerns.

Postfeminist healthism

The maturing literature on postfeminist sensibility highlights the reoccurring elements of femininity as a bodily practice, sexual subjectification and the transformation imperative, with its associated need for self-monitoring and self-discipline in relation to both the body and mind (Riley et al., 2017). The literature also shows how postfeminism works as a form of incitement, interpellating young women to experience themselves as fun, valued and empowered through the take-up of postfeminist subjectivities. Postfeminist subjectivity is that of a happy, carefree young woman who works hard on her body and on her mind so that she can live optimally. This understanding holds an assumption that all women have access to resources to work on the self and body and should want to work on themselves in similar ways. Thus, those who fail to successfully work on themselves to meet cultural ideals are constructed as failed citizens, with an underlying flawed psychology demonstrated by their inability to discipline themselves appropriately. Postfeminism thus also creates its abject, women unable to make 'appropriate' choices that lead to a 'good life'. This understanding masks structural inequalities in the resources women have to work on their bodies and minds and locates problems that were once considered to have social solutions on the individual. For example, exercise becomes a matter of self-discipline, rather than the outcome of environments that reduce possibilities for regular movement.

With its individualist discourse of choice and blame, postfeminist sensibility folds into neoliberalism, a set of political-economic ideas that underpin advanced capitalism and which produce formulations of ideal citizenship. Neoliberalism is

a global project, and although there is variation in how it develops in different countries, neoliberal citizenship orients around values of self-management and self-enterprise made sense of through discourses of risk, responsibility, choice and freedom (Ong, 2006). Within neoliberalism, consumerism is a key mechanism for citizens to undertake this self-management, so that consumer and lifestyle choices become associated with citizenship and demonstrating being a good person. From this perspective, Cronin (2000) also argues that consumption ‘provides one of the few tangible and mundane experiences of freedom which feels personally significant to modern subjects’ (Cronin 2000 p.3). Neoliberalism provides the conditions of possibility for postfeminist sensibility, since, as we discuss in this book, an understanding of the self as in need of constant work and transformation, often through the use of consumption, is shared by both neoliberal and postfeminist sensibilities.

Neoliberalism also provides the conditions of possibility for healthism, a term Crawford (1980) used to define a shift in how we understand health. Crawford argued that health has increasingly come to be understood as a risk to be managed by the individual. Good health thus represents as person’s ability to manage risk through their lifestyle choices, with a person’s health reflecting the kind of person they are. Healthism ties government policy and commercial interests to the desires of individuals because, in general, people desire to be thought of as good people. The desire to understand oneself and be understood by others as a good person thus drives attempts to work on one’s health, for example by exercising regularly, not smoking, or using healthy shopping apps. Within the logic of healthism, if people are responsible for their health they are also responsible if they become unwell. This means that health and social problems that were once understood as the responsibility of the state or the outcome of the ‘luck’ of biology are now interpreted as the responsibility of the individual. The outcome is a very different way of understanding the relationships between health, citizenship, healthcare provision and consumption.

Neoliberal economics have a direct effect on the way people understand themselves and can be understood by others. The language of economic deregulation, involving the market, competition, choice and privatisation, structures our consumption, but also our health and subjectivity. In the Thatcher era in the UK, for example, privatisation became one of the top priorities as the government attempted to dismantle the welfare state and practice an anti-interventionist mode of governance. This included the privatisation of British Rail, British Gas, British Telecoms and British Airways, creating the opportunity for large numbers of companies to compete for custom. The outcome being that now people can choose flights from a range of airlines, British Airways, EasyJet, Flybe, and so on, as well as make price comparisons on websites such as Expedia, Go Compare and Travel Supermarket. The sense making that underpinned commercial deregulation was also applied to people. As the notion of competitive and privately owned institutions became embedded into the way people experienced consumption – from electricity to holidays – people in neoliberal economies also learnt to separate themselves from the state, becoming ‘companies of one’ (Read, 2009, p. 7). People started to understand

themselves through the language of the market, for example, by considering themselves, their skills or relationships as assets or investments (McRobbie, 2016), or by learning to market themselves competitively, for example in the online dating marketplace (Illouz, 2007).

Competitive marketisation also informed healthcare provision. Although public healthcare systems, such as the National Health Service (NHS) in the UK, Scandinavian healthcare systems and those in Canada, Australia, New Zealand continue to exist, they exist within the context of increasing privatisation of health care. The privatisation of health care across Western societies is associated with neoliberal reforms (Mackintosh and Koivusalo, 2005; Sen, 2003), one outcome of which has been to produce health through the lens of the same kind of competitive consumerism that we see in the airline example above. This includes food choices, which now come with a range of claims about health benefits to convince us to buy them: zero fat, zero sugar, added vitamins and minerals, high in amino acids, high in omega-3 fatty acids, high in fibre, high in potassium, high in nitrate, low-carb, and food praised for being macrobiotic, antioxidant and organic. Much like the way the health of the market depends on how consumers choose between competitive brands, so now our own health is demonstrated by the foods we eat, with those choices determining how healthy our 'companies of one' can become.

The result of the privatisation of health is that people come to value themselves based on how well they participate in healthy activities and practices. This also requires people to measure themselves, and be measured by others, in terms of how well they are doing against an assumed norm (Crawford, 1980, 2006). New digital technologies and developments in the accessibility of these technologies has greatly shaped how we understand our position against health norms and thus our own achievements in health. New technologies have created heightened self-awareness and self-monitoring, since recognising oneself as taking part in healthy practices of the self often requires that others know about these activities. For example, by using the hashtag #workoutwednesdays, people can communicate their exercise routine and receive recognition from others. Another element of these new technologies is how they allow us to monitor our own activity. For example, the Fitbit wristband records all activity within the day, including measurements on the quality of sleep. The Nike+ app encourages users to constantly improve their running with a digital 'personal coach' and Tweets the user's times and distances out to compare with others. As Lupton (2015, 2017) suggests, such technologies heighten self-awareness and require conscious reflecting on how well one is doing, making the technologies geared towards producing citizens who reflect cultural and social ideals of what is considered 'healthy'. We would also argue that these new technologies set the user up with the contradictory expectation of continuous transformation and reaching ideal health, even while the bar gets increasingly high against a body that has physiological parameters. Rather than ever truly feeling 'healthy', the combination of self-monitoring within a diverse and competitive consumer culture means that people rarely reach their 'targets' and are left feeling disappointed. As Crawford argues, any 'thoughtful consideration of the social meaning of health must ponder

the irony that the more important health becomes for us, the more insecure we feel' (2006, p. 403) or, as the sartorial Daily Mash put it 'fitness – "a nightmare that never ends"'¹.

The postfeminist healthism that we talk about in this book demonstrates a new way of understanding postfeminism as we move through the early twenty-first century. Through the term *postfeminist healthism*, we describe a way of thinking about women's physical and mental health that is formed at the intersections of: a postfeminist sensibility; a neoliberal imperative to be self-enterprising, risk managing and to treat oneself as a business; an historically shifting landscape of gender relations that put women in the spotlight of a new form of citizenship; and a construct of health as an individual responsibility that is managed through good consumer activity.

We also suggest that the understandings produced at these intersections are subtly sexist through the way that health and appearance concerns are linked together for women, so that at a time when there is a mounting critique against the way women's bodies are scrutinised for attractiveness, scrutiny of women's bodies and work on their bodies is re-legitimised under a discourse of health. The outcome is a blurring of appearance and health, epitomised in the construct of a 'healthy dress size', a phrase used by a participant in a project about women's weight (Tischner and Braun, 2017). What is also significant is that the self-disciplining, regulation and body work that women do to meet cultural norms and be a 'healthy dress size' is understood as being driven by autonomous choice and desire and with the aim of 'good health'. By constructing health as a reflection of who we are as a person, 'looking good' becomes read as an ability to appropriately take care of oneself. In this way, beauty work becomes naturalised – a natural outcome of living life the 'right' way; even as we have to work on it in increasingly intensified ways. This good life is connected to notions of happiness and perfection, making postfeminist healthism a deeply emotional and aspirational construct, a promise of transforming both the mind and the body for optimal living. Addressing the absence of health research that contextualises women's health within postfeminism, we argue that to make better sense of a range of health-related women's issues and practices in the Anglophone West, we need the lens of postfeminism. In this book, we therefore contribute an important dimension to thinking about health by examining seven issues where health and postfeminist sensibility seem particularly entangled, summarised under chapter headings of self-help, weight, technologies, sex, pregnancy, intimate responsibilities and pro-ana.

Overview of the book

As academics, we are located in psychology and media studies, but to develop a critical account of postfeminist healthism we draw not just from psychology, media and cultural studies, but also from sociology, political science, medicine, cultural geography, gender and women's studies, cultural studies, education, history and a

range of other critical approaches in the social sciences and humanities including international development, consumer theory and economics.

Different disciplines are organised around different concerns and core questions. We argue that it is through drawing on these differences that we can develop a rigorous and sophisticated analysis of the relationships between postfeminism, neo-liberalism and healthism, and how they impact on women's subjectivity and health. Cross-fertilising ideas between disciplines allows us to develop an approach that can illuminate particular patterns within the complexity of issues like health and gender. Health and gender also require a theoretical framework that can deal with complexity, particularly the intersections of subjectivity, discourse and materiality, and for that we have mostly drawn on work that uses critical, 'poststructuralist' perspectives.

By poststructuralist, we mean accounts that do not take the world as a given. Sex or gender are not essential, natural, universal or inevitable, but are made sense of through language located in specific sociohistoric moments. There are continuations and disjunctures across time and place in these understandings. Historical ways of understanding can thus influence how we might think about gender today, making part of the task of this book to explore the historical antecedents of contemporary discourses of gender and health. For example, in several chapters we show how historical discourses that situate women as closer to the body and emotions and men to mind and logic underpin contemporary discourses around emotions and embodiment.

Critical perspectives also share an 'anti-humanist' approach to understanding the world. Where humanism constructs the self as coherent, bounded, self-determined and an existing entity that might be freed, poststructuralist approaches offer a view of the self that is decentred, fragmentary, dispersed and produced through the sociohistoric discursive regimes in which it is located. Within these ideas, a range of poststructuralist theorists can be located and by drawing on Foucauldian ideas teamed with analytics developed by Deleuze and Guattari, we highlight and explore the interconnections between subjectivity, discourse, materiality, technology, institutions and power, which, as we demonstrate in this book, are all important for understanding postfeminist healthism. We also use this framework to identify examples of activism that challenge cultural discourses in ways that offer glimpses of alternative possibilities for expanding women's capacities to act. Throughout the book, while we engage in a rigorous way with poststructuralist theorists, we introduce the analytics that we use in each chapter in an accessible way, so that readers both familiar and new to poststructuralist thinking can engage with the ideas we develop in this book.

Chapter 1 explores the contribution of psychological language to our understandings of health. Examining discourses of women's inherent emotional vulnerability in classic and postfeminist media texts, including books and films that orient around the concept of 'mean girls', the chapter shows how, within a postfeminist sensibility, women are constructed as both inherently flawed and able to transform themselves into (postfeminist) perfection. Self-help literatures are examined

to show how they offer a route map from flawed to perfect and how this goal ultimately remains elusive.

Chapter 2 considers relationships between health and citizenship. Body mass index (BMI) is analysed as a form of government through desire (governmentality) and a significant critique of BMI as a measure of health is developed, highlighting the relationships between commercial interests and governments that led to a focus on weight over other issues that might be more relevant to health. The chapter develops a gendered analysis of Crawford's healthism, arguing that if neoliberal healthism is an address to all citizens, it interpellates women in specific ways that make weight management a postfeminist issue. The chapter also evaluates alternative discourses that seek to avoid conflating health with weight or self-control.

Chapter 3 considers the way that technological developments complicate neoliberal discourses of the responsible and self-disciplined subject. Using concepts of governmentality, normalisation and confession, the chapter examines two very different examples, weight-loss surgery and female genital cosmetic surgery. These examples enable an exploration of the complexities and contradictions of postfeminist constructs of choice, freedom, empowerment and agency; for example, how certain surgeries enable women to participate in a neoliberal imperative to take control by taking away control or the paradoxical use of surgery to be 'normal', when 'normal' is attainable only through intervention and an understanding of women's natural bodies as flawed.

Chapter 4 focuses on a central theme of postfeminist sensibility, developing it in relation to health, considering how a 'healthy sex life' became the marker of the good life. The chapter examines the explosion of talk about sex and sexuality from the Victorians onwards. Governmentality, normalisation and confession are used to develop an analysis of the role of experts in directing desires. The chapter shows the way that apparently radical sex advice often supports traditional gender relations, such as the need for women to please men and the construction of hetero-penetrative sexual relationships as normal and ideal, absencing lesbian sexual experiences and despite statistics suggesting that heterosexual women rarely experience penetrative orgasm. Sex advice thus leaves most women outside the norm, creating another paradox in postfeminist healthism whereby what is normative is unattainable.

Chapter 5 develops the book's analysis of the 'expected unattainable' to explore postfeminist pregnancy as part of a fantasy of living an ideal-yet-also-normal life. The chapter traces links between postfeminist pregnancy and historical constructs of the sanctity of pregnancy, revised through postfeminist re-traditionalisation, technological developments and intense scrutiny that intersects with discourses of citizenship and gendered, racialised and classed discourses. The outcome being particular ways of 'knowing' pregnancy, that circulate across a range of media (e.g. films and apps) that have profound implications for women's experience of their embodiment and health care, and which reduce the radical potential of the doubly embodied pregnant body for challenging neoliberal individualism.

Chapter 6 develops discussion of re-traditionalisation by considering how women are positioned as carers their children's health. The chapter considers how postfeminist discourses of choice, autonomy and empowerment are tied to biological essentialist arguments, so that, rather than see a resurgence of patriarchal forces, a turn to traditional women's roles is interpreted as both choiceful and driven by women's biology. The chapter links postfeminism to 'intensive mothering', which legitimises significant scrutiny of mothers while producing a subject position that is empowering and pleasurable for those women who can take it up, even while it creates anxiety and is exclusionary. Using breastfeeding as an example, the dynamics of postfeminist healthism are explored as they intersect with women's traditional caring role and commercial interests.

Chapter 7 considers online communities of women who engage with anorexic practices and promote and share these with each other. Exploring the historical antecedents to pro-ana in the pathological feminine, the chapter considers the emergence of pro-ana as a twenty-first century digitally mediated health issue. Pro-ana communities provide an interesting example of what is constructed as unhealthy, allowing an analysis of how boundaries between the 'healthy' and 'unhealthy' are secured in a digital context. Discussing the similarities between apparently unhealthy 'thinspiration' and healthy 'fitspiration' online representations, this chapter further develops a theme that runs through the book, that part of the power of postfeminist healthism lies in its contradictions.

These chapters allow us to examine the topics of self-help, weight, technologies, sex, pregnancy, intimate responsibilities and pro-ana as sites of intersections between postfeminism, neoliberalism and healthism. Each chapter employs a similar structure to address these topics. In line with our poststructuralist perspective, we organise the chapters around a historical examination of the concept, before considering how these historical antecedents set the scene for contemporary forms of sense making that are located in neoliberal economies and which have particular implications for women's health. In conjunction with our identification of the wider discourses that inform contemporary sense making, each chapter also offers in-depth analysis of specific issues. For example, BMI in Chapter 2 on weight or how the concept of 'mean girls' moves across art, literature and film in Chapter 1. Throughout the book, we offer examples from a range of different media, including magazines, film, social marketing and health promotion, advertisements, social media and digital apps. We chose these to show the breadth and interconnectedness of postfeminist media culture, to explore the different affordances of different media, and for their ability to help illuminate the dynamics between discourse, materiality, technology and practice that enable postfeminist healthism to flourish.

Throughout, the chapters also take an intersectional perspective, considering how postfeminist sensibility works across the intersections of gendered, classed and racialised identities, as well as geographical location and dis/abled bodiedness. Where we have a more focused lens is on age. Perhaps driven by ageist and sexist notions that sexual subjectivity was only relevant for younger women, postfeminist media has mostly interpellated younger adult women, aged around 20–40 years.

Our analysis therefore reflects this age focus. However, we note an increasing widening of the reach of postfeminist sensibility to include girls and possibly older women too (see our discussion of older sexuality active women in Chapter 4).

Although we have employed a similar structure and approach to each of our chapter topics, there is also variation. Each chapter draws more or less strongly on the work of Foucault, building a 'toolbox' of analytics including genealogy; power as disciplinary, diffuse and productive; governmentality; technologies of production, self and subjectivity; norms and confession. Similarly, we bring in the work of Deleuze and Guattari in different ways, depending on where we see the use of their analytics in developing thinking about the chapter topics. Such analytics include capacities for action, assemblages, visibility and lines of flight. The chapters also have variation in the amount of popular culture and media analysis, so while we cover a range of media in each chapter, some chapters offer more indepth original analyses of particular films and apps (Chapter 5) or social media (Chapter 7). There is also variation in how much we draw on previous work or produce empirical analysis in our bid to extend theorising and shed new light on specific constructions and understandings around postfeminist sensibility and health. The decisions on whether to draw on existing empirical work or produce new cultural analysis was based on what was already available and where we identified gaps that needed to be addressed for the book to put forward its strongest arguments. As we discuss at the end of this book, our method is indebted to Lather's (2009) notion of 'getting lost', allowing us to take the directions we needed to think through postfeminist healthism at a deep level.

Overall, each chapter offers an original analysis of its topic through an approach that brings together Foucault, Deleuze and Guattari to examine the dynamics between women's subjectivity and practice and media and cultural representations of women and health in the context of postfeminism, neoliberalism and healthism. We draw together this analysis in our epilogue, highlighting in particular how postfeminist healthism works through incitement of desire, offering women a route to future health and happiness. Why would any woman want to walk away from that? Read on.

Note

- 1 Daily Mash 2 March 2015. Fitness 'a nightmare that never ends': www.thedailymash.co.uk/news/health/fitness-a-nightmare-that-never-ends2015030295841

1

SELF-HELP

Nobody can be anybody else, but we can all be better¹

Two women talking in Scotland. One saying she had seen a counsellor for workplace bullying and found herself exploring how her responses to her colleagues were linked to a childhood trauma. The other looked incredulous. Her constant feelings of anger, now dealt with as far as she was concerned with medication, had at one point also led to counselling sessions. There she was made to do ‘stupid’ things like imagining a room upside down and filling in worksheets that were ‘like homework’.

Woven into this overheard conversation are three key themes of self-help: a ‘therapeutic attitude’ in which past experience is understood as affecting the current self, often in unconscious ways; an understanding that the self can work on the self, with the help of psychological experts who offer a ‘pedagogy of the self’ through tools like homework; and a normalisation of psychological discourse for making sense of ourselves. For example, that workplace bullying and anger are understood in terms of the women’s individual psychology and brain chemistry, rather than, for example, wider political, economic or societal issues that may create unhealthy contexts for women (or indeed that perhaps ‘anger’ is a bad character trait for women).

Making sense of the self through psychological discourse is part of a wider assemblage called the ‘psy-complex’ (aka ‘psy’). The psy-complex is a term used to describe the way that psychological institutions have developed to inform how we make sense of ourselves and what it means to be a good person. The psy-complex is a ‘material and ideological meshwork of psychological ideas and institutions that structure academic departments, professional interventions, and popular-cultural representations of mind and behaviour ...[it] includes prescriptions for good behaviour in the fields of psychiatry, psychotherapy, education, social work, and self-help’ (Parker, 2015, p. 6–7). Within psy-discourse, a good psychological self is one who

is able to look inwards and explore their motivations, cognitions and underlying frameworks that she or he uses for thinking about issues. These reflexive skills are understood as allowing the self to know itself better and, from this more knowledgeable position, work on itself so that thoughts and behaviours can be directed towards its chosen goals.

Psy-discourse provides the foundations for self-help, a huge global industry (reported to be an \$11 billion industry in the United States alone; Groskop, 2013), which includes TV shows, magazines, books, DVDs, YouTube channels and a range of social media. Self-help hails in its audience an understanding that they can transform themselves. From one standpoint, this is an exciting prospect. Classic psychology suggests that self-actualisation is the pinnacle of human need (Maslow, 1954) and self-help offers a pathway to self-actualisation through self-mastery. Self-help offers the message that we can be agents of change to a better, healthier, happier life. What's not to like?

But, as we show in the first section of this chapter, poststructuralist-informed work suggests that we treat self-help literature with caution. Critical perspectives of the self-help literature challenge the idea that therapeutic discourses are the route to freedom. Instead they argue that self-help can be understood as a form of control, tying people to a particular and limited understanding of the self that has profound implications for subjectivity and practice. From this perspective, discourses of self-liberation are harnessed in the service of control, in particular, directing people towards individualism which meets the needs of late capitalist economies.

A second concern regarding self-help is the gendered aspects of therapeutic discourse. Self-help literature is taken up by significantly more women than men, even though it was originally a male genre (McGee, 2005; Schrager, 1993). And is often explicitly or implicitly focused on issues related to femininity. See for example, the bestselling books across the decades, such as *Women Who Love Too Much* (Norwood 1985), *Men and from Mars, Women are from Venus* (Gray 1992) and *Lean In: Women, Work and the Will to Lead* (Sandberg, 2013). As Gill (2007c) states, 'in a culture saturated by individualistic self-help discourses, the self has become a project to be evaluated, advised, disciplined and proved or bought "into recovery"'. What is so striking, however, is how unevenly distributed these quasi-therapeutic discourses are ... it is the women and not the men who are addressed' (p. 262). Self-help thus constructs not just an ideal subject, but an ideal *female* subject: an issue that has received less attention in the literature on postfeminism or in critical psychology beyond it being mentioned as a key space of postfeminist sensibility. We explore the gendered character of self-help in this chapter as we attempt to develop an account of why there is such an uneven distribution. To explore and contextualise the gendered aspects of self-help literature, we use the second section of this chapter to consider the way gendered ideas of mental health and illness are culturally produced and transmitted. In so doing, we offer a (partial) genealogy of how women's psychology has historically been tied to notions of emotional fragility, as represented through the figure of Ophelia in a range of media texts about girlhood.

Having critically explored self-help and located this analysis within wider historical discourses of femininity and mental health, in our third section we develop our analysis to examine contemporary self-help within postfeminist sensibility. Self-help is a key feature of postfeminist sensibility (Gill, 2007b), yet self-help is rarely (if ever) central to postfeminist analyses. To address this gap, we explore how discourses derived from historical notions of women as inherently emotionally vulnerable compete with postfeminist ‘girl power’ discourses. As we show throughout this book, postfeminism is produced and enabled through contradictory discourses and, here, we explore how, within a postfeminist sensibility, women are constructed as both inherently flawed and able to transform themselves into (postfeminist) perfection. We argue that self-help bridges the gap between this contradiction, offering a route map from flawed to perfect through the use of self-help techniques, techniques that become part of the repertoire for good citizenship so that women are held accountable for transforming themselves into particular cultural ideals of femininity. Returning to the idea that self-help produces a particular ideal citizen that aligns with the needs of the economy, we explore how contemporary self-help constructs ideal femininity in terms of economic citizenship: a woman who can contribute productively in a shifting economy. Underpinning these ideas is an individualist perspective, so that it becomes an individual responsibility and expectation to work on the self, finding individual solutions to individual problems despite the potential for them to be considered social problems with social solutions. Furthermore, the work of transformation is never done; there are relapses and new areas to improve, so that self-actualisation through transformative self-help remains an elusive goal. The promise of perfection is a cruel optimism.

Historicising our ‘inner self’

Self-help literature offers an array of apparently different routes to happiness and fulfilment. Some explicitly come from areas within psychology and psychoanalysis, such as cognitive behavioural therapy, neurolinguistic programming, acceptance and commitment therapy, sometimes even neuropsychology. Others draw their expertise from different arenas, creating an apparently eclectic range, including thinking positively (e.g. *The Secret*, Byrne, 2006), tidying up differently (e.g. *The Life-Changing Magic of Tidying Up*, Kondo, 2014) or self-hypnosis (e.g. *Hypnotic Gastric Band*, McKenna, 2016). Despite apparently drawing on a range of theoretical approaches, sometimes in eclectic ways, critical analysts argue that what is notable is how similar the vision of what makes us happy is across self-help literature, identifying a reoccurring trope of a highly individualised ideal self. This individualised ideal self is one who is able to use therapeutic language to think reflexively about its thoughts, emotions and behaviour in order to be autonomous, self-knowing and self-regulating (Rose, 1990). Such a self is able to take an ‘Olympian view’ (de Vos, 2015, p. 252; Blackman, 2004) and, using psychological language, turn ‘the psy diagnostic gaze upon itself’ (Hazleden, 2003, in de Vos, 2015, p. 252), identifying its faults and working on them to transform the self and move it towards

self-actualisation and its vision of ideal self. This psychologised, self-managing self is thus the ‘wellspring of freedom, responsibility and choice ... [a self who] possess the ability to *choose* happiness over unhappiness, success over failure, and even health over illness’ (Rinke, 2000, p. 73). To understand why a wide range of self-help literature, including anti-self-help literature, should articulate such a similar ideal self, we consider below the conditions of possibility produced from the psy-complex, feminism, religion, other historical attempts at self-betterment and contemporary neoliberal political economies.

Augustine’s *Confessions*, written around 400AD are typically held as marking the first ever autobiography and a landmark transition of thinking that demonstrated a reflective, private self (Freeman, 1993; Rose, 1997). But, as Elias and others argue, it was not until the Middle Ages when a collective shift to this kind of private thinking happened. This move towards a more reflexive, private self related to changes in political organisation that required a calculating self, able to manage the intrigues of court, rather than a more vicarious personality suited to the battlefield (Elias, 1983). This psychologisation was further developed by a shift from sovereign to disciplinary power; as the power of monarchy decreased in favour of democratic government, so did the power of the monarch to use overt punishment to control people. Governments instead required ways to encourage its citizens to choose to comply with regulations and one technique to do this was through the development of a psychological understanding of citizenship, in which good citizens monitored and regulated themselves (Foucault, 2008; Miller and Rose, 1990; Rose, 1996; also see Chapter 2, where we develop these ideas of disciplinary power and governmentality). The stage was thus set for a psychologised culture receptive to the ideas of psychoanalysis that emerged in the early twentieth century.

Freud developed his theory of the self in a clinical context, mostly analysing women who were understood as suffering neurotic and hysteric symptoms, but the ideas he developed from these various case studies were presented as universal issues that could help make sense of everyone. Psychoanalytic constructs thus brought together the normal and the pathological (Illouz, 2008). Everyone had an ego managing the competing demands of the id and the super-ego. Everyone progressed through the tensions of psychodynamic development. Those who lost their object of desire in favour of gender identification and sexual normativity became melancholic and those who did not had attachment issues or were stuck, fixated in earlier stages of development. Key Freudian terms like ‘repression’ and ‘denial’ filtered into everyday talk, as well as being taken up by psychological, academic and media institutions, which in turn circulated these ideas, including into self-help literature. For example, Stephen Grosz’s (2014) *The Examined Life: How we Lose and Find Ourselves* was one of the Times Bestsellers of 2014. Grosz, a trained and practising psychoanalyst, offered a series of case studies of his patients in which unconscious responses to childhood traumas were identified. In ‘Emma’s’ case study, for example, her disagreements with her boyfriend were related to a childhood memory where her father embarrassed her because she had declared her love for a female teacher. In this account, Emma’s analysis allowed her to recognise her inability to feel emotions

and her memory of lost feelings for her teacher grants her the space to reconnect with herself.

As well as psychoanalysis, the twentieth century also witnessed the development of another important psy-discourse, that of humanism. Humanism brought in a focus on the importance of individual actualisation so that the self could be freed. Humanism conceptualised the self as coherent and authentic, located in the person, able to be found and freed. Thus, although they are different schools of thought, both psychoanalysis and humanist psychology conceptualise the route to self-development in individualistic terms, through a person's ability to look inward, identify their thoughts and feelings and reflect on these in a deep way usually with the help of an expert, such as an analyst. Through such reflection, a better understanding of the self can develop and from this understanding a more 'choiceful' life, since self-understanding is associated with self-mastery. Psychological language thus made the self intelligible in a particular way, which was taken up across a range of institutions and in everyday language. A therapeutic culture developed that normalised the ideal of a self-regulating, psychological self: 'not confined to the schoolroom, the courtroom, the social work interview, the therapy session ... [psy-discourse] proliferate across practices of everyday life – of domesticity, of erotics, of leisure, the gym, the sports field, the supermarket, the cinema' (Rose, 1990, p. 264).

The filtering of psychological language into everyday life gave people a universal language with which to make sense of themselves: all have a self who would benefit from 'emotional healing' and associated transformation towards greater wellbeing. This psychological language offered a liberationist vision of self-actualisation and freedom 'the emancipation of transformation, and an understanding that through working on the self we can achieve happiness and the good life: fulfilment in our work, our relationships, our lifestyles, minds and bodies' (de Vos, 2015). But equally, therapeutic culture was predicated on understanding that all people are in need of transformation, always already vulnerable and dysfunctional. Therapeutic culture (and associated self-help) thus produces a subjectivity interpreted 'through a prism of illness' (Brunila and Siivonen, 2014, p. 61). Therapeutic culture also required a self that was the agent of its own transformation. But to be an agent of self-transformation, people need to learn skills and techniques of reflection and interpretation and to do this they must turn to psychological experts (counsellors, therapists, self-help books, websites etc.). Therapeutic culture is therefore predicated on the self only being able to help itself by turning to experts. The 'freedom' of self-help thus comes at a price: to understand ourselves as always already flawed, in need of transformation, able to help ourselves but only with experts of psy and only in the direction of an individualised, psychological self.

Psychoanalytical and humanistic psychology have been significant in proposing a self with an interior that can be 'fixed' by self-help and the expert. However, already existing constructs made the entry of these disciplines into cultural life smoother. Of the various historical contexts that facilitated the normalisation and resonance of these psy-discourses across a range of institutions, both feminism and religion have been important precursors. Illouz (2008), for example, argues that the focus

on the psychological interior as the source for self-development and happiness was facilitated by twentieth-century feminist emphasis on 'the personal as political'. The second-wave feminist standpoint that public and private lives were connected by ideology contributed to a blurring of distinctions between public and private, since what went on in the home was understood as representing wider gendered power relations. Feminist ideas combined with therapeutic culture so that, in a range of public and private life, from factory management to intimate relationships, a healthy self was understood as one which could look inward, identify problematic patterns in thinking and then work on this thinking to facilitate change.

This process of looking inward and identifying faults as a stepping-stone to self-improvement had earlier antecedents in Christian religious dictates of pastoral care, purification and confession. Parallels have been drawn between the focus on self-reliance and self-control in contemporary self-help literature and historical and contemporary religious practices concerned with self-betterment and transformation (e.g. Hochschild 1994; McGee, 2005; also see Chapter 4, where we explore links between confession and subjectivity further). Hook (2010) draws parallels between psychology and the historical role of the pastor and other religious positions. Comparing contemporary psychology with historical Western cultures structured by Christianity, Hook argues that both involve a 'shaping of the private self' by providing norms and rules to follow and schemas of self-transformation and guidance. In this comparison, both psychology and religion come to define what is normal and acceptable (Rose, 1999; Hook, 2010).

Religion and psychology offer transformational tools for understanding who we are and what we hope to become. But, rather than see psychology as supplanting religion, Rose (1997) argues that we should pay attention to the subtle ways in which self-help, psychology and religious ideas interact. For example, one of the reasons that the new (psychological) ideas of the self were able to percolate into cultural norms was because they interconnected with established (religious) knowledge. Similarly, Illouz (2008) suggests that in drawing on the narratives around Greek characters like Oedipus and Narcissus, Freud refashioned older concepts of the self into psychoanalytical theory.

Religious institutions and practices thus offer important conditions of possibility for the rise of self-help in the twentieth century. Other historical antecedents contributing to an understanding of the self as able to transform with the help of expert advice include books designed for social mobility. For example, the first book with self-help in the title, *Self-help* by Smiles, published in 1859, offered a manual that advised men on how to become wealthy and famous. Another example includes Victorian manners books (e.g. *The Ladies' Book of Etiquette and Manual of Politeness*, Hartley, 1860/2014). Usually written for a female audience, the authors took on the role of expert to instruct the reader in etiquette, so that they would be able to understand and act in the world differently with view to increasing their class status. Like the therapeutic culture that was to follow, these books required a reflexive self, able to learn to interpret the world differently in order to transform themselves. However, although the discourses above have been important in normalising

psychological health, in modern times these have been brought together even more profoundly through the economic doctrine of neoliberalism and the effect that this economic policy has had on subjectivity, which we turn to next.

Between *Homo economicus* and *Homo sentimentalis*

Ideas of transformation through reflexivity and psychological language have been essential tools in the shift to neoliberal economies that started in the late twentieth century and which continues to this day. Neoliberal economies are market driven and require flexible workers who are able to respond to fluctuations in economies that require different skills in their workers. To be a flexible worker, people need to develop skills in recognising economic shifts, so they can respond to changes in the market and remain employable by reviewing and developing their skills. To remain employable (and thus not a welfare burden on the state), people must work on themselves, becoming ‘entrepreneurial selves’ (Rose, 1996).

The neoliberal entrepreneurial self is imagined and idealised as autonomous, rational and risk managing: a subject who draws on skills in self-reflection and whose desires are directed towards understanding individual transformation as the route to living a good life. This version of ideal subjectivity (autonomous, reflexive, transformative, with desires aligned to cultural ideals) maps to the ideal self in psy-discourse (Blackman, 2004). Neoliberal subjectivity is thus enabled by psy-discourse and its normalisation of a psychological, reflexive self who is engaged in a project of self-transformation. The relationships between neoliberalism and therapeutic culture are thus multidirectional. Psy-discourse gives neoliberalism subjects with skills and desires directed towards neoliberal citizenship, while neoliberalism gives contemporary self-help an economic flavour. For example, the language of the market (such as deciding how much to ‘invest’) is a recurring trope in self-help books on relationships with others (Hochschild, 2012a; Gill 2009b; Frith, 2015b). In this way, self-help is one of the ways that ‘the ideals and aspirations of individuals, with the selves each of us want to be, are aligned with wider authorities’ (Rose, 1990, p. 213).²

Analysts of self-help and the psy-complex have recognised the way that therapeutic culture structures understandings of good citizenship, including economic citizenship, employability and transition into adulthood. For example, in Brunila and Siivonen’s (2014) analysis of 60 publicly funded educational employability programmes in the 1990s to 2000s that targeted young adults, the authors noted the deployment of therapeutic language by both participants and staff as techniques to create more employable subjects in line with neoliberal subjectivity. In parallel with the normalisation of pathology in self-help, language around exploring emotions in a safe space or diagnostic practices (e.g. tests for attention deficit hyperactivity disorder, dyslexia or other learning difficulties) constructed the students’ sense of self in terms of ‘imperfection, vulnerability and failure’ (p. 62). For the young people in the study, such language was often experienced as legitimising (e.g. that they were not stupid, but learnt differently), but Brunila and Siivonen (2014) question the

final consequences for co-opting humanistic individualism into a neoliberal project to produce worker citizens who must first understand themselves as broken and in need of self-fixing. Their concerns focused on medicalisation, self-knowledge and individualisation, which we unpack below.

Brunila and Siivonen were concerned with how the use of diagnosis and subsequent medication for some of the young people in their study (e.g. for attention deficit hyperactivity disorder) produced increasing numbers of young people labelled as faulty and oriented to understanding themselves in terms of deficiency. Self-help literature also combines individualism with diagnosis, again with the outcome of ignoring the structural factors that impact on health. For example, the popular self-help book *Women Who Love Too Much* (Norwood 1985) brought the term 'love addiction' into public parlance, making the emotion of 'love' a diagnosable dependency that brings it in line with other addictions such as drugs and alcohol, while also proposing appropriate methods of 'recovery' from its addiction. The outcome is a 'survivor' subject position, requiring identification with low self-esteem, anxiety, stress or learning differences. In the context of Brunila and Siivonen's (2014) research, the young person must play the role of a (psychological) victim in order to be recognised. Thus 'instead of autonomous and rational individuals, what therapisation actually produces is vulnerable and fragile as well as imperfect and incapable subjectivities' (p. 67).

Brunila and Siivonen's (2014) second concern was that in employing a humanist understanding of a true authentic self that needs to be discovered, the task becomes about the need to discover this 'true self'. This requirement masked other ways of understanding the self (e.g. as multiple, partial or contextualised selves) and created anxiety in those unable to perform this task. Others have argued that the self-focus of self-help creates a form of narcissism. For example, Twenge and Campbell (2009) accuse self-help of creating narcissistic cultures of self-serving inward-looking individuals: 'In place of love for another person, put love for the self; in place of caring, put exploitation; and to commitment, add "as long as it benefits me"' (p. 213; see also Lasch, 1979. and Furedi, 2004).

Brunila and Siivonen's (2014) final concern was that therapeutic culture and neoliberal subjectivity locate the problems people experience (such as unemployment) and their attendant solutions in the individual. Problems are thus to be solved by the individual alone, as one participant said, 'Now I know it's all up to me, I can manage if I really want to' (p. 65). This individual responsibility, characteristic of neoliberal subjectivity, creates significant pressure on individuals. The individual responsibility framework also masks the social and economic context that structures young people's capacities to act, which include economic and political instability, as well as structural factors that correlate with youth unemployment, such as poverty. Issues that might be considered as related to structural problems, for example, inequalities in health outcomes structured around gender, class and ethnicity, become framed through an individual lens, as individual problems with individual solutions. Many analysts therefore highlight how both neoliberalism and the language of contemporary self-help depoliticises mental health issues, since a

turn to individual solutions is a turn away from collective action (see, for example, Cvetkovich 2012 in relation to depression and Chapter 4 of this volume on the links between obesity and poverty).

One example from the self-help literature that captures these themes is the bestseller *Lean In: Women, Work and the Will to Lead* (Sandberg, 2013), a self-help book providing advice for the emotional life of women leaders written by Sheryl Sandberg, a woman who worked at the highest levels in Google and Facebook. Aligned with the individualism of neoliberal subjectivity, *Lean In* provides women with advice for successful careers that fit with, rather than challenge, patriarchal corporate culture while turning a blind eye to instances of sexism in the workplace. *Lean In* has come under heavy criticism from feminist analysts for blaming women for their own lack of representation within the boardroom and suggesting that women's problems in the workplace may be femininity itself, which needs to be overcome through competitive, aggressive and 'masculine' forms of leadership. Similarly, the self-help book *The Confidence Code: The Science and Art of Self-Assurance* (Kay and Shipman, 2014), and its accompanying online platform, seeks to explain women's (already assumed) lack of success as a result of their (already assumed) lack of confidence. Thus, women's lack of representation at high levels in corporate institutions is understood as a flaw in women's psychology (e.g. not being assertive enough) and not systematic organisational bias that creates conditions in which men are more likely to flourish. In mental health too, gendered accounts of mental health make gender and sexuality problematic while ignoring the cultural and political explanations for feelings of helplessness and worthlessness (Cvetkovich, 2012). Mental distress is thus constructed, not as public or social failure, but a failure of the self.

An individual framework means that responsibility for betterment lies with the individual. 'It is a characteristic current assumption that all human conflicts are, to a significant degree, psychological problems and that they can, with enough reading, guidance, determination and industriousness, be set right at the level of psychical individual self-discipline' (Rimke, 2000, p.73). Self-help offers itself as the route to addressing our problems through its 'array of (semi)commercial, and (semi)academic and popular resources offering exercise, devices, or even alternative drugs to balance or boost ones' brain' (de Vos, 2015, p. 255). While there is something very attractive about the idea of self-help, there is a troubling moral dimension to this sense making. If the individual is responsible for change and there are technologies available to that individual, it becomes a moral obligation for the individual to 'choose' to use them. Not to choose self-help technologies is thus a wilful act of anti-citizenship, a poor lifestyle 'choice'. An outcome of this thinking is what Stainton-Rogers (2011, p.77) calls a "blame the victim" culture', where vulnerable people are held responsible for their misfortunes. Framing mental health and distress within a discourse of individual responsibility can also reduce wider social empathy and a sense of duty of care. 'When vulnerability is tied to individual responsibility, there is no obligation on the part of the "social fabric" to take care of the disposed' (Brunila and Siivonen, 2014, p. 67).

Such thinking also folds us into understanding neoliberal subjectivity as the only 'right' way to think about subjectivity and for care of the self to be prioritised over care of the other, a reoccurring theme in self-help literature (Rimke, 2000). For example, self-help repeats the claim that women must learn to love themselves before they can love someone else (and typically a man; Barker, 2012). Self-help discourse reconstructs love of the self away from potentially negative associations with egoism or narcissism towards an understanding of it as a moral obligation, something necessary for 'healthy, normal and functional self to emerge and prosper' (Rimke, 2000, p. 66).³ Prioritising care of the self over care of the other is a cause for concern for many critical analysts, who see individual strength and happiness, as well as solutions to significant health, social and environmental problems as, at least partly, located in interpersonal relationships and collective action.

Above, we have argued that although self-help uses the language of freedom, therapeutic discourse can be understood as less about freeing an existing self as producing a particular self, a neoliberal one who is individualised, psychologised and whose desires align with the needs of the economy. We have also explored the conditions of possibility of this self, notably the psy-complex, feminism, religion, other historical attempts at self-betterment and contemporary neoliberal economies, which reiterate and draw on aspects of each other, reinforcing the natural and normalness of a reflexive psychologised self whose happiness lies in self-transformation. These accounts make the self responsible for itself. But, the consequences of taking up this psychologised construction of subjectivity is that our capacities for thinking are directed in limited ways that reduce our capacity to empathise or seek collective solutions to our problems.

As critical psychologists note, the valued self in self-help literature is one who is able to fulfil the current economic need for autonomous, flexible workers. But what these analysts often miss is the way such ideal selves also have a significant gender dimension, since understanding the self as autonomous is traditionally associated with the masculine, while being located in relationships is associated with traditional female gender roles and values (Gilligan, 1982). The autonomous discourse in self-help literature thus devalues feminine values traditionally related to interconnectivity, care of, and responsibility to the other. Equally, criticisms of self-help cultures as 'narcissistic' have themselves been criticised for calling women narcissistic for attempting to take up culturally valued constructs of (masculine) self-reliance (Tyler 2006). There is also a significant historical gendered narrative of women's flawed psychology which impacts on contemporary self-help. To develop the critical psychology literature on self-help with a gendered analysis, below we develop an (always partial) genealogy of historical constructions of women's psychology. Drawing on cultural and media representations of women, we examine historical antecedents of ideas of women's psychology that inform contemporary self-help, including postfeminist self-help literatures. To do this, we turn to the figure of Ophelia.

The women are not all right

Ophelia is the love interest in Shakespeare's *Hamlet*. Ophelia descends into madness that ends with her drowning, implied as suicide. Her madness is represented as an outcome of her obsession with Hamlet and her father's concern over the consequences of that relationship. Although *Hamlet* is not the only Shakespeare play to depict feminine madness and irrationality,⁴ Ophelia is a significant figure of these associations. Typically characterised as a waif-like, eerie and erratic character, often with flowers in her hair (themselves symbolic of both fertility and death), the image of Ophelia represents a romanticised, pathologised female psychology that has circulated across media, medical and therapeutic discourse for over 400 years. (Do an online images search for 'Ophelia' to see what we mean; many of the images come from, or are derivatives of, John Everett Millais' infamous pre-Raphaelite painting of *Ophelia* floating in a river).

In her analysis of a range of images of Ophelia, including paintings, performances of *Hamlet*, films and photographs, Showalter (1985) highlighted the way that these representations articulate an ideology of femininity, sexuality and madness as interconnected (see also Appignasnesi, 2009, for an historical analysis of the associations between insanity and femininity). One example included an early use of photography that involved taking the picture of women who had been hospitalised for hysteria (or illness of the womb) and other 'female complaints' dressed as Ophelia. Analysing these and other representations of Ophelia, Showalter (1985) argued that part of the ideological work of these images is the creation of a male–female dualism. The presence of Ophelia, the woman who felt too much and was unable to cope with these emotions, contrasted with its absence, the logical, reasonable man who can keep his emotions in check. Showalter also showed how the new language of psychoanalysis, which was largely constructed through clinical diagnoses with 'hysterical' women, was able to perpetuate the Ophelia myth by providing a new language to articulate feminine pathology.

The links between women, madness and emotional fragility are also evidenced in many performances and images of Ophelia's death. That Ophelia chooses to end her life through drowning is not a coincidence. Although Ophelia's death happens offstage in *Hamlet*, her death through drowning re-establishes associations of femininity with water that have significant historical lineage. In *Madness and Civilization*, for example, Foucault (1965) notes how Ophelia's madness is among many representations in art, literature and history of madness depicted alongside water. In such images, water is associated with femininity and the leaky, lactating, menstruating female body. Water also shares an historical lineage with the moon, which dictates the highs and lows of the tides, creating popular understandings of water as being 'owned' by the moon, and thus also menstruation. Associations between the moon and madness date all the way back to Aristotle and provide the aetiology for our word 'lunacy'. Water, femininity, the moon and madness are thus deeply imbricated and it is through these associations that the figure of Ophelia emerges.

Ophelia continues to represent troubled young femininity. For example, in 1994, a bestselling and influential self-help book about broken femininity was published under the title *Reviving Ophelia*. In *Reviving Ophelia*, clinical psychologist Mary Pipher (1994) outlined a crisis of modern femininity, wherein the cultural pressures experienced by young women in adolescence cause a split between a 'true' and 'false' self. The teenage girl leaves behind her true self, the one that is active, energetic, excitable, talkative and spirited. She instead adopts a 'false self', a position of nonchalant indifference and teenage angst. For Pipher, this identity shift is problematic, associated with girls becoming unstable, emotionally dependent and cruel to one another, and with increased vulnerability to a range of mental and emotional states, chances of drug and alcohol problems, abusive relationships, depression and suicide.

Reviving Ophelia can be placed in a long tradition of self-help literature that represents young women as mentally unstable and emotionally insecure. Marshall (2007) refers to this literature as 'Ophelia narratives'. Often written for the mothers of young girls rather than for girls themselves, Ophelia narratives can be analysed as much as a projection of cultural anxieties about young women as the actual problems young women experience (Peterson and Williams 2012; see Egan, 2013, for a similar analysis in relation to the sexualisation of culture).

Reviving Ophelia influenced a subsequent raft of popular social commentaries and self-help books that offer the same trope of troubled adolescent femininity. These texts include *Ophelia Speaks* (Shandler, 1999); *Queen Bees and Wannabes* (Wiseman, 2003), *The Myth of the Perfect Girl* (Homayoun, 2012), while film examples include *Mean Girls* (2004), *Reviving Ophelia* (2010) and *Thirteen* (2003). Many of these works are intertextual; the inspiration for *Mean Girls* (2004) came from *Queen Bees and Wannabes* (Wiseman, 2003), while the film *Reviving Ophelia* (2010) borrows heavily from Pipher's (1994) original book. In their intertextuality, these texts and films circulate a particular narrative of broken femininity that is over 400 years old. But in our analysis below, we show how such films, presented through contemporary media and located in contemporary situations, work to align historical Ophelia narratives with postfeminist sensibility. The outcome is a reiterated discourse of flawed femininity, a discourse through which women and girls may understand themselves and be understood by others, and one that also intersects along axes of class and ethnicity.

In *Mean Girls*, the protagonist Cady (Lindsay Lohan) joins an American high school. Cady's induction to her new school is by two pupils who explain the politics of the school's student cliques. In this introduction to the micro-politics of school life, the film documents the gendering of emotion and pathology. Alongside the 'Desperate Wannabes', 'Burnouts' and 'Jocks', cliques also include 'Girls who don't eat anything', 'Girls who eat their feelings' and 'the Plastics', a group of attractive and popular girls made up of Regina (aka 'Queen Bee'), Gretchen and Karan.

The Plastics rule the school through mean-girl 'tactics', that are used against other girls and as a way of regulating power between themselves, most notably through a collectively produced 'Burn Book' that contains gossip and rumours

about other girls. The film represents postfeminist fantasy in which whiteness, popularity and money are objects of desire, with Regina shown to embody each of these, partly accounting for her Queen Bee status. But these fantasies are used as forms of symbolic (and ultimately real) violence and a space in which feminine indirect aggression rules the interactions between young women (Karlyn, 2011; Winch, 2013). Living the fantasy becomes painful, all the young women in the film suffer from the cruelties of social interactions between girls, and in attempting to infiltrate the Plastics, Cady loses her 'true' self and becomes 'Plastic'.

Winch (2013) and Ringrose (2006) both refer to the practices represented in *Mean Girls* as 'normative cruelties'. This association of meanness with girlhood constructs femininity as a negative gender category and creates an essentialist understanding of the universality of psychological pathology of women and girls (Kelly and Pomerantz, 2009; Ringrose 2006). *Mean Girls* can be said to articulate a postfeminist sensibility because it calls on feminist ideas while simultaneously repudiating them. For example, a female teacher tells the girls that 'you all have got to stop calling each other sluts and whores. It just makes it ok for guys to call you sluts and whores'. However, notions of female solidarity in the face of sexism and misogyny are also repudiated in ways that trivialise feminism. For example, on hearing that Cady fancies Arron, Gretchen tells her he is off limits because he is Regina's ex-boyfriend: 'it's, like, the rules of feminism'.

When considering what kind of girls are represented in *Mean Girls* (and Pipher's *Reviving Ophelia* on which it was based), critical analysts have tried to understand not just the characters present in the texts but also those who are absent. Gonick (2006), for example, notes that Ophelia became a 'symbol of a crisis of girlhood' (p. 11) and the 'shadow twin to the idealized empowered girl' (p. 15). *Mean Girls* thus sits in contrast to 'girl power', a discourse emerging out of the 1990s that represented a healthy female subjectivity which was both carefree and ambitious (see, for example, the way pop group 'Spice Girls' was marketed under the banner of girl power and our discussion of the Spice Girls in the prologue of this volume). This idealised empowered girl maps to neoliberal ideal subjectivity so that, Harris (2004) argues, the ideal neoliberal subject is feminine; a flexible worker able to do the emotional work required of a service and consumer oriented economy. What both Gonick and Harris also discuss is how idealised and crisis girl subjectivities are interpolated through class and ethnicity, in that both are white and middle-class subjectivities, with economic and consumer power. Girls who are not white or financially privileged are excluded from postfeminist Ophelia discourses, with attendant material effects. Harris (2004), for example, argues that, in general, white and middle-class girls' problems are medicalised and treated through psychiatry and rehabilitation, while black and working-class girls are criminalised and dealt with through the criminal justice system.

The exclusionary practices of Ophelia narratives in relation to consumption and class can also be seen in representations of girls in film. For example, *Thirteen* (2003), a partly autobiographical film of actress Nikki Reed, tells the story of 13-year-old Tracy (Evan Rachel Wood), who befriends Evie (Nikki Reed), a popular but

rebellious teenager. This friendship leads Tracy to adopt what Pipher (1994) would call a 'false' self, with Tracy, previously a good student, losing interest in school, taking drugs, having sex, self-harming and becoming involved in petty crime. Her fashion sense also changes and she takes on the persona what in other accounts of girl-panic around working-class femininity would term 'skank' (Oppliger, 2008; see Egan 2013 for a critique).

McRobbie (2005) suggests that *Thirteen* demonstrates the tensions of emerging femininity in the context of apparent freedoms permitted to young women in the wake of feminist politics, but that it also holds out hope for notions of community within postfeminist societies. For example, we see Tracy's mother in a state of distress at her daughter's behaviour, but she is supported by a network of close female friends within her immediate community. McRobbie (2005) also cites the film as opening up possibilities for a critique of heteronormativity in exchange for sexual flexibility, represented through the girl's friendship. For, while boys remain the object of sexual desire, Tracy and Evie's own relationship is shown as more intimate and intense. However, what is also evident in *Thirteen*, when placed alongside *Mean Girls*, is its working-class location and the low-income context that Tracy and her mother occupy in contrast to the young women in *Mean Girls*.

The socioeconomic status of the characters in these films greatly shapes the forms of freedoms permitted. For example, in both films, consumerism features heavily as a practice of contemporary femininity; both films depict scenes in the mall and, in both, the act of shopping acts as Cady and Tracy's 'initiation' ritual as fully fledged members of the popular group. But risk is differently experienced by Cady and Tracy. Cady and the Plastics return from their visit to the mall to the glamour of Regina's mansion-esque home, with the following scenes alluding to the bedroom cultures of girls' friendships (McRobbie and Garber, 1976; Obach, 2009; Winch 2013). In contrast, Tracy's initiation ritual involves shoplifting. Cady and the Plastics' association with consumerism is represented as superficial, normalised but ultimately 'safe' and appropriately middle class, whereas Tracy's consumerism is linked to a problematised working-class girl culture (see, for example, Ringrose and Walkerdine's (2008) discussion of how working-class women's consumption practices are systematically problematised in TV makeover shows). In comparing these films, the Ophelia narrative of middle-class pathology sits against one of working-class savagery (see also Ringrose's (2013) analysis of young female looters in the 2011 London riots; and the chapters on pregnancy (Chapter 5) and intimate responsibilities (Chapter 6) in this volume, where we develop our intersectional analysis of postfeminism in relation to pregnancy and childcare responsibilities).

Ophelia narratives thus (re)produce representations of girls' mental health as inherently pathological, a trope that interacts with discourses of race, class and sexuality in ways that privilege white, middle-class, heterosexuality (see Marshall (2007) for further discussion). Media texts, such as the book *Mean Girls Grow Up* (Dellasega, 2005) also extend the 'mean girl' life narrative into adulthood, folding in Ophelia narratives of inherent female pathology into postfeminist sensibility, as we explore in the section below.

Mean girls grow up

Ophelia narratives in adult womanhood are evident in films like *The Bachelorette* (2012). In girl films, female madness and meanness is located in the biological (and hence naturalised) transition between childhood to adulthood. But in adult Ophelia narratives, it is the women's teenage experiences that leave them mentally damaged. As such, these films draw on Ophelia narratives of women as pathological and therapeutic culture to construct the past as affecting the present. There is also a postfeminist move in these narratives in which feminist values are simultaneously articulated and refuted. For example, in *The Bachelorette*, the central character Regan's (Kirstin Dunst) high-profile career has clearly benefited from second-wave feminist activism regarding women's employment opportunities. But her career is also associated with her inability to find happiness, itself associated with her failure to participate in feminine norms. For example, she is known by the other characters as bossy, controlling and manipulative. A central part of the storyline is structured around a speech made at the wedding dress rehearsal, where one of the bridesmaids reveals that bride and 'fat friend' Becky suffered with bulimia and purged in the school toilets. Later in the story, it is revealed that it was actually Regan who was purging and that Becky covered for her in an attempt to become friends with the popular girl.

All the main female characters in *The Bachelorette* are damaged by modern femininity. Here and in other contemporary narratives where equality has (apparently) been achieved, blame for women's failure to attain economic, social and psychological stability and success is located in the essential, negative qualities of women. Young and adult women are depicted in popular culture as mean, unstable and manipulative of other women. Women are variously shown to suffer from these homosocial relationships, including negative impacts on their self-esteem, body image and confidence. *The Bachelorette* can therefore be read as one of many texts that articulate anxieties around women's freedoms gained through feminism. In line with social anxiety around those gains, the freedom, 'choices' and opportunities of the women in the film become the site of pain and humiliation. Regan's successful career is only ever the outcome of a damaged femininity, and the masculine characteristic of 'bossiness' becomes evidence of her pathological notions of self-control represented through her bulimic self.

Without the means to critique her situation, all Regan's disappointments with her life are turned in on the self. McRobbie (2009) identifies this turning against the self in the lives of young women living in the aftermath of feminism. She argues that women become angry about the inequalities they experience, but they do not have a language to articulate these inequalities because a postfeminist sentiment constructs their world as equal (and thus not in need of feminism). Postfeminism thus denies women a language to explain their anger, creating a form of 'illegible rage' from which women turn their pain against themselves.

The postfeminist flavour of contemporary Ophelia narratives of adult women involves calling on and refuting of feminism, but also ideas of working on the self

that draw on makeover culture, self-help and its wider therapeutic culture, which, in turn, fold into neoliberal discourses of self-responsibility and transformation. These ideas work together to produce a subjectivity that is always in need of work. For example, *Psychology Today's* website tagline 'Health, Help, Happiness + Find a Therapist' is the suggestion that 'Health', and 'Happiness' are co-dependent on 'Help'. The tagline implies a process of labour and the assumption that we need (and therefore do not already possess) all three (see Ahmed 2010 for a critical analysis of the promise of happiness as a tool for regulation). The commercial element of the website, with its opportunities to consume goods and services, as well as exposure to advertising, is also significant, since postfeminist therapeutic cultures have 'commercial intent' (Madsen and Ytre-Arne, 2012, p. 29). Also see Blum and Stracuzzi's (2004) discussion of how constructions of Prozac circulate across medical, commercial and public discourse.

Postfeminist media address hails in women an understanding that their psychological health is always already needing work. One recurring trope is the construction of apparently successful women as secretly failing in their bid for the good life. For example, one expert in *Psychologies'* blog post 'Improve Your Social Confidence' suggests that one of her clients lacked confidence, but that 'If you meet her, she's glamorous, she's sociable ... she doesn't seem shy, but she's absolutely terrified. She's worried that people will find her dull and boring, or that she'll get something wrong'.⁵ Similarly, the self-help book *Examined Life* (Grosz, 2014) describes case studies of clients whose surface appearance is deceptive. For example, in the opening pages, Grosz describes 'Miss A.', who 'presented as a cheerful young woman who insisted that she did not need treatment. In time, however, I learned that she was bulimic and regularly, compulsively, cut herself' (pp. 2–3). A different version of this trope is the woman whose success is linked to therapy, such as the editor of a woman's magazine who includes seeing a therapist as one of her self-care techniques (Madsen and Ytre-Arne, 2012).

A second way that postfeminist media positions women as always already needing work is to construct its readers as needing work. For example, a recent *Psychology Today* blog post alluded to a common idiom of self-love wherein 'If you can't believe you're good enough, how can you believe a loving partner could choose you?'.⁶ Such a question asks the reader to consider themselves worse than their idealised 'loving partner' and to assess themselves on this basis.

In her analysis of sex advice in *Glamour* magazine, Gill (2009b) argued that contradictions are part of how postfeminist sensibility is accepted by its audience. For example, it is easier for women to accept advice about caring for men's emotional needs above their own if they are also told they are independent women who know how to look after themselves. In a similar vein, we argue below that a third way that postfeminist self-help constructs its audience as always already needing work is by interpolating them through discourses of perfection.

Postfeminist media address takes for granted the savvy, successful and self-determining woman, who is confident, assertive and self-reliant and able to transform herself so that she lives in a permanent state of 'optimal living'. Such a prescription

for mental (and physical) perfection sets up the reader to fail. Such optimal living cannot be totally achieved because it is impossible (e.g. to be permanently happy) and attempts to do so require resources of time, money and expertise that are not available to the average woman (Evans and Riley, 2013). There is also a temporal, future-oriented insecurity embedded in exhortations for perfection that undermine any sense of achievement and success. Slim women need to work on the body to avoid becoming fat; equally, psychological health cannot be taken for granted. For example, when one of us took *The Confidence Code's* online test, the outcome was that we were 'confident', which should be a positive outcome. But, our result came with a warning, 'even those who are fairly confident often experience periods of self-doubt. Or perhaps you feel confident in most areas, but still feel more nerves than you would like before a speech'. Transformation is thus never complete, and perfection becomes both a prescription while also being an impossibility.

Since failure is inevitable, women hailed by postfeminist perfection need to account away this failure in ways that do not challenge postfeminist sensibility. One way to do this is to acknowledge failure, while constructing failure as something to be overcome in the journey to optimal living. For example, women are told they can be their 'best self' but also that 'You cannot be, or give, 100% of the time' (Madsen and Ytre-Arne, 2012, p. 30). To manage this contradiction, magazines offer examples of women who have transformed themselves and, in general, stick to their new lifestyle, but are also adaptable enough to give themselves slack on occasion without ever fully losing control. Failure is thus possible, but only in the context of an upward trajectory and the possibility of sustainable transformation (Madsen and Ytre-Arne, 2012; also see our discussion of Coleman (2010) in Chapter 2 in this volume, in relation to how Weight Watchers online deals with repeat customers).

The outcome of postfeminist perfection is that women are set up for failure and to understand themselves as lacking if they do not achieve optimal living. As in our earlier section, where we made parallels between self-help and religion in terms of directives to work on the self, here we also draw comparisons between postfeminist self-help and religion. Both postfeminism and Christianity prescribe perfection. But Christianity also understands perfection to be an impossibility for humans, and so forgiveness is preached alongside perfection. Similarly, humanist psychology constructs change as starting from a place of self-acceptance. In contrast, postfeminist self-help constructs perfection on Earth as a possibility, the starting point for change as identifying self-lack and the failure to live optimally as a failure of individual will and the outcome of poor choices. In postfeminist perfection, there is little room for forgiveness and a lot of room for judgement (see, for example, Riley, Evans and Mackiewicz, 2016).

Postfeminist self-help thus interpolates women by constructing both successful and everyday women as needing self-help because they are fundamentally flawed. Such flaws are understood through essentialist frameworks, often mapping to the resurgence of biological essentialism that is also part of a postfeminist sensibility (Gill, 2007c). For example, an expert on Oprah Winfrey's website *O Magazine* explained women's lack of self-esteem in relation to 'hormonal surges in the female

brain ... [that] make a woman more sensitive to emotional nuance, such as disapproval or rejection'⁷. Essentialist arguments construct men and women as fundamentally different, even alien to each other (e.g. *Men and from Mars, Women are from Venus*, Gray, 1992); reiterating earlier binaries of women (femininity, moon, water, lunacy) to men (masculinity, sun, rationality). Such accounts can be used to position women as in need of fixing so that they can be more like men.

Blum and Stracuzzi (2004, p. 271), for example, contrast analysis of Valium as the 'ambition-thwarting' drug that allowed 1970s white middle-class women to inhabit traditional gender roles, with the advertising of Prozac as giving women a 'muscular femininity' required by professional workers in neoliberal economies. In their analysis, Blum and Stracuzzi (2004) show how media representations of Prozac presented this antidepressant drug as a technology for allowing contemporary women to meet cultural ideals, including, staying slim through regular jogging while other middle-aged women get fat; giving people a 'competitive edge' at work; or allowing them to manage their emotions in difficult work situations. Advertisements included statements from users such as 'God, I'm so efficient. I've never been able to handle this much work' (p. 278) or attributed living optimally to the drug, such as the mother and successful business woman described as needing 'a little chemical help to be a super mom' (p. 280).

Blum and Stracuzzi (2004) argue that Prozac is therefore constructed as a technology that aligns the psychology of its workers with the needs of competitive economies characterised by intense and insecure work conditions that are psychologically unhealthy. Such economies require women with 'muscular femininity' (p. 279). That is, women who embody traditional femininity (e.g. slim, graceful), but psychologically inhabit traditionally masculine spaces in terms of being individualist, less emotional and less caring. The idea of muscular femininity aligns with Illouz's (2008) analysis of contemporary emotional lives as 'cool intimacies', in which relationships are made sense of through an individualist framework and the language of the market. Similarly, Hochschild (1994) notes the genre of self-help that celebrates a kind of rugged individualism where ideal femininity is understood as not needing others.

One solution in self-help literature to the 'problem' of women, then, is to align them with traditional notions of masculinity. An alternative solution is to turn back the tide of feminism, and return to traditional gender roles, but with a postfeminist spin as a lifestyle choice not social prescription (Broekhuizen and Evans, 2016; Negra, 2009; see Chapter 5 in this volume for further discussion of re-traditionalisation). What neither of these solutions offers is a social critique of a toxic society unable to organise in ways that allow women (and men) to take up public roles in ways that are psychologically fulfilling and healthy. Instead, activism is neutralised by the discourse of self-care and that a good self is prepared to work for a good life – how can you argue against that? Instead, postfeminist self-help positions women between two contradictory discourses – as inherently flawed and as able to meet normative perfection. We argue that self-help acts as the bridge that brings these two contradictory positions, of inherently flawed femininity and postfeminist perfection, together.

Conclusion: the confidence trick

Foucault's later work conceptualised people as having agency. People could work on themselves in particular ways with the goal of transforming the self to make them happier. Foucault called this work 'technologies of the self'. The therapeutic turn we describe above offers a range of technologies of the self. Many people have benefited from these technologies and the opportunities for reflexive thinking that therapeutic tools offer. The same might be said for self-help; one website described self-help books as 'having a good friend talk to you'. This is a comforting notion and we do not want to invalidate positive experiences that people might have from self-help literature. Equally, we argue it is important to think critically about the kind of self constructed in these texts. From a critical perspective, it is important to ask what capacities for thinking and action are enabled by these texts? What capacities are limited? A critical perspective also considers the wider assemblage of material and discursive practices in which the topic of study is located (what Foucault termed 'technologies of subjectivity'). For self-help this includes neoliberal economies, as well as historical and contemporary understandings of gender, including postfeminist sensibility.

In this chapter, we have argued that postfeminist self-help constructs an expectation for women to work on themselves with view to living optimally. Gill (2007c) argues that this represents an intensification and extension of surveillance over new spheres of life that include a 'focus upon the psychological – upon the requirements to transform oneself and remodel one's interior life' (p. 261). Developing this account, we have discussed how postfeminist self-help draws on a recurring trope of self-reliance as a marker of emotional health and happiness that occurs across a range of twentieth-century and contemporary self-help literature. The postfeminist 'spin' added to this trope is a simultaneous drawing on and refuting of feminism; the construction of all women, however apparently successful and 'well adjusted', as needing transformation; and the use of contradictory standpoints.

We have also discussed how postfeminist perfection is both an expectation and an impossibility. Postfeminist perfection sits against historical discourses of women as inherently psychologically flawed. It is often explicitly or implicitly a response to feminism and cultural shifts including women's increasing participation in the workplace and the public arena; their greater control of their bodies through reproductive technologies; and increased recognition of equal rights, including those to sexual pleasure. At one level, women have never had it so good, yet postfeminist representations of women construct them as mentally distressed.

If psychoanalytical ways of understanding the self-made notions of women's madness legitimate, we might want to suggest that self-help works in the service of keeping women anxious. New labels and diagnoses emerge that rehearse the discourse of inherently pathological femininity. For example, women's 'achievement dysmorphia' means that they are unable to accept compliments, while their 'negativity receptor' will only hear critique, condemnation and ridicule; women are working too hard, or not hard enough, either way it is their fault that they are

unable to overtake their male counterparts in the rat race of competitive careerism; 'compassion deficit disorder' is the result of self-sexualisation, where women are no longer able to connect with others at an emotional level; and 'compassion fatigue' means that, in the context of a feminisation of work life and everyday emotional labour, women have become easily over-invested in the needs of others to the point of self-induced stress, exhaustion and depression. These arguments extend into physical health too, since it is women's fault if they become stressed, exhausted or physically ill while trying to 'have it all' and participate in ideal femininities of neoliberal economies.

Women are said to lack self-esteem, body-image satisfaction and self-assurance, at a time when the expectations of postfeminist perfection seem to promise confidence, self-reliance and self-determination in all areas of life. This creates a particular contradiction within postfeminist sensibility. Just as the postfeminist promises of happiness, health and wealth become expectation, problematic femininity is made normative, so that postfeminist perfection and pathological femininity simultaneously construct female subjectivity. Davies (2013) argues that people can get a sense of achievement and happiness from being able to take up socially valued subject positions, but conflicting, impossible or problematic constructions of femininity deny women that possibility. The outcome is an imperative to work on the self, to turn inward to understand both the source and solution of our problems, blaming ourselves for failing to meet contradictory requirements and ignoring our fundamental interdependence. Instead of working to build a better society, the prescription is to build a better self and, as we see in the next chapter, a better body.

Notes

- 1 Women's magazine editorial, cited in Madsen and Ytre-Arne (2012, p. 25).
- 2 See Chapter 3 in this volume, for further discussion on self-work and neoliberalism and chapter 1 in Evans and Riley (2014) for an in-depth discussion of how neoliberalism lays the conditions of possibility for contemporary forms of female subjectivity.
- 3 Note that this is a generalisation. Hochschild (1994), for example, also identifies a self-help discourse developed in response to second-wave feminism that constructs women's route to happiness in traditional female roles such as caring for a husband and children.
- 4 See, for example, Illouz (2012) for an analysis of *A Midsummer Night's Dream*.
- 5 <https://psychologies.co.uk/self/social-confidence.html>
- 6 Suzanne Lachmann, 10 Ways Low Self-Esteem Affects Women in Relationships. www.psychologytoday.com/us/blog/me-we/201312/10-ways-low-self-esteem-affects-women-in-relationships
- 7 www.oprah.com/omagazine/Why-Women-Have-Low-Self-Esteem-How-to-Feel-More-Confident

2

WEIGHT

In a fat-hating society, is everyone fat?

In 2010, a company in the Netherlands released a series of images on their billboards in an attempt to encourage others to fill the space with advertising. The advertising featured fat men and women who became increasingly naked over a period of weeks, with the tagline: 'the sooner you advertise here, the better'. The message on the billboards was clear; fat bodies need to be removed from view urgently. The advert worked because of a cultural disgust with fat bodies. This disgust has historical antecedents that associate fatness with contamination and morality, which in turn construct fat femininity in particular ways: as unruly, excessive, unattractive and, more recently, as evidence of a weak-willed psychology and poor citizenship (see, for example, Bordo, 1993a; Kyröla, 2014; Lupton 2013a; Malson, Riley and Markula, 2009; Tischner and Malson, 2012; Tischner, 2013).

Fat female bodies can be contrasted against the 'thin-ideal', a pervasive media representation of what is aesthetically valued in contemporary women's bodies and, historically, one of the most enduring and global fashions in female body shapes (Stearns, 1999; Swami, 2015). But, in current media discourses there is also a pushback against the 'thin ideal', with its connotations of unhealthy food restrictions and body image anxieties. Kim Kardashian is celebrated for her curvy body, Jennifer Lawrence is applauded for looking 'healthy' (that is, not skinny) and a number of women are commended for appearing sexy through a figure reminiscent of '50s glamour'. In media and public discourse, such nostalgia for a bygone era that valued larger women lies alongside calls to resist the thin ideal and 'love your body', as well as contradictory ideal body types epitomised in terms such as 'lean curves'. Yet, magazines that deplore the thin ideal as unhealthy are the same magazines that feature slim models as the figures of desirability. Postfeminist sensibility is thus an

unsettling one, where weight is a central measure of a woman's health and attractiveness, yet no weight ultimately appears ideal.

In this chapter, we explore why weight is such a powerful lens through which women understand themselves. We start by discussing the body mass index (BMI), a measurement that has shaped popular understandings of weight. We see BMI as making a cultural impact on understandings of health at the same time as postfeminist sensibility, neoliberalism and what Crawford (1980, 2006) calls 'healthism', created a moral imperative of self-control and risk management, set against a backdrop of obesity epidemic discourse. The outcomes of this sense making is an intensification of discourses that tie together health, weight and morality, creating a body-anxious culture, where weight and health are treated as interchangeable and representative of a woman's worth. We also consider alternative frameworks that shift attention away from weight. Such alternatives include a focus on exercise, pleasure and 'health at every size'. We explore these responses through a critical poststructuralist lens to understand how particular meanings around weight and health are produced and the ways of being and capacities for action that they enable.

Governed by the scale

BMI is a surrogate measure of body fat. It is calculated by dividing a person's weight in kilograms by the square of their height in metres. This gives a single-figure score that maps to one of several categories, such as 'underweight', 'healthy/normal weight', 'overweight' and 'obese', with three sub-categories within the obese range. The terminology for healthy/normal weight differs across countries, for example in the United States it is 'healthy', in the UK and Australia 'normal' (Keys et al., 1972). These categories are mapped to levels of risk for health problems including type 2 diabetes, cardiovascular disease and certain cancers, such as ovarian and breast cancer (Williams et al., 2015). The healthy/normal BMI range is between 18.5 and 24.9: a range produced in recognition of individual differences in physiology, with 25 being considered a standard healthy figure. To put this in context, a woman of 165 cm (5' 5") with a BMI of 25 would weigh 68 kg (10 stone 7 lbs), with a healthy/normal weight range of approximately 50–68 kg (8–10.5 stone).

Quetelet developed the index in 1832 to chart the average man's [sic] build and explore population patterns in body size (Bedogni, Tiribelli and Bellentani, 2005; Jutel, 2006; Keys et al., 1972). For a while, it fell out of favour, but was then taken up in the early twentieth century as a predictor of health by insurance companies, whose actuarial statistics demonstrated a correlation between higher BMI and incidence of coronary heart disease and type 2 diabetes. Subsequent population weight gain, associated with changes in diets and reduced physical activity (linked to new work patterns and technologies related to labour saving and food manufacturing), led to government epidemiological surveys that included BMI (Gard and Wright, 2005; World Health Organization Europe, 2015). BMI also became increasingly popular among clinicians because of its low cost, standard use in clinical studies and ease of use compared with other measures such as waist-hip ratio and magnetic

resonance imaging, despite research showing its limitations as a measure of health (Williams et al., 2015).

BMI is now a ubiquitous measure of adiposity in the twenty-first century. It is treated as an objective quantitative measure of disease (Jutel, 2006). BMI is used by the UK National Child Measurement Programme (Public Health England, 2016), US Centers for Disease Control (2016) and the World Health Organization Europe, (2018); the UK government pays its primary care trusts to measure patients' BMI (Department for Education and Department of Health and Social Care, 2015); schools in the UK, United States and Australia routinely measure it; home and public weighing scales calculate it, sometimes communicating that information to the person's smart phone; the UK National Health Service self-assessment health tools use it; university human resources department emails offer it as an incentive (get a 'health MOT test'!) and interactive computer games like Wii Fit create players' avatars with it. A search for 'BMI calculator' on the iPhone App Store returned 436 results of applications that can help to measure and monitor a user's BMI and even more weight-loss applications (many targeted at women) incorporate it into their functionality. Thus, we have a myriad of ways to understand ourselves through BMI. These ways allow BMI to be a measure through which we learn to understand ourselves differently; from which we categorise, monitor and act on ourselves, with the desire to be considered a 'healthy weight'. From this perspective, BMI is an exemplar form of governmentality and disciplinary power.

In *Discipline and Punish*, poststructuralist philosopher Michel Foucault (1977) traced a change in forms of power that had a profound impact on how we think about ourselves as people. In 'sovereign' power, monarchs were considered to have divine rule as God's representative on Earth and, as such, could wield direct power over their subjects. But as countries began to be governed through more democratic processes, those in governing positions needed to be able to manage the country with the general agreement of their populations. What was required for this new form of governance was the ability to understand the population in order to encourage them to manage their behaviour towards that considered most 'profitable' or 'socially cohesive'.

The outcome was a form of governing ('governmentality') that acted on people's psychology, working on their subjectivity so that people would manage themselves, what Foucault (1982, p. 221) called 'guiding the possibility of conduct' (*conduire des conduites*, 1994, p. 237). But this created a paradox at the heart of modern government's understanding of the individual; the ideal citizen was both free and autonomous but located within a regulated society that requires the management of their behaviour. Foucault argued that managing this paradox and the conduct of conduct required a new form of power, not one wielded from above, but one that was *productive*, *disciplinary* and *diffused*.

Foucault theorised power as *productive* because it produces understandings about the nature of reality, which are then largely agreed upon by the population (e.g. that slimness is a sign of health or that staying healthy is an individual's responsibility). We analyse BMI as a form of productive power since BMI allows us to understand

people in particular ways in relation to their weight. Through this measure, we know others and ourselves differently, as 'overweight' or 'obese', for example. Without BMI, we might have thought of such people through other available cultural discourses, such as 'womanly', 'fertile' or 'gluttonous'.

In producing ways of understanding the self, productive power may be experienced as repressive, affirmative, or a combination of both repressive and affirmative, since opening up possibilities for thinking in one way shuts down other possibilities. This is the 'productive' aspect of power and part of why governmentality works so well because we do not feel as if power is wielded against us. Instead, we are interpellated, incited to understand ourselves through discourses that seem to offer us important or positive ways to make sense of the self and body. For example, both Heyes (2006) and Coleman (2010) note the way that weight-loss organisations construct dieting through discourses of self-development, mastery and transformation, creating the conditions for weight loss to be experienced as empowering. As Foucault stated: 'What makes power hold good, what makes it accepted, is simply the fact it doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse' (1980, p. 119).

But productive power is directive. BMI is a measurement that makes the body visible in particular ways that couple health with weight and create categories of people, such as those who are normal/healthy and those who are not, 'the overweight', 'the obese', and so on. The categories of people produced through BMI are assigned different values, clearly demarked by terms such as 'normal' or 'healthy'. In general, governments are keen to have healthy citizens, so to manage the conduct of conduct ('*conduire des conduites*', Foucault, 1994, p. 237) citizens need to be encouraged to want to be categorised as healthy/normal. Because more of the population is considered unhealthy overweight than underweight, these measures focus on encouraging the population to be concerned about being or getting fat. And one way to encourage people to monitor their 'fatness' is to encourage them to use BMI. This aspect of power is considered *disciplinary* because people take up and internalise the 'truths' created within a particular discursive regimen. Internalisation is a process by which people come to understand themselves through discourses and then 'discipline' themselves according to these ideas. Thus, while the parameters of normality maybe set by governments and medical institutions, they are adopted and internalised by individuals through a process of surveillance, by the self and others.

Nikolas Rose and colleagues developed Foucault's theorising of governmentality by highlighting the role of measurement, arguing that when you measure people you render them 'knowable' (e.g. Miller and Rose, 1997). What they mean by this is that measurements for governing create categories of people, which structure how people think about themselves and others. BMI for example, creates an understanding of health through a measure that conveys a sense of objectivity, since it is a calculation apparently supported by scientific and medical discourses. This measure then gives us an understanding of people in relation to their weight, so

that, through BMI, we know them and ourselves differently. Similarly, Deleuze (1999) talks about governmentality as beams of light that crisscross over an object and make it visible. In their visibility, these objects become easier to manage, control and 'govern', so that with visibility also comes forms of surveillance. The application of disciplinary power in the area of health and medical knowledge was termed bio-power (Foucault, 2003a) and bio-politics (Foucault, 1997, 2003b). Bio-power is not just about the gathering of statistics, institutions and regulation which occurs in a population, but it also transforms how we understand ourselves, bringing us under control through calculations and measurements of the body (Foucault, 1988). Modern power thus involves a gaze:

Just a gaze. An inspecting gaze, a gaze which each individual under its weight will end by interiorising to the point that he is his own overseer, each individual thus exercising this surveillance over, and against himself. A superb formula: power exercised continuously and for what turns out to be a minimal cost.

Foucault, 1980, p. 155

Disciplinary power is thus exerted when a person concerned about their health logs on to the NHS BMI calculator and, on seeing the indicator in the red, feels a sense of shame, anxiety or self-anger. Equally, we see disciplinary power when women experience weight-related stigmatisation by others (Rogge, Greenwald, and Golden, 2004; Jackson, Beeken, and Wardle, 2014). The myriad of opportunities to know ourselves and others through BMI is also an example of how power is *diffuse*, since the power to construct people through BMI is distributed across a range of interactions and sites across society rather than belonging only to those few at the top of the social hierarchy (Foucault, 1980, 1997).¹

BMI is a medical discourse, and medical discourses are powerful in their own right. However, we contend that part of the 'hold' of BMI is that associations between health and weight resonate with a wider assemblage of institutional and historical discourses, of which we are not always aware (what Derrida (1988) calls 'structural unconsciousness'). Jutel (2005, 2006), for example, argues that weight has been transformed into a disease entity in part because health is understood in terms of appearance norms, creating an 'aesthetic of health' (2005, p. 113). Building on this work, we highlight the importance of gender in cultural constructions of weight, health and appearance.

Thinness, slenderness and fatness bear strong associations with femininity, as has the body more generally, in contrast to historic associations between masculinity and the mind, logic and reason. Historically, slender young female bodies represent the potential of fertility, while older fat female bodies demonstrated their capability to sustain children (Stearns, 1999). Through associations with fertility then, the fat female body can be understood as a feminine body. Equally, we can trace associations between thinness and femininity that link femininity and self-sacrifice. Women were often expected to consume fewer resources, denying their own needs

in order to prioritise others in their family (Orbach, 1978; Malson, 1999; Riley et al., 2008). There are also historical associations between fragility, femininity and a Judeo-Christian ethic of denial and fasting (see our discussions of the waif, thinness and the myth of Ophelia in Chapter 1, which we develop further in Chapter 7). The rise of Puritan Protestantism in particular, which 'associated restraint in eating with holiness' (Stearns, 1999, p. 6), produced a holy denial that was also gendered, offering women a chance to redeem themselves. After all, it was Eve's lack of restraint that led to man's [sic] ejection from the Garden of Eden.

Women are thus located within a set of discourses through which disciplinary power operates, which position weight as an important measure of health, fertility, attractiveness, femininity and morality. Such a range of discourses produces a powerful lens on body weight, as Malson argues:

It might be hard to imagine how body-weight could be made to signify more ... it is already more than familiar as a fictive index of one's personality, moral character and aesthetic value; one's un/successful embodiment of femininity (or, increasingly, masculinity) and one's ability to properly conduct a self-directed life; one's health and, as a consequence of all this one might imagine, one's entire life.

Malson, 2008, p. 38

Discourses structure how we make sense of ourselves and they can have significant affective impact even when we are critical of them. For example, feminists critical of weight and beauty norms also report a desire to meet those norms (Riley and Scharff, 2013; Throsby and Gimlin, 2010). In knowing themselves through the value-laden categories of BMI, women come to understand their worth, which is tied into a range of emotional registers. Shame and guilt are often reported in qualitative research exploring the experiences of fat people (e.g. Throsby, 2009; Tischner, 2013). Conversely, 'successful' weight loss elicits pleasure and a sense of triumph, in part because, as we discuss below, it evokes a discourse of self-control and willpower that is valued within neoliberal subjectivity. BMI is therefore a form of governmentality *par excellence*, a ubiquitous measure, structuring women's understanding of themselves and their health.

Problems with BMI (or, what to say next time a nurse suggests weighing you)

The World Health Organization and governments across the globe concerned about rising obesity use BMI as an apparently objective measure through which they can encourage and monitor the success of their populations in maintaining a 'healthy' weight. Gard and Wright (2001) contextualise such concerns within Beck's (1992) idea of risk society, where governments construct anxieties around the body that focus on avoidance of risk rather than facilitating health. This approach leads to health promotion that focuses on identifying risk factors associated with morbidity

and mortality and setting targets to reduce these risks in particular populations, such as increasing physical activity in school pupils (Lupton, 1995; Royal College of Paediatrics and Child Health, 2015). The rationale in this approach is that lines of causality can be identified and problems avoided by behaviour changes in at-risk populations. The problem with this rationale is that it involves the ‘erasure of uncertainty with respect to knowledge about the body’ (Gard and Wright, 2001, p. 537). The causality approach thus creates an illusion of mastery over our health outcomes, when a more realistic understanding is that we are managing probabilities of risks and cannot completely know or eliminate the factors that will contribute to our inevitable death (Bauman, 1992). The illusion of mastery over health, which creates an understanding of illness as “‘occasioned’ by the self” (Stacey, 1997, p. 175), is particularly relevant to weight because of the contested evidence base for BMI as a measure of health. Indeed, as we explore below, evidence regarding weight as a cause of illness is contradictory, limited and ‘overemphasized in the medical literature’ (Ernsberger, 2009, p. 31).

BMI health/weight categories are produced from research designed to predict population outcomes (Atrens, 2000; Lupton, 1995). Despite the status of BMI as a universal measure of health/weight, there are contextual factors and individual differences that reduce its applicability. Differences in genetics and epigenetics, and the multifactorial processes involved in illness and health, mean that population-level statistics are poor predictors of an individual’s health outcomes. BMI is not only determined by dietary intake and energy expenditure, but there is also evidence for individual differences in a biological ‘set point’ for weight. For example, some people appear to have a naturally higher point towards which their weight will tend to return after dieting (Muller, Bosy-Westphal and Heymsfield, 2010). In considering the BMI standard of 25 as a measure of health, Burgard offers a dog analogy: “It would be like starving a Saint Bernard because a study of dogs showed that greyhounds live longer” (2007, p.44).

Using BMI as a measure of health is also limited by the possibility that weight may be either a protective factor or a risk factor at different times in one’s lifespan. For example, weight might be a risk factor for chronic heart disease for someone in their 60s, but protective if they live into their 70s, when they are at a greater risk of degenerative diseases (Burgard, personal communication). Thus, for older people the U-shaped curve relating BMI to morbidity and mortality is moved higher in terms of BMI, with older people who are overweight having better health outcomes than those who are in the ‘normal’ range (Flegal, Groubard and Williamson, 2005; Lavie et al., 2014).

BMI categories also differ across ethnicity, with the UK’s National Institute for Health and Care Excellence (NICE) advising South Asian and Chinese adults to have a lower standard BMI of 23 because of their higher risk of developing type 2 diabetes and cardiovascular disease. In contrast, weight is not a significant predictor of African American women’s cardiovascular health (Wilson, 2009), while in New Zealand, Maori and Pasifika people have higher BMIs, but these do not reflect the same levels of adiposity and fat distribution as they do in white Europeans

(Rush et al., 2007). Children, athletes and elderly people's body composition is also not well captured by the standard BMI categorisation process (Childers and Allison, 2010).

A further limitation is that BMI does not distinguish between locations of fat nor between bodies of the same BMI with different kinds of body composition, including muscularity. The location of fat in the body has been shown to better predict health outcomes than BMI. For example, Yusuf et al. (2004) found in their multi-country study that although abdominal obesity was a significant predictor of coronary heart disease, BMI was not.

Researchers critical of the way BMI statistics have been used to develop BMI as a measure of health also argue that it is predicated on research that fails to engage with the complexity in the data. For example, Burgard (2009) argues that 'correlations between higher BMI and ill health fail to control for important variables known to mediate this relationship, including socioeconomic status (SES), physical activity levels, nutritional quality, sleep quality, access to quality medical care, exposure to weight-based stigma or even trying to lose weight (weight cycling)' (p. 46; also see Jackson, Beeken and Wardle, 2014). Weight can be a protective factor for health for poor women (Schorb, 2013), with Ernsberger (2009, p. 28) concluding: 'if you are rich it is dangerous to be fat (but being thin is fine); if you are poor it's much more dangerous to be thin than to be fat'. This inequity reinforces Wilkinson and Pickett's (2009) argument for tackling health problems through the inequality and social injustice with which they are indivisibly associated.

Other evidence of the complexity in relationships between weight and non-communicable lifestyle-related disease includes a large, international study that ranked smoking, high blood pressure, high cholesterol and diabetes as the strongest predictors of coronary heart disease (the leading cause of death for men and women in middle- and high-income countries) ahead of weight, diet and exercise (Yusuf et al., 2004). Despite these findings, weight dominates health information and advice as a risk factor for heart disease relative to less visible but more significant factors such as high blood pressure and cholesterol. The conflation of weight with health may occur because factors such as diet and exercise can affect both weight and risk for heart disease. Diet and exercise are independently associated with heart disease (Malhotra, Noakes, and Phinney, 2015, 2016) and can also contribute to other risk factors such as high blood pressure, high cholesterol and type 2 diabetes, but, in the paradigms of health promotion, these associations are oversimplified as direct causal relationships between weight and heart disease (Bacon and Aphramor, 2011).

Although, at low and high extremes, BMI is associated with higher rates of disease and death, in recent years an 'obesity paradox' has been identified which suggests that moderate levels of 'extra' weight do not impact on health or can even offer a protective factor in health and illness. For example, Flegal, Groubard and Williamson, (2005) showed that people in the 'overweight' BMI category have no increased mortality risk. Research on adults with a diagnosis of coronary heart disease showed that those in the overweight or mildly obese BMI categories had the

best health outcomes, and unfit, lean people the worst outcomes (Lavie et al., 2014). Other findings that run counter to dominant discourses of weight and risk indicate that the BMI associated with lowest cause mortality has shifted 3.3 points higher, from 23.7 to 27, over the past 40 years (Afzal et al., 2016). The same study reported that whereas in the 1970s there was a 30% higher mortality rate in the population with a BMI of over 30, in the most recent cohort examined there was no excess mortality associated with this category of BMI. The increases in population weight that have so concerned governments have also occurred at the same time as increases in life expectancies (Gard, 2010; Gard and Wright, 2005). The findings that indicate that weight is protective for certain populations and conditions thus undermine the authority of promotion of weight loss and a low BMI as universally good for health. They also point to a lack of certainty and understanding of the relationships between weight and health, indicating that other factors besides weight shape health outcomes at a population level (Bacon and Aphramor, 2011; Childers and Allison, 2010).

Weight outcomes are shaped by poverty, poor-quality environments, discrimination and other stressors related to sex, ethnicity and body-size inequalities, including the discrimination against fat people that leads to poorer employment outcomes (Puhl, Andreyeva and Brownell, 2008; Solovay and Rothblum, 2009; Tischner, 2013). The narrative of 'lifestyle choice' hides these factors, however, so that accountability for weight is located in individuals regardless of the inequalities in their circumstances. While it is important to recognise the role of structural factors in weight, we note that simply reframing the cause of obesity from individual psychology to environmental and social factors does not challenge conflation of weight and health (Schorb, 2013). Critical perspectives that focus on the limitations of BMI in accurately measuring body fat or upon inconsistencies in the narrative that BMI determines health, leave assumptions that slim bodies equals health unchallenged. BMI is not only problematic because it may be inaccurate and/or misapplied, but because as a single measure of a single factor, it contributes to the construction of weight as the major determinant of complex processes of health and illness, to the exclusion of other factors, and with considerable potential for harm (Campos et al., 2006; Oliver, 2006). The quality, as well as the calorific value, of food is important for health. Engaging in physical exercise reduces risk of morbidity and mortality regardless of weight, and there is emerging evidence that it is the inclusion of certain foods in the diet, such as fruit, vegetables, fish and olive oil that confers a health benefit, rather than the avoidance of traditionally less healthy items (Malhotra, Noakes and Phinney, 2015).

Commercial and business interests also complicate these already complex relations, as they benefit from the use of BMI as a measure of health. Medical, policy, commercial and public discourses around health inform each other in often complex ways, directed in part by the possibilities for increasing profits for pharmaceutical and insurance companies (Blum and Stracuzzi, 2004; Chappell et al., 2016; Oliver 2006). For example, after commercial lobbying in 1998, the US Federal Government lowered the BMI measurements for overweight and obese categories,

creating millions of overweight people overnight and legitimising them as targets of pharmaceutical and diet industry interventions and/or increased insurance premiums (Mundy, 2010; Peretti, 2013; Wann, 2009). More recently, public outcry led to a fizzy drink with a red and white logo being removed from the UK's 'eat well plate', a visual image used to communicate healthy eating produced in collaboration between government and industry that is used across a range of government institutions including schools. Monaghan, Hollands and Pritchard (2010) also identify groups of 'obesity epidemic entrepreneurs' who profit in different ways from perceptions of weight as a personal, social and global threat. Other examples include US and UK governments' public health 'war on obesity' campaigns that were both funded and endorsed by commercial weight-loss companies such as Weight Watchers and Slim-Fast (Lyons, 2009, citing Fraser, 1997; see Chapter 3 for further discussion on commercial interests in health). More recently, Weight Watchers, for example, partnered with UK and US governments to offer weight-loss health programmes in prisons and through the NHS (Jolly et al., 2011). These companies offer professional services relevant for governments concerned with rising obesity, but their involvement creates a vested interest in commercial companies for government health policies to focus on weight.

The focus on weight as a normative measure of health takes attention away from problems associated with attempts at weight loss. Long-term weight loss is difficult for many people and dieting often leads to weight cycling, weight gain over time, hypertension and unhealthy and unhappy relationships with one's body, food and exercise (Burgard, 2007; Campos et al., 2006; Maclean et al., 2011; Mann et al., 2007; Tischner and Malson, 2012; also see Chapter 3). The construction of BMI as a causal factor in ill health affects how health professionals respond to their patients; for example, directing attention to weight-loss programmes rather than interventions that focus on health outcomes independently of weight loss. Understanding BMI as a causal factor in health can also lead to advice to lose weight regardless of lifestyle and health factors that suggest health, and to medical professionals being dismissive of fat people's health issues and/or missing other potential causes of illness, resulting in weight being misattributed as the source of health problems and larger people being less likely to seek treatment or take up screening for fear of weight stigma (Lewis, 2015; Lyons, 2009; Phelan et al., 2015; Teachman and Brownell, 2001).

The coupling of weight with health also provides the conditions of possibility for unhealthy weight management practices such as smoking and excessive monitoring of calorie consumption and expenditure. Linking health with weight also allows unhealthy messages to be articulated under the banner of health, such as when magazines with 'health' in their title validate rapid weight loss. Further, the associations between body weight, health, morality and a person's psychology can produce intense shame and blame for women who do not conform to thin ideals of femininity and healthy citizenship (Aubrey, 2010; Browne et al., 2013; Burns and Gavey, 2008). See, for example, Roxan Gay's (2017) memoir of being a larger woman in a fat-phobic society, which included strangers feeling they had the right

to remove items from her shopping trolley/cart. A focus on weight also creates a paradox in that to understand oneself as needing to lose weight a person must be dissatisfied with their body, but dissatisfaction is a causal factor in weight gain (Rauscher, Kauer and Wilson, 2013). Thus, not only is there contested evidence for BMI as a measure of health, there is also evidence to suggest that BMI, aligned with an understanding that weight is a proxy measure for health, can increase weight gain and feeds into an unhealthy culture of dissatisfaction, anxiety, blame and judgement about the body. Such an unhealthy culture of dissatisfaction contributes to a range of eating difficulties that disproportionately affect women (Haines and Neumark-Sztainer, 2006).

‘Your health your choices’

The rhetoric of blame and judgement associated with weight is, in part, enabled by neoliberal governments who manage the conduct of conduct through a construction of the ideal subject as someone who is autonomous and rational and can thus make free choices and be held responsible for themselves (see the Prologue and Chapter 1 in this volume). Part of this responsibility involves making ‘appropriate’ consumer choices so that risks can be managed through lifestyle choices. At the heart of neoliberalism, then, is the paradox of governmentality: people are free to choose, but their choices should align with government definitions of good citizenship, including weight.

Weight dominates government health policies and promotion, constructing BMI as a risk factor for ‘lifestyle diseases’, and in so doing inferring a causal relationship between weight and health (Williams et al., 2015), creating the intense focus on weight. For example, the NHS online self-service ‘BMI healthy weight calculator’ has under the strap line ‘your health your choices’ an instruction that it is ‘use[d] it to calculate adult BMI and child BMI accurately, and get advice and information on healthy weight’.²

The dominant discourse for weight management is energy in/out (Aprahmor and Gingras, 2008; Prentice and Jebb, 1995), which focuses attention on to people’s choices around eating and exercise. An example can be seen in a soft drink advertisement that compares a slim (read healthy) 1970s man with his fatter (unhealthy) contemporary counterpart, who by implementing lifestyle changes such as using the stairs rather than the lift, returns to the slender health of historic masculinity. Both historic and (healthy) contemporary man are thus united by their slender/health and by their consumption of the sugary drink advertised. Such adverts work on the premise that health is an individual responsibility, managed by individuals making easy, small and simple changes (in this instance to their physical activity). Manufacturers of sugary drinks are not positioned as part of the problem nor in need of government regulation within individualised discourses of healthy lifestyles. Sometimes it is acknowledged that modern, free-market economies offer opportunities for over-consumption. But, responsibility remains with the individual, who must be extra vigilant in order to make responsible choices based on expert advice

and scientific evidence passed on through public health campaigns, advertising and other media, as well as through contact with health care professionals (Golden and Earp, 2012; Lindridge et al., 2013).

Within neoliberal societies, weight/health is constructed as a risk to be managed by individuals through their lifestyle choices. The construction of health as a risk to be managed by the individual, often through consumption, is part of what Crawford (1980, 2006) terms 'healthism'. Healthism is characterised by a medicalisation of everyday life, including diet, and locates responsibility for health problems and solutions with the individual, even though individual's management of health is still guided by expert knowledge, medical institutions and the state. Health also becomes a site of identity formation, 'in a health-valuing culture, people come to define themselves in part by how well they succeed or fail in adopting healthy practices' (Crawford, 2006, p. 402). Maintaining a positive health identity thus involves an understanding of lifestyle behaviours as representing a risk or benefit to health and an understanding that one's own lifestyle constitutes appropriate levels of risky and beneficial practices. Non-adherence to behaviours associated with healthy lifestyles opens an individual up to criticism or judgement. Healthism thus creates a moral imperative of care of the body, which is often translated into self- and body-control (Gard and Wright, 2005).

Healthism is part of neoliberal governance, creating a powerful lens on the body and enabling an understanding of the body as malleable and representative of a lifestyle choice, a choice for which people can be held accountable and judged. The outcome is a recurring discourse that weight equals health and that responsibility for keeping a low weight resides in the individual. Thus, despite the significant stigma on larger bodies (with the implication that people would prefer to avoid stigma), a discourse of choice is mobilised to construct fat people as wilfully wrong (see also Ahmed's 2014 work on 'wilful subjects'). Through this logic, fat people are constructed as failed citizens, with bodies that evidence their inability to regulate their consumption in line with cultural expectations (Tischner and Malson, 2012). People internalise understandings of themselves as faulty, blaming their genes, their emotional functioning or their willpower for their failure to achieve or maintain weight loss (Green, Larkin and Sullivan, 2009).

The conditions of possibility are thus set for a range of weight stigma practices, including weight-based bullying (Brownell et al., 2010); aggressive 'concern trolling' (see, for example, Twitter responses to plus-sized model Tess Holliday); regular media reports of 'over consuming' fat people, such as the *Mirror* newspaper's headline 'Two million obese Brits to get free gastric band operations ... [which] could leave the already strained NHS with a £12BILLION bill'; or comments from experts, such as those from diabetes researcher Professor Craig Currie, who on national television called overweight people 'lazy porkers' (BBC, 2013).

Where once a religious discourse linked denial with morality and consumption with sin, now morality is coupled with weight, through neoliberal discourses of responsibility and rights to a finite healthcare system. This is despite epidemiological evidence for the complexity of the relationship between diet, weight and

health that should produce a multifaceted response (Jou, 2014; US Department of Agriculture, 2015) and research indicating that fat shaming and consequent body dissatisfaction are associated with weight gain, suggesting that making fat people feel bad about their bodies tends to make them fatter (Hunger et al., 2015). Simplistic and judgemental medical discourses exclude the experiences of women whose weight may form part of complex responses to traumas, such as child sex abuse or sexual harassment, or who accept and like their bodies at the weight they are (Lewis, 2015; Holland, Peterson, and Archer 2018)

Despite the critiques outlined above that problematise the conflation of health with weight, BMI and weight continue to dominate health promotion and government health policies. For example, the Welsh government's 'Big Fat Problem' health promotion booklet, a precursor for the UK-wide Change4Life campaign, constructed weight as a measure of health and the responsibility of the individual who could manage it with easy, yet effective lifestyle changes. Swapping rather than cutting consumption is recommended; for example, in not ordering a creamy korma curry when having a take-away. The cover of Big Fat Problem showed a familiar media trope of the obese, a dehumanized headless torso, clothes straining against presumably uncontrolled growth. The title makes the issue clear too – this person is a problem. The booklet thus reproduces a fat shaming ethic, along with neoliberal ideas of a rational person able to act with agency and consume appropriately once given correct information.

In contrast, Change4Life did not employ shame, but an inclusive address in which lifestyle-related weight gain was presented as part of everyday life, creeping up on people and then problematically affecting health, again in ordinary, everyday ways (e.g. not being able to play football), but the message remained located within healthism, with weight constructed as an individual responsibility, to be managed by a rational, agentic individual, making simple but important behavioural changes in relation to eating, drinking and exercise (Brownell et al., 2010).

The logic in health promotion programmes for constructing weight loss as easy is that it maximises the likelihood of take-up. Critics of this kind of health promotion argue that it fails to engage with important issues including 'obesogenic' environment factors, the contradictory discursive landscape of consumption and human psychology. For example, critics point to environmental factors that limit an individual's control of their consumption. Such factors can make an 'obesogenic environment' defined as a range of micro- and macro-environmental issues that 'predispose, enable or reinforce ways of living that promote (or inhibit) the consumption of high calorific foodstuffs and simultaneously discourage physical activity' (Swinburn, Egger and Raza, 1999, p. 564; also see US Department of Agriculture, 2015 and Rao and et al., 2003: for an analysis of the costs of un/healthy foods and drink such as fizzy drinks rather than milk). Examples of obesogenic environmental factors include industrial production of food (e.g. use of high calorie corn syrup as a food filler), government policy outcomes, social norms, feeling safe to go out, access to fresh food, the costs of healthy food and drinks, and stress related to lack of money and discrimination.

Obesogenic environment arguments state that while individuals may have agency in terms of how they might act, they do so within a context that is not of their own making. And the context for some individuals, particularly urban poor people, is skewed towards high calorie, processed food that is associated with unhealthy weights. Obesogenic environments contribute to structural inequalities, which may be felt particularly strongly by women (Ernsberger, 2009). Yet within the logic of healthism, people are held to be individually responsible for their weight as if the context in which they live is neutral (Jou, 2014). Crawford (1980, 2006) thus argues that healthism produces a non-political, individualistic understanding of health, since health is the outcome of the choices of individuals and not a public health issue, which is the responsibility of government. The outcome is that even when health professionals advocate government policies to address structural factors related to obesity, governments are reluctant to implement them, because within neoliberal sense making they are seen by both policy makers and the public as unacceptably and unnecessarily paternalistic (Greener, Douglas and Teijlingen, 2010).

Thus, even when alternative discourses are mobilised, for example, concerns around processed food, such critiques are often reappropriated back into a neoliberal individual responsibility framework. For example, the 'traffic light' system in the UK that allows consumers to see how much salt, sugars and fats are in food places the responsibility for healthy food consumption on the consumer rather than the producer. There is the possibility that, based on this information, consumers change their behaviour in significant enough numbers that market forces lead to producers changing their practices. But, as a form of health promotion it ignores the range of ways that consumers respond positively to unhealthy food. The cost of food, and pleasures associated with sugar, salt and fats, affects food choices and eating (Crum et al., 2011; Forwood et al., 2013; Mai and Hoffman, 2015; Rao et al., 2003). Food producers also minimise the way they present information that might put consumers off, such as giving a clearly seen traffic light code, but with small print saying it is for only half of the product, while store layouts maximise purchases of chocolate and snack food (Sigurdsson, Larsen, and Gunnarsson, 2014).

As well as failing to engage with obesogenic environment issues, healthism fails to engage with contradictory cultural prescriptions in which people are exhorted to fulfil their consumer desires and simultaneously deny their desires and constrain consumption (McSharry, 2009; Robertson, 2006). Healthism also fails to engage with individual differences in physiology, including genetic variability in the metabolism of food and the laying down and value of fat (Jou, 2014; Burgard, 2007) or with aspects of human psychology, particularly the role of conscious and unconscious emotional drives related to eating, exercise and gender roles, despite a range of research highlighting their importance (Gimlin, 2008; Orbach, 1978, 2009). By absencing the complex assemblage of meanings and effects around food and exercise, failure to consume in the direction desired, eating a biscuit even when on a diet, for example (Heenan, 2008), is constructed as a failure of will and thus a failure of the (neoliberal rational) person.

Although neoliberal healthism is an address to all citizens, it interpolates women in specific ways so that, we argue, if fat is a feminist issue (Orbach, 1978, 2009) then weight management is a postfeminist one. Postfeminist sensibility genders the weight/health/worth disciplinary lens through its construction of femininity as a bodily practice requiring self-surveillance and work. Postfeminism reworks the historical connections between weight, femininity, fertility and beauty we discussed earlier to create an understanding that women should want, and be able, to work on themselves to produce their bodies into cultural ideals of health and beauty. Postfeminism thus limits the range of acceptable female bodies in ways that are not experienced by men. For example, positive masculinities may encompass both adoption and resistance of healthy identities and practices (Gough, 2009; Robertson, 2006). Men, for example, may celebrate unhealthy eating as masculine or question each other's healthy eating choices as unmasculine, as did one man we overheard in an airport commenting on his fellow traveller's choice of salad.

Although weight may be important aspect of men's embodied identities, it is almost inescapable for women. For women, weight is a 'major marker of place and power' (Rice, 2007, p. 167; Tischner, 2013) and a defining factor in how young women come to understand themselves, since it structures how others treat them (Kyröla, 2014; Rice, 2007). In the context of women being avid consumers of health- and body-related information, women's magazines are an important vehicle for circulating post-feminist sensibility, as well as transmitting body dissatisfaction and anxiety (e.g. Blood, 2005; Gill, 2007c; Grogan, 2007; McRobbie, 2009; Stevenson, 2002). But we would argue that postfeminist sensibility is now more than a media address. Rather, we see it operating as a form of diffuse disciplinary power, imbricated in neoliberal healthism and situated across a range of institutional and interpersonal interactions. From the formal classroom to informal 'girlfriend' cultures, girls and women are encouraged to understand that their worth is read through their weight and ability to meet cultural appearance ideals (Rich and Evans, 2008; Riley, Evans, and Mackiewicz, 2016).

Failure to maintain an 'ideal' weight thus creates a sense of failure as a person. People who have dieted and failed to lose the desired weight or lost the weight only to put it back on attribute this failure to their flawed individual psychology (Green, Larkin and Sullivan, 2009; Greener, Douglas and van Teijlingen, 2010, also see Chapter 3 in this volume). Yet, failure in dieting is normative, with research consistently showing that it is an unsuccessful long-term strategy for weight loss (Maclean et al., 2011; Pietiläinen et al., 2012; Tischner and Malson, 2012; Vogel and Mol, 2014). But women keep on trying.

In her analysis of *Weight Watchers Online*, for example, Coleman (2010) shows how weight loss and its related body monitoring is presented as convenient and easy, a familiar trope evidenced in *Big Fat Problem* and a range of other weight-related health promotion. But what *Weight Watchers Online* also does is to enable alternative constructions that take into account problems with weight loss and past failure. So that in different parts of the site, *Weight Watchers* crafts contradictory discourses of weight loss as both likely to be easy and successful and its opposite, accounting both for experience of recidivism/failure and creating a hoped for future self to feel possible in the (near) present.

Drawing on the Foucauldian conceptualisation of productive power outlined in the earlier section of this chapter, Coleman (2010) also explored how practices of weight monitoring and dieting are enabling. Thus, rather than see women who diet as cultural dupes under the tyranny of the thin ideal, Coleman recommends an analysis that examines what enabling features these practices have, such as a sense of self-mastery. Coleman's work maps to other research on positive identities experienced through weight loss, including feeling that you have found something you are good at (Rich and Evans, 2008) or giving older (widowed) women the chance to cook for themselves and meet their own needs and desires for the first time in their lives (Gimlin, 2008). We would add that features such as self-mastery and ability to transform yourself align with cultural ideals of health that also map to ideal neoliberal subjectivity, further reinforcing engagement with these weight-loss practices. Thus, as with many other disciplinary practices of postfeminist perfection, it is important to consider how women are tied into them through associations with pleasure. (See Chapter 3 for further discussion of the pleasure of fulfilling social norms).

The pleasures in postfeminist transformation and meeting cultural ideals of femininity are not fully available to everyone. Located within a neoliberal rationality, postfeminism is predicated on regulation of the female self to fall within the parameters of acceptable body size and shape. But these parameters are not just narrow, they are also contradictory, requiring, for example, women to be slim yet curvaceous, voluptuous yet also toned and muscular. Cultural ideals of embodied femininity are also structured around class and ethnicity. There are implicit classed discourses in health promotion that problematised working-class bodies and lifestyles (Wardle and Steptoe, 2003). For example, advice in *Big Fat Problem* includes 'don't just sit on the sofa eating a burger', which we see as a classed discourse associating high-fat, low-quality food eating with other culturally devalued eating habits such as sitting on a sofa rather than at a table. Similarly, despite being an apparent address to all, health promotion and postfeminist media speak differently to women who are not white (Butler, 2013; Rice, 2007).

The figure of white, slim health is such a repeated motif in health promotion and postfeminist media that it becomes hard to imagine how larger bodies might be fit or healthy. The slim figure of health also works to exclude a range of women for thinking that fitness or health might be 'them'. For example, Rice (2007) showed how Canadian school and government programmes aiming to increase girls' take-up of exercise marginalised and excluded girls and women who did not see themselves reflected in the images these programmes used of slim, white, athletes wearing revealing sports clothes.

In contrast, a recent Sport England (2015) 'This Girl Can' campaign attempted to broaden representations of body size, age, and ethnicity, to provide an inclusive address that invited women to enjoy physical exercise. The campaign articulated a postfeminist sensibility with its 'girlification' of adult womanhood that echoed 90s notions of 'girl power' ('this *girl* can'). The advertisement also articulated a new variation of postfeminist 'having it all' messages, constructing exercise as a form of release from cultural requirements for sexy appearance. In their 'sweating like

a pig feeling like a fox' advert, feeling sexy ('like a fox') is disassociated from key constructs of looking sexy ('sweating like a pig') to produce a 'feel-good factor' in aid of encouraging more women to exercise that is not related to appearance or weight loss. In so doing, the campaign promised an active, pleasurable, hedonistic participation in exercise. But, despite its attempts at being a significant departure from the representations of fitness in other health promotion, critics noted that the campaign had a greater representation of younger, smaller, white female bodies and, in inviting the viewer to look at women's bodies, reproduced the idea that women's worth is in their bodies (Rice, 2007; Fullagar and Francombe-Webb, 2015; Hansson, 2015).

In our analysis above, we have shown how weight is a 'visibility' through which women understand and value themselves, with the conflation of weight with health part of a wider assemblage that includes government, medical, media and public discourses of women, both historical and contemporary. These discourses fuel a fat-shaming culture and are part of a wider judgemental culture facilitated by neo-liberalism in which all people are encouraged to feel anxious about their bodies, even as classed, racist and sexist discourse problematise some bodies over others. The breadth of this address is evidenced in the rise of 'skinny shaming', although we recognise the wider discrimination experienced by fat people. Alternative approaches are thus urgently needed and we explore some of these below.

Health at every size?

There are several alternatives to the weight equals health promotion approach. One example continues to reproduce the idea that weight is a proxy measure of health, but sees the route to achieving healthy weight through means other than directly focusing on weight restriction. This approach leads to projects that focus on reducing social inequalities, draw on discourses of pleasure rather than control, aiming to develop positive body image or shift the focus to exercise.

Projects that focus on reducing social inequalities highlight structural factors that affect weight levels of people in certain communities, particularly those with limited access to safe places to exercise and who also have 'over-access' to high fat and calorie foods that are likely to lead to higher BMIs in that population (Wilson, 2009). Such projects often attempt to raise consciousness about obesogenic environments, including systemic factors such as racism, weight discrimination, sexism, poverty, violence and safety. The aim is to facilitate change across individual, social and potentially political levels, should an outcome be successful government lobbying. As Kmiotowicz argued, the likelihood of people become obese is:

affected by factors like whether we have easy access to affordable fruit, vegetables, and other healthy foods and if it is safe to let our kids play outside. ... a government focus on personal choice alone is, at best, a red herring and, at worse, a dereliction of duty.

2013, p. 8679

However, a concern with this 'ecology' approach is that it also does not challenge the 'fat is bad' discourse, despite weight being a potential protective factor for poor women (Schorb, 2013). It also reproduces a white heteronormative ideal. Wilson (2009), for example, argues that black and lesbian communities often have greater acceptance of body diversity and that traditional health promotion which focuses on weight undermines such women's right to define and value themselves or to draw on their cultural valuing of larger women's bodies with its associated possibilities for positive body image.

A second set of projects that do not challenge the health equals weight argument but which seek to respond to high recidivism and low sustained weight loss in target populations shift the focus from weight to exercise. In these projects, people are encouraged to positively increase physical activity rather than see food as a negative restriction. But, critics of this approach argue that it enables unhealthy dietary practices, which Malhotra, Noakes and Phinney (2015) support in their assertion that 'you can't outrun a bad diet' (p. 967). They argue that a focus on exercise as a way to burn calories so that people can stay a 'healthy weight' while consuming whatever they want (including sugary drinks and junk food) is a position encouraged by commercial companies and goes against scientific evidence that suggests calories from sugar (rather than fat or protein) are linked to greater risk of lifestyle related illnesses such as type 2 diabetes.

Health promotion that focuses on exercise has also been criticised for their explicit or implicit weight-loss agenda. Low rates of physical inactivity in women are a health concern. For example, less than one-quarter of Canadian women are physically active (Scott-Dixon, 2008), while the statistics for England and Wales are 28% and 23%, respectively, for women who meet physical activity guidelines (Department of Health, 2011). But health promotion focused on exercise is often imbricated in a wider assemblage of healthism/weight and a moral obligation to work on the body and produce it in ways that meet culturally valued aesthetics. The potential for exercise and fitness to facilitate health and a sense of empowered embodiment for women as they enjoy what their body can do thus becomes lost as fitness is 'largely imagined in a very limited individualistic, apolitical sense that does not disrupt dominant ideologies or structures' (Scott-Dixon, 2008, p. 23). As Scott-Dixon (2008) describes in her own personal story around fitness, despite being an active child, the Canadian national fitness tests she was expected to compete in were met with dread because of the shame and humiliation she experienced attempting to meet standardised measurements of fitness that did not suit the way her body worked.

A similar pattern can be found in projects focused on aspects of health other than weight. For example, Rauscher, Kauer, and Wilson (2013) describe a programme focused on increasing body satisfaction and psychological wellbeing in a response to research that showed body dissatisfaction to be a risk factor for obesity (Cash, 2004). Thus, despite the programme's apparent non-weight agenda, its very existence was predicated on a concern around weight, a concern that was also reproduced by the participants in the programme and coaches who provided it. For example, the

participants engaged in 'fat talk' and concerns around weight loss were articulated and upheld as a legitimate health concern in interactions between the participants and the coaches. The researchers concluded that programmes focused on health need to overtly engage with how weight reduction issues structure sense making around health (Ensslin et al., 2016; Rauscher, Kauer and Wilson, 2013). Rauscher, Kauer and Wilson (2013) also found that neoliberal influences permeated the behaviour and language of the coaches and girls, with health constructed as an individual responsibility. Their talk reflected hegemonic identities relating to class and ethnicity, so that even in this ethnically diverse healthy living initiative, white, middle-class ideals of femininity (e.g. a 'good' body is small, slender and toned) were reproduced. Similarly, Michelle Obama's 'Let's Move' campaign shifted from putting pressure on food companies and supermarkets to offer healthier food, particularly in poor areas with limited access to fresh food, to one that advocated exercise and healthy food choices by individuals (Shen, 2013). Such examples show the way that projects seeking to produce an alternative to weight focused health promotion often reproduce the weight-health discourse and emphasise a controlled and disciplined body in line with neoliberal healthism.

Other approaches have more successfully challenged neoliberal healthism and its construction of health as predicated on disciplining the body. Such interventions focus on skilling-up participants to attend to the needs of their bodies (with the implication that it will then reach its 'natural' set point). Vogel and Mol (2014), for example, highlight a range of interventions that sought to train people to be sensitive to their needs and to the pleasures of food, cooking and dining, in order to make it easier to consume foods that are healthy and in the quantities needed. Vogel and Mol (2014) identified commonalities across practitioners, who, despite working with different models, shared the perspective that denial and control of food produces problematic relationships with food that are part of the weight-cycling process (e.g. if you have been 'good' this week, you may find yourself being 'bad' next week).

The commonalities across the practitioners included reframing appetite as a good thing because it allows knowledge of what the body needs to be satisfied; identifying satisfying foods (since they tend to be lower sugar and more nutritious); exploring where pleasures and satisfaction from foods come from and being attentive to emotions, both pleasurable and painful (something that many women have to relearn, given that femininity is often associated with denial of needs and we are culturally attuned to avoid negative feelings). Through engaging in such practices over time, people learn that they do not have to follow rules and or deny bodily pleasures, so that in cultivating sensitivity to pleasure they may develop resilience against obesogenic environments. Vogel and Mol (2014) thus offer an important alternative to thinking about consumption as a process of controlled discipline. However, the interventions they identify employ an individualistic approach, training people to negotiate obesogenic environments rather than challenge them. Vogel and Mol (2014) also recognised that these interventions did not acknowledge health inequalities (such as access to healthy food or the ability to afford it) or other

interpersonal and social factors such as eating with others and the middle-class values implicit in some of the dining advice. We note that there is also the possibility that 'eating what is good for you' can translate into just another neoliberal prescription around care of the self (see for example, Cairns and Johnson's (2015) analysis of healthy eating blogs).

The focus on developing healthy relationships with one's body is also articulated in the third approach we review, that of, Health at Every Size (HAES). HAES is located within Body Positive movements, which, for example, argue for 'taking up occupancy inside your own skin, rather than living above the chin until you're thin'.³ These movements share a vision of women being able to eat 'based on internal cues of hunger, satiety, and appetite; individual nutritional needs; and enjoyment, rather than on external food plans or diets' (Burgard, 2007, p. 43). They also value exercising for pleasure in physical activity and for health benefits. HAES also has a political standpoint, articulating a 'weight neutral' position that celebrates body diversity and lobbying governments about weight discrimination. The outcome is a politically informed feminist rejection of beauty/weight prescriptions without also rejecting issues of health, an issue that has concerned some feminists in relation to body acceptance arguments (Scott-Dixon, 2008).

The weight-neutral approach focuses on other factors linked with health, such as eating, exercise and self-care so that the focus becomes on facilitating health benefits known to be 'based on quality nutrition, regular physical activity, social support, restful sleep, freedom from violence and stigma, abstention from smoking and excessive alcohol and drug use, access to quality medical care' (Burgard, 2007, p. 47). Their diversity standpoint involves 'respecting and appreciating the wonderful diversity of body shapes, sizes and features (including one's own!), rather than pursuing an idealised weight, shape or physical feature' (Burgard, 2007, p. 42). The celebration of diversity and 'beauty and worth in EVERY body' stands in direct contrast to health promotion and commercial weight-loss organisations that evoke dislike of the current body and a future orientation to a different body. Thus, although there is an individual element to self-care, it is not tied into achieving a culturally normative ideal appearance.

HAES also directly challenges the lack of recognition in health promotion and wider public discourse of natural diversity in body size and shape, and the belief that fitness and fatness are mutually exclusive (a position supported by a range of other researchers, e.g. Rauscher, Kauer, and Wilson, 2013; Sykes and McPhail, 2008). These ideas also map to new developments in consumer research which suggest that some consumer groups are put off by thin models in advertising and mannequins, creating the opportunities for retail industries to represent greater diversity of body sizes as a commercial advantage (increasing sales, public relations and associated media coverage).⁴ These moves create an understanding that valuing diversity is an issue of equality, but what is less accepted is an understanding that diverse bodies may also be healthy. Thus, despite a range of criticisms of the BMI as a measure of health, including that it is a poor health measure at individual and population levels, the BMI remains one of our defining measure of health.

Conclusion: health is not a lifestyle

Neoliberalism, healthism and postfeminism combine to create a powerful and often painful lens on the body particularly around weight. Neoliberal healthism constructs health through individualist discourses of choice, risk and responsibility, articulated in such phrases as ‘your health your choices’. Being overweight is presented as a threat to individuals’ health and costly to the country’s health economy, positioning overweight people as irresponsible on a personal and social level, and the role of health promotion as reducing weight.

By using Foucault’s concept of bio-politics, we have considered how BMI is a measure by which we come to know ourselves and others, and thus a form of governmentality, producing particular understandings that we take up to make sense of ourselves and others, and which others take up to make sense of us and themselves. And we have shown how the contradictory evidence base regarding the risk factors of adiposity and the complexity of research findings looking at relationships between health and weight problematise the BMI. We are left unable to answer the question ‘what is a healthy weight?’. Is it better to be a BMI of 25 (recommended) or 27 (which is associated with better health outcomes) or to have an even higher BMI but with high body satisfaction and self-esteem (since these are also associated with positive health outcomes)? The notion of ‘healthy weight’ now seems so troubled that it is impossible to answer the question ‘what is a healthy weight?’. Furthermore, we should not ask it. In the exceptionally judgemental culture produced by healthism and an understanding of weight as a proxy measure of health, Wann argues ‘Just as Kurt Cobain of Nirvana (1993) sang, “Everyone is gay”, in a fat-hating society everyone is fat’ (2009, p. xv).

Deleuze and Guattari (1987) offer us a path forward when they recommend reframing the question, ‘what is it?’ to ‘how does it work and for whom?’. Rather than thinking about phenomena such as weight, diet or exercise as intrinsically or morally good or bad, Deleuze advocates investigating the ramifications and highly individual ways that people are affected, producing a local, embodied and personal ethics that resists generalisations and totalising judgements (Deleuze, 1988; Duff, 2014). Thus, we can ask about the capabilities, powers and capacities of affecting and being affected that certain intersections between discourses and materiality afford. Exercise may be affirmative for a fat woman who joins a football team, for example, by increasing her connectedness and capacities, but it may also disempower her through fear or experience of stigmatisation, mockery, and discrimination. When we ask, ‘what does it allow?’ we can explore the complexity of lived experience, explore how women can meet their needs in line with known health outcomes and offer a challenge when neoliberal discourses reduce these capacities.

We might also ask how discourses gain a ‘hold’ on us. We have reviewed the ubiquity of BMI and the range of ways the ‘health equals weight’ discourse is reproduced across assemblages of meaning around health, gender, psychology, citizenship and morality; we have also explored some of the ways that it can be enabling or offer direction for taking up positive senses of self in line with cultural

values. But why does fulfilling norms feel so good? How is it so hard to resist them even when we are critical of them? We take up these questions in the following chapter, when we explore how norms are not outside us, but used to construct our understanding of self.

Notes

- 1 For further discussion of power in Foucault's theory of governmentality see Chapter 4 in this volume. We also recommend Hook's (2004 pp. 239–272) discussion on power and subjectivity, and also Hook (2007) and Dean (1999).
- 2 www.nhs.uk/Tools/Pages/Healthyweightcalculator.aspx, retrieved 22/4/16
- 3 www.bodypositive.com/whatisit.htm, retrieved 28/1/16
- 4 www.bbc.co.uk/news/magazine-25402020

3

TECHNOLOGIES

Upgrading the body

Technologies facilitate how we make sense of our bodies. In the previous chapter, we considered how technologies can be used to measure and monitor weight. In this chapter, we further explore and expand the role of technology by examining the practice of two kinds of technologies, weight-loss surgery and female genital cosmetic surgery (FGCS).

We focus on weight-loss surgery and FGCS because they allow us to explore particular patterns in thinking about technology and health within a postfeminist sensibility. Both are controversial surgeries; they carry health risks that are rendered unnecessary within certain discourses. For example, weight-loss surgery is a ‘last resort’ surgery, while FGCS is legally conceptualised as sexual mutilation in some countries. Critics of these surgeries also argue that they reinforce inequalities experienced by women compared with men and between women across class and ethnicity, which fold women back into concerns about femininity and appearance and place white, middle-class aesthetics at the top of a hierarchy of values. Yet research also shows that these surgeries can be experienced as liberating and empowering for the women who undergo them, allowing women to feel more embodied, more in control, more ‘them’ (see Davis (1995) for an exploration of these arguments in relation to cosmetic surgery).

In this chapter, we consider weight-loss surgery and FGCS through Foucauldian concepts of technologies of production, self and subjectivity, as well as his thinking around governmentality, normalisation and confession. We use these ideas to offer a framework for why women might participate in weight loss and cosmetic genital surgery and how these surgeries can be constructed as health giving when located within the rationality of neoliberal healthism. In our analysis, we trouble this sense making and examine the way the desire to be understood as normal

can paradoxically create non-normative bodies. Throughout, we show how post-feminist sensibility ties into neoliberal healthism, so that the moral obligation to work on the body to meet cultural ideals becomes a normalised feminine practice, in which appearance-related body work becomes the route to health and the happiness of living a 'good life'.

The technologies we explore in this chapter also allow us to examine some of the complexities around agency, choice and empowerment that we have been developing in this book. Surgery is an agentic act that abdicates agency to the hands of the surgeon (Braun, 2007; Gilman, 1999) and, in this chapter, we explore how weight-loss surgery enables women to participate in the neoliberal imperative to take control by giving away control. Similarly, we explore how FGC Scan be framed as the act of an individual agentially working towards greater health and not as one of the few responses available to the women considering labiaplasty who appear to be operating in social and cultural contexts that are judgemental and homogenising.

In exploring agency and control, we show how a hope for the radical potential of technologies to facilitate new ways of being and alternatives to the historical devaluing of women have given way to concerns over normativity and conformity. The celebration of cyborg potential (Haraway, 1991) now seems a distant possibility within a drive to be 'normal', when 'normal' is attainable only through surgical intervention and an understanding of women's natural bodies as flawed. However, we conclude that more optimistic possibilities are opened up when we consider Foucault's thinking around normalcy that was less in line with governmentality and more in terms of an ability to be attuned to a range of possible norms.

Technologies: self, subjectivity, norms and experts

In this chapter, we use the term 'technologies' in different ways to develop our exploration of how women are working on their bodies within the context of postfeminism. The topics in this chapter, weight-loss surgery and FGCS, are what we might call 'material' technologies, physical tools that are used to act on or change the experience our world or bodies. To use a Foucauldian term, these are 'technologies of production' that 'permit us to produce, transform or manipulate things' (Foucault, 1988, p. 18).

To make sense of weight-loss surgery and FGCS, we also draw on two other Foucauldian concepts, technologies of subjectivity and technologies of self. Technologies of subjectivity refers to the ways that 'the subject [is] established at different moments and in different institutional contexts as a possible desirable, or even indispensable object of knowledge' (Foucault 1997, p. 87). Technologies of subjectivity are the discourses or ways of understanding the world that produce subject positions; that is, particular kinds of people who exist within certain discourses. For example, medical discourses produce the subject position of 'the morbidly obese' who, with a body mass index (BMI) of 40 or above (or 35 with comorbidities) is considered a candidate for weight-loss surgery. As we discussed in Chapter 2, neoliberal governments create a context in which people want to take

up particular subject positions because these subject positions are associated with living a 'good life'. People therefore usually seek to move towards preferred subject positions (e.g. 'healthy weight') and away from dispreferred ones (e.g. morbidly obese). To do so they employ 'technologies of self'.

Technologies of the self are practices that people employ on themselves to enable the take-up of a subject position. Foucault defined technologies of the self as those 'which permit individuals to effect by their own means, or with the help of others, a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection or immortality' (Foucault, 1988, p. 18). Undergoing surgery for weight loss or female genital cosmetic surgery, for example, are technologies of self, since people use these surgeries, with the help of others (such as surgeons), to move towards a more positively framed subject position associated within being healthy, attractive or, as we see below, 'normal' (Berlant, 2008; Coleman and Moreno Figuero 2010; Davis, 1995).

Normalisation is a core component in governmentality, the process by which governments create desire in people to 'choose appropriately' (Evans and Riley, 2014; also see Chapter 2 in this volume). Technologies of subjectivity enable normalisation by creating a 'regime of visibility' (Rose, 1996, p. 105) in which people are made sense of in terms of particular aspects of their being (e.g. their weight as a measure of health or the shape of their genitals as a measure of beauty). This sense making renders people 'knowable' in terms of these aspects (e.g. health/beauty) and allows them to be evaluated and then managed in relation to how much they conform or deviate against particular standards determined for these aspects (Rose, 1996). These standards are created by and distributed through various semi-autonomous 'dispositif': institutions, bodies of knowledge, disciplines, organisations and agents, who articulate these norms across public discourse, including women's magazines (e.g. Blood, 2005; Braun 2005) and cosmetic surgery websites (e.g. Moran and Lee, 2013). People then take up (or 'internalise') these ideas of what is normal or good to make sense of themselves.

Within neoliberalism, a key normative expectation is for people to be rational and to apply that rationality so that they can engage in self-management, working on themselves and taking up desired subject positions. This model of people as rational and autonomous is the dominant framework for health promotion, which works on the logic that if people are given information they will then act on it in a rational manner (Lupton, 2014b). There are, however, fundamental challenges to this conceptualisation of subjectivity. The challenge to autonomy is that people are located in a range of interpersonal relationships and socioeconomic contexts that structure their thoughts and actions (in relation to cosmetic surgery, see for example, Gimlin, 2012). The challenge to rationality occurs from the evidence that power often takes unconscious forms (e.g. Butler, 1997; Orbach, 2009) and those who suggest that emotions and rationality may be co-dependent and not opposed to each other (e.g. Burkitt, 2014). Another challenge is the argument that even if people were utterly rational when they make decisions, they do so within uncertain

contexts because there are contradictory discourses to negotiate and not all risks are known (e.g. Evans and Riley, 2014).

Neoliberal health promotion thus employs an overly simplistic model of human subjectivity. Yet when people fail to take up health promotion messages and keep one's body in line with normative expectations, it is constructed as individual failure: a failure to process information appropriately, a failure in rationality, a failure to be normal, and thus a failure to be able to position oneself as a good person living a 'good life'. Discourses that locate problems at the social level are discounted through individual arguments; magazines might create toxic environments for young women, but not everyone gets an eating disorder, thus those who do must have personal vulnerabilities. A similar argument is that high fat processed food might be cheap and easily accessible, but no one is taken to a burger bar at gunpoint (with apologies to Bartky, 1990, p. 75,¹ for our misquote). As Stainton Rogers (2011, p. 77) argues, this creates 'a "blame the victim" culture, where the poor, the obese, the dispossessed and the pathetic losers, the homeless and the stateless are held responsible for their misfortunes'.

Davies (2013), discussing Butler (1997), offers an explanation for how and why people internalise norms that construct them problematically. From a psychodynamic perspective, to have a sense of autonomous existence people must be recognised by another. In simplified terms, to know you exist in your own right, you need another person to recognise this (see Benjamin 1997; and Evans and Riley, 2014; Riley, Evans and Mackiewicz, 2016, for how this has been taken up in research on postfeminism). From this perspective, recognition is essential to self, but occurs on other people's terms. These terms come from the concepts that the people doing the recognising have internalised from their language and cultural communities, so that people are made sense of through a particular set of cultural lenses, what Rose (1996) calls a 'regime of visibility'.

Norms therefore become the way that we are recognised as to how well we meet cultural criteria of being an acceptable human. The dynamic between norms and recognition is why it can feel so good when we meet culturally valued ideals (for example, someone complimenting us on how we look), because it gives us a deeply needed sense of validation. However, as we explored above, neoliberal subjectivity requires us to understand ourselves as autonomous and rational, and Butler (1997) argues that this means that we must (in psychoanalytical terms) repress our knowledge of our dependency on other people (and their norms) for our existence. Instead, we understand these norms as part of our own values and thought processes, and they become part of us.

Norms provide the lens through which we see ourselves. Since we understand ourselves through these norms, we do not 'exist' outside of them. The outcome is a 'passionate attachment' (Davies, 2013, p. 24) to these norms, a longing to fulfil them and positive emotions when we do. It also means that to go against these norms in some way is to lose oneself. If, for example, you gained a sense of self from being the 'pretty one', what happens if you lose your looks or read feminist essays that argue looks are not important? If the norm that makes you is challenged, so too is your

existence, eliciting powerful emotions such as fear, anger, anxiety or disgust ‘toward the one (which might include oneself) who transgresses the norms and thereby risks destabilizing them’ (Davies, 2013, p. 24).

Not to be considered ‘normal’ and not to consider oneself ‘normal’ is thus very risky. It is to risk understanding yourself as problematic and to be construed as such in public. It is perhaps why the debates that have emerge around hashtags like #skinnyshaming and #fatshaming are so contentious, because the body is understood around a distinctly visible norm, creating a direct threat to subjectivity. To risk being fat shamed or skinny shamed is to fear others’ judgement and experience disgust and anxiety at one’s own body. No wonder then, that people turn to others who offer the hope of transformation and normalisation. Indeed, the process of seeking expert help is in itself a move towards a more acceptable subject position, since it represents the act of a rational, agentic and autonomous choosing to act on the self (Throsby, 2008).

Governmentality works on normalisation, but also confession. Within neo-liberal times, confession refers to the requirement for people who have failed to employ appropriate technologies of the self to ‘look inward’, recognise their psychological failings and engage in self-improvement with the help of experts (Brown and Stenner, 2009; Ringrose and Walkerdine, 2008). Neoliberal societies are characterised by a plethora of transformational experts. Such people may have professional qualifications but also need to demonstrate their experience or expertise though their own successful take up of culturally valued subject positions (for example, the way television show presenters embody success in makeover programmes, or have experienced the same hardships that become the topic of their shows, see Illouz (2003) for an analysis of Oprah Winfrey). Conversely, research shows that people are less likely to take advice from experts who themselves do not embody cultural ideals such as a fat doctor or nutritionist (Puhl et al., 2013), creating troubled identities for healthcare professionals as well as patients who do not meet thin ideals (Phelan, 2014; Puhl and Heuer, 2010)

Experts thus jockey for position as facilitators towards self-transformation and access to ‘the good life’. They are part of the diffused circulation of technologies of subjectivity, and act as facilitators of technologies of self. They may also drive the technologies of production; for example, in wielding the surgical knife. It is how these technologies are mobilised within postfeminist discourses of health that we explore in the following sections when we look at weight-loss surgery and FGCS. In the process, we address the question: within a postfeminist sensibility, what kinds of desire are produced through surgical technologies?

Striving for normalcy with weight-loss surgery

As we saw in Chapter 2, weight is culturally associated with health, beauty and morality. Unsurprisingly, then, weight management is a central concern for many women. Women experience vigilance and concern around food as a normative aspect of life (e.g. Green, Larkin and Sullivan, 2009; Throsby 2007), with surveys

reporting high proportions of women on diets. For example, Neumark-Sztainer et al.'s (2000) large-scale survey of thousands of Americans showed that 57% of adult women were on a diet, while a UK Mintel survey (2014) found 37% of women dieting 'most of the time'.²

In Chapter 2, we also discussed how government and commercial weight-loss programmes often construct weight loss as easy and possible through managing calorie consumption and exercise. Yet sustained weight loss is very difficult. For example, Ogden, Clementi and Aylwin's (2006) analysis of a range of studies showed that 90–95% of people who successfully lose weight through multidimensional behavioural programmes (that include dietary advice, behavioural skills training and self-monitoring) regained the lost weight or even gained more weight within three to five years (although for a more optimistic analysis, see Wing and Hill, 2001).

High levels of adipose tissue (which stores fat in the body) are associated with a range of health problems such as hypertension, type 2 diabetes and some cancers, as well as physical pain and movement problems (Greener, Douglas and van Teijlingen 2010, Ogden et al., 2005). Obesity is also associated with psychological problems, such as low self-esteem and confidence (Ogden et al., 2005), and social problems, including discrimination in workplace, experiencing social aggression in public spaces, social isolation and health inequalities (Puhl and Heuer, 2010). For example, healthcare professionals can have negative attitudes about patients who are overweight or obese (Budd et al., 2011; Swift et al., 2013), with patients delaying or avoiding seeking health care as a result. Even clinicians who treat patients with eating disorders have biases against overweight individuals (Puhl et al., 2013). An 'obesity epidemic' discourse also frames obesity in terms of a moral panic in which it is understood as 'a medical, financial and social problem ... [that] threatens individual, national and global well-being' (Throsby, 2007, p. 1562).

In this context, fat people are vulnerable to a range of discourses that position them as problematic. To avoid being viewed through this negative lens, they need to account for their larger size in ways that are understandable, often through explanations that shift responsibility away from them (e.g. that ill health led to weight gain or that their bodies metabolise food differently). Such accounts challenge associations between fat and moral failure, but not the idea that fat itself is a problem that needs solving through individual solutions. Indeed, to demonstrate their morality fat people must show that they are taking actions designed to facilitate weight loss (Ogden et al., 2005; Ogden, Avenell and Ellis, 2011; Throsby, 2007, 2008). One such action is weight-loss surgery. The entrenched fat phobic/stigmatising discourses around the fat body thus provide the conditions of possibility for surgery to be considered an important viable health option for fat women despite its attendant health risks (Throsby, 2007).

There are different kinds of surgical interventions for weight loss, the two most common being the gastric bypass and the gastric sleeve mastectomy. Gastric bands have also been used in the past, but are now considered less effective (Vogel, 2017). These surgeries limit the amount a person can eat through restriction of stomach capacity and/or the shortening of the intestine. This physical restriction reduces

the need to psychologically control eating. The gastric bypass reduces food absorption after ingestion, creating an unpleasant excreting experience when high-calorie food is ingested, which also acts as a negative feedback loop. In the UK, clinical guidelines suggest that surgery is offered to people who have a history of repeated failed attempts at weight loss and have a BMI over 40 kg/m² or over 35 where comorbidities are present. Statistics from the British Obesity and Metabolic Surgery Society (2017) show that the NHS performed 5704 bariatric surgeries in the UK in 2015/16, with data from previous years showing that 1316 gastric band insertions, 1618 gastric band maintenance procedures and 5407 bypasses were performed in 2011–12,³ representing a significant year-on-year increase for the previous five years (although there was a decrease in 2013–14,⁴ according to the Statistics on Obesity, Physical Activity and Diet: England, 2015 Report; Health and Social Care Information Centre, 2015). In the United States, the figures rose from 158,000 surgeries in 2011 to 196,000 in 2015 (American Society for Metabolic and Bariatric Surgery, 2016).

Surgery is thus a technical solution to a failure in self-management. People turn to surgery when they feel ‘out of control of their weight, out of control of any attempts at weight loss’ and thus need to hand control over someone else (Ogden, 2012, p. 281). Surgery also offers the possibility of a future self who can self-manage, since it requires the patient to learn new ways of eating. As such, we constitute surgery for weight loss as an ideal neoliberal solution: an agentic subject who through confession identifies a problem and enlists the help of experts to facilitate their move into a desired and normative subject position associated with health and happiness. For some, the outcome is transformative, like a miraculous rebirth into a ‘new’ person whose thinking and behaviour in relation to food is like a ‘normal’ person (Throsby, 2007, 2008; Ogden et al., 2005).

Research suggests that patients may look forward to a range of positive outcomes that include eating less but more healthier foods; feeling more control and enjoyment of food; increased self-confidence, self-acceptance and self-care, positive responses from others and greater energy and ability to nurture relationships, enabling for example, the sense of being a better parent (Throsby, 2007, 2008; Ogden et al., 2005). Listening to the experiences of patients who have undergone weight-loss surgery, Ogden’s team (2005, p. 277), for example, described becoming ‘increasingly impressed with the effectiveness of surgery ... as a positive treatment alternative’. The first large-scale, longitudinal quantitative study also suggested it to be effective for both weight loss and maintaining weight loss in comparison with conventional behavioural interventions (Torgerson and Sjöström, 2001). This review also showed that surgery improved quality of life and psychological functioning (including reduced anxiety, depression and use of antidepressants, and improved social interaction), but had mixed results about eating behaviour, for example, surgery was linked to a reduction in binge eating for only some patients.

Subsequent studies have, however, questioned the effectiveness of weight-loss surgery. For example, two reviews of the literature have suggested that weight gain occurs for between approximately 30–60% of patients within three years (Herpertz

et al., 2004; Magro et al, 2008), while other studies have shown that patients need more than one intervention for success (Ogden, Avenell and Ellis, 2011). Qualitative studies have also highlighted problems, finding that some patients reported eating less healthily, a continued sense of feeling out of control in their eating, or had developed ways to ‘cheat’ the surgery by, for example, consuming higher-calorie food little and often (Ogden, Avenell and Ellis, 2011; Ogden et al., 2005).

Weight-loss surgery also carries risks of chronic adverse effects and complications, which vary across different surgeries and include infection, malnutrition, vomiting, diarrhoea, heartburn, digestive and intestinal problems and, in a relatively few cases, death, estimated at 0.1–1.1% (Throsby, 2008). Indeed, all patients experience a period of post-surgery adjustment that may last several weeks (sometimes months) that includes feeling ill, sick, pain, hungry, dehydrated and a need to adjust to the new body, learning for example, how to eat in new ways that include small amounts, eating very slowly and avoiding high-fat foods and liquid with meals (Kalarchian, et al., 2008; Ogden, Avenell and Ellis, 2011). Paradoxically then, even when successful, surgery creates a ‘healthy weight’ through a process of ill health. The outcome is that National Institute for Health and Care Excellence (2009) guidelines have surgery as both the treatment of ‘last resort’ (Throsby 2008) and the ‘treatment of choice for morbidly obese individuals’ (National Institute for Health and Care Excellence, 2009 guidelines, cited in Ogden et al. 2011, p. 950). Despite this, the NHS website provides only success stories of creating a ‘new’ self on the outcomes of weight-loss surgery itself.⁵

Ogden et al.’s work suggests that complex issues of control are central to understanding the variation in success rates for surgery (defined as sustained weight loss and healthy eating practices; Ogden et al., 2005; Ogden, Avenell and Ellis, 2011; Ogden, Clementi and Aylwin, 2006). Paradoxically, patients need to feel that they gain agency over their eating by relinquishing control of their eating to, for example, the surgeon or to the stomach after surgery, which is subsequently understood as in charge of eating. Surgery thus produces a complex context in which agency can be located in the person seeking treatment, but this treatment requires them to relinquish agency (Vogel, 2017). But patients must also ‘buy into’ the surgery, so that this relinquishing of control is experienced as choiceful. To create a sense that the surgery is being done to the patient facilitates a sense of rebellion (leading to attempts to cheat the surgery) or a feeling that the psychological issues they managed through food are unaddressed (leading, for example, to continued emotional eating).

The dominant self-efficacy model of health that puts the patient in control often does not map to patient needs in this context (Ogden, 2012). Ogden’s (2012) research also highlights, for example, the importance of psychological support in facilitating post-surgery transition and the importance of both mind and body, since surgery was more likely to fail when patients felt that control was external (the surgeons or the surgery) and when they held a clear distinction between mind and body that left their body at the control of external forces but their mind independent and their own. Success then, was more likely when patients were able to

give up control of their eating to the surgery, but with a sense of ownership of the process and an alignment of their body and mind, so that a collaborative process between surgeons, surgery, patient, body and technology formed, enabling a kind of managed loss of control. Similarly, Vogel (2017) describes a private clinic insisting that its clients sign up to a range of pre- and post-surgery activities led by experts such as dieticians and psychologists, in order that the surgery might be more successful in producing significant and sustained weight loss.

Ogden's research highlights the importance of not neglecting the mind and of including the psychological aspects of the biopsychosocial model that underpins weight-loss surgery. But, focusing on the psychological issues that might affect surgery outcomes locates obesity – both the problem and solution – in the individual. This individualistic focus minimises considerations of the cultural context in which women develop 'disordered' eating, leaving these conditions unchallenged (Throsby, 2007). Approaches that do not focus on weight as a measure of health are also absent, including those that focus on inhabiting the body more fully, as defined in terms of taking pleasure in its functioning, including eating and exercise, and allowing the body to stabilise at the weight level where functioning feels good (see for example, the Health at Every Size approach discussed in Chapter 2).

Throsby (2007, 2008) also notes the way that the moral discourse around fat folds into a neoliberal norm of an autonomous, disciplined subject. The outcome is that those seeking surgery for weight loss are motivated to be not just healthy, but normal. One of Throsby's interview participants, for example, gave the rationale for her surgery as 'the desire to be "normal", to "eat what everyone else eats" and to "diet like a normal person"' (2008, p. 126). The irony then, is that the outcomes of surgery often distinguish those who undergo it from 'everyone else' in terms of their implied psychology as well as their physical functioning and appearance, as we discuss below.

When weight loss is attributable to surgery, people are vulnerable to being constructed as failing to meet the supposed norms of a disciplined subject with will-power. This attribution to a flawed psychology can create the emotional distress associated with failure to meet norms that we discussed earlier and is evident, for example, when Ogden et al.'s (2005) participant described her surgery as represented self-mutilation and a betrayal of values and Throsby's (2008) participant whose weight loss was considered 'cheating'.

Weight-loss surgery also distinguishes people in terms of their physical functioning. After surgery, people have to eat abnormally small meals (that need to be accounted for when eating with others) and may experience physiological effects that cannot be disguised or disguised easily, such as uncontrolled bad-smelling flatulence or being sick. The bodies of those having undergone surgery may also be experienced as non-normative. Informal conversations we have had with women who are obese in the course of writing this book point to particular tensions about weight and appearance, and the traps of the intense decontextualised focus on weight. For example, one woman who underwent surgery told how her 'before' fat body looked like how you would imagine it without clothes. In contrast, the slim

post-surgery body appeared normal in clothes, but naked was as wrinkled as one might expect on a woman 50 years older. For her, the offer of normalcy through surgery was therefore an illusion. Similarly, another women argued that swapping one object body for another (a fat one for one with loose skin) was a disincentive to lose weight.

The transformations promised by weight-loss surgery are therefore not easy or without significant risks, not just in terms of health, but also in terms of normalcy. The rapid weight loss produced by surgery has further implications for appearance-related normalcy, since its outcome can be significant hanging folds of redundant skin. Body contouring surgery needed to remove what can be between 10–15 pounds (4.5–6.8 kg) (Al-Hadithy, Aditya, and Stewart, 2014) of this ptotic skin is not considered to be part of the surgery. Although there are now some guidelines for post-bariatric body contouring, this is not part of the standard bariatric surgery pathway in the NHS in the UK (Highton, Ekwobi, and Rose, 2016). Some primary care trusts do fund this surgery but only for functional or health problems associated with redundant skin and not for cosmetic reasons or for psychological distress related to the appearance of the post-weight-loss body (NHS Wales, 2016). Weight-loss surgery thus offers a rare example of a separation of feminine appearance concerns and health, which sits in contrast to post-cancer breast reconstruction surgery (where a conflation between health and appearance creates the context where women find it hard to refuse surgery (Frith, Harcourt and Fussell, 2007; Gillespie, 1997)).

Without the thousands of pounds to pay for body contouring surgery, women may be left with flapping skin and failed aspirations that their weight loss would allow them the pleasures of fulfilling feminine attractive norms or simply being ‘normal’. Unsurprisingly then, research comparing those who have post-bariatric surgery body contouring with those who receive only bariatric surgery find body contouring associated with a range of positive outcomes including better social interaction, less smoking uptake, increased exercise and enhanced career prospects. Such findings are being used as an evidence base to challenge the construction of massive weight-loss body contouring as a ‘purely aesthetic surgery’ (Al-Hadithy, Aditya, and Stewart, 2014). In the section below, we explore this idea further, asking if, in the context of established historical associations between femininity and appearance and the way norms structure our ability to construct a positive subjectivity, can there be a purely aesthetic surgery?

Female genital cosmetic surgery – choice in what context?

FGCS is a set of cosmetic surgery procedures, popularly referred to as a ‘designer vagina’. These procedures include a set of genital alterations whose primary function is to change the look of a woman’s genitals. Motivation for changing the look might, however, be functional or psychological, such as increasing orgasmic function, removing discomfort or enhancing pleasure by reducing anxiety about negative judgements from intimate partners. Braun (2005, p. 405) lists a range of

female cosmetic genital surgeries, including labiaplasty, labia majora ‘augmentations’, liposuction, vaginal tightening, clitoral hood reductions, clitoral repositioning, G-spot ‘amplification’ and hymen reconstruction. These surgeries involve a range of procedures such as tissue removal and injections of fat or collagen.

Female genital surgery whose rationale is sexual functioning or which blurs appearance and sexual functioning has a long history in Western and non-Western cultures. For example, after childbirth gynaecologists used what became known in the 1950s as the ‘husband’s stitch’, to make the vagina narrower and purportedly increase vaginal sensation and sexual satisfaction for both partners. ‘Vaginal tightening’ surgeries and non-surgical alternatives remain common, although the efficacy and long-term effects are not well studied (Dobbeleir, Van Landuyt and Monstrey, 2011). However, for the purposes of thinking about FGCS through the lens of postfeminism, it is useful to distinguish it from other contemporary genital surgeries whose primary focus is sexual functioning, gender reassignment, changing the appearance of intersex individuals, or practices which are categorised as female genital mutilation (FGM; although later we explore the usefulness of comparing FGCS and FGM).

The most common form of FGCS is labiaplasty, which involves a reduction of the degree of protrusion of the labia minora (Sharp, Tiggemann and Mattiske, 2015; Veale et al., 2014). The number of women undergoing labiaplasty has rapidly increased in recent years. American research suggests a 64% increase between 2011 and 2012, while Australian and UK statistics show a 2.5–5-fold increase in labiaplasties between 2000 and 2010, with, for example, 2000 labiaplasties being performed in the NHS in 2010.⁶ In 2016, 138,033 labiaplasties and 55,606 recorded vaginal rejuvenations were performed worldwide. The top countries were Brazil, USA, Russia, Turkey, Colombia, Mexico, India and five European countries (not the UK; International Society of Aesthetic Plastic Surgery, 2017). In the United States, labiaplasty is the nineteenth most common procedure, with a 23% increase in the number of labiaplasties in the United States between 2015–2016 (International Society of Aesthetic Plastic Surgery, 2017). These statistics do not include private clinics where most cosmetic surgery occurs, so the true number is not known and is likely to be much higher (Runacres and Wood, 2015; Sharp, Tiggemann and Mattiske, 2015; Veal et al., 2014). Although Sharp, Tiggemann and Mattiske (2015) note that there are at least five more popular cosmetic surgery procedures than labiaplasty, cosmetic surgery organisations such as the California Surgical Institute report some findings of labiaplasty being the third most common cosmetic surgery after face lifts and breast augmentation. The rise in labiaplasty is despite risks that include bleeding, infection, tissue scarring, reduced sensitivity or painful sex.⁷

Motivations of women seeking labiaplasty can be categorised into four: functional, aesthetic, sexual and psychological, although these categories may blur; for example, concerns over aesthetics might reduce sexual enjoyment (Sharpe and Tiggemann, 2016; Veale et al., 2014). Functional reasons include ‘discomfort, irritation or pain during (nonsexual) activities’ (Veale et al., 2014, p. 831) and might be associated with, for example, labia minora rubbing uncomfortably against tight

clothing (Bramwell, Morland and Garden, 2007; Sharp, Tiggemann and Matiske, 2015). Aesthetic, sexual and psychological reasons are associated with thinking that one's genitals are ugly, abnormal or 'untidy'. These concerns can create negative feelings about one's body, including anxiety and disgust. In turn, such feelings can increase self-consciousness or concerns about negative evaluations from others in public places or while being intimate with a partner (Bramwell, Morland and Garden, 2007; Veale et al., 2014).

Although surgery may address functional issues such as reducing physical discomfort, concerns about the labia's appearance are the most commonly reported motivation for this surgery (Sharpe and Tiggemann, 2016). However, measurements of women seeking labiaplasty suggest that the vast majority have genital size and shapes within a normal range, in the context of there being a wide diversity in size, shape and appearance considered normal (Lloyd et al., 2005).

The literature on motivations and predictors of labiaplasty highlight the social factors involved in women's decisions to undergo surgery. Social interactions are shown to influence a woman's decision to undergo labiaplasty; for example, negative comments from partners about genital appearance correlated with consideration of labiaplasty, while '(c)onversations about genital appearance with friends may direct women's attention to this issue, reinforce its importance, and advocate genital appearance ideals' (Sharpe, Tiggemann and Matiske, 2015, p. 190). This work, combined with others (e.g. Bramwell, Morland and Garden, 2008; Sharpe and Tiggemann, 2016) also suggested that seeking a partner, seeking a partner's approval and wanting more sexual confidence were predictive motivators for this surgery; in contrast, 'being involved in a satisfying romantic and/or sexual relationships actually protects women from considering surgery' (Sharpe, Tiggemann and Matiske, 2015, p. 190). As such, this work highlights a judgemental culture in a world of body scrutiny that is particularly harsh for women, given that women make up the vast majority of cosmetic surgery clients, at up to 90% in the United States (Sharp, Tiggemann and Matiske, 2015).

In the research described above, we see a complex merging between technological innovations that have allowed a mass market for labiaplasty and more traditional constructs of femininity, such as seeking to 'improve' the look of one's body for the approval of men. Postfeminist constructs of the self-defined, agentic and empowered woman seem far removed from such traditional notions of femininity. In such a context, how are these differing and contradictory ideas made to seem coherent? The research discussed above shows the importance of understanding women's reasons for surgery within the wider context in which they occur, including the role of media, norms and relationships. But to better understand the increase in cosmetic genital surgery, we argue for a need to contextualise these practices within postfeminist expectations to work on the body through consumption.

Within the postfeminist expectation to work on the body, FCGS can be positioned at one end of a continuum of bodywork practices (Braun, 2005; Tiefer, 2008). The focus on the genitals as a site for body work is associated with increasing concerns around genital appearance produced by fashions that draw attention to

this part of women's bodies, such as thong underwear; developments in hair removal, such as Brazilian waxing and laser hair removal; increased access to pornography, cosmetic surgery websites and media representations of FCGS itself – for example, in articles on the 'designer vagina' – all of which make the vulva more visible, and often a vulva that has had some technological intervention, including airbrushing to reduce the size of the labia minora (Braun, 2005; Rodrigues, 2012; Moran and Lee, 2013; Sharp, Tiggemann and Mattiske, 2015, Tiefer 2008). Although these media representations and cultural fashions do not automatically get taken up by women uncritically (otherwise, how else would we, as women, be able to discuss them?), there is necessarily a shaping of subjectivity in line with wider cultural discourses (see Gill 2007a, for a discussion of 'critical respect'). We see this as a dynamic process, which includes mediation between technologies of subjectivity and technologies of the self.

The increased visibility of the vulva encourages women to compare their appearance with others within a consumerist regime of visibility that may limit the kinds of images women see by not showing the range of normal diversity or by constructing the 'natural' female body as problematic in ways that elicit negative affect (e.g. disgust, horror). For example, for a time during the writing of this book, Australian laws prohibited images of larger labia majora, exposing viewers to airbrushed images that normalise small labia majora, while cosmetic surgery websites show a diverse range of 'before' images that are rendered problematic in contrast to 'after' photos that repeat a much less diverse ideal (Moran and Lee, 2013; Sharp, Tiggemann and Mattiske, 2015). Thus, we have an increased visibility of a homogenised vulva, which provides motivation for technological intervention.

The increased focus on the vulva is also part of a wider visibility of female sexuality that can be traced to second-wave feminist celebrations of female sexual agency and the subsequent development of postfeminist new sexual subjectivities, such as the 'sexual connoisseur' and 'pleasure pursuer' (Evans and Riley, 2014). New sexual subjectivities map to neoliberal discourses of self-transformation so that 'the pursuit of (more and better) sexual pleasure is situated as a legitimate, or even obligatory ... pursuit for the "liberated" (sexual) subject' (Braun, 2005, p. 414; also see Chapter 6 in this volume). Such accounts enable FCGS to be positioned as a technology to achieve this goal through accounts which position women who undergo such surgery as agentially acting on the self to enhance their own sexual pleasure (Braun, 2005).

There are also significant commercial and media influences in the new visibility of the vulva. Media analyses of FCGS highlight the twin processes of normalisation and problematisation, and the way that discourses tied to commercial interests are presented as neutral information. Normalisation works by exposing women to images and discourses that construct cosmetic surgery as normal. Magazine articles, for example, represent FCGS as new, trendy and increasing popular (Braun 2005). Problematisation, on the other hand, happens through a narrative structure of 'problem named, solution offered'. For example, magazine articles suggest women's genitals should be symmetrical and, if they are not, they can be 'corrected'

with surgery. Constructing such a problem thus creates a sense of deficiency in the reader, who then turns to the solution suggested (for further discussion of the problem–solution structure in media representations of women’s bodies see Bordo 1993b; Braun, 2005; Tiefer, 2008).

Commercial interests encourage the problem–solution pattern in media representations of cosmetic surgery. Tiefer (2008), for example, highlights a blurring between medical, business and media representations of FGCS produced by deregulation and consumer lobbying. These changes allowed direct-to-consumer advertising in the United States and subsequent rebranding and intense advertising of cosmetic surgery that created ‘a seismic shift within plastic surgery from a medical necessity model to a business model’ (Tiefer, 2008, p. 467). Within a business model, surgeons need to encourage consumer demand, which they do through overt and covert advertising. The latter includes problem–solution articles and surgery reviews from journalists who received undisclosed free procedures from the surgeons they wrote about, creating hidden conflicts of interest (Tiefer, 2008).

Along with other researchers (e.g. Sharpe, Tiggemann and Matiske, 2015), Tiefer (2008) also identifies the ‘makeover’ TV format as an important site for marketing FGCS (e.g. *Extreme Makeover*, *The Swan*, *Dr. 90210*). These shows have global coverage through national network agreements and YouTube uploads, and work to ‘educate viewers as to the expanding menus available to glamourize, feminize, and normalize’ (Tiefer, 2008, p. 469). Moreover, the focus is on instant success, with before and after story arcs minimising the recovery process, including ‘the full reality of pain, recuperation, unpaid time off from work, medical complications, and mixed reactions from friends and family’ (Tiefer, 2008, p.469). For other discussions of ‘minimising narratives’, see Banet-Weiser and Portwood-Stacer (2006), Tait (2007) and Leve, Rubin and Pusic (2012).

Extreme makeover television programmes capitalise on the transformational ‘makeover’ language of postfeminism that locates happiness in appearance and bodily transformation and is ‘precisely about making *visible* the technologies used to construct self’ (Banet-Weiser and Portwood-Stacer, 2006, p. 263; also see our discussion of cruel optimism in Chapter 5). Similarly, various media celebrities contribute to the normalisation of cosmetic surgery through aspirational transformational postfeminist discourses of perfecting the body so that cosmetic surgery is represented as ‘accessible and healthful, forward-looking and medically legitimate’ (Brooks, 2004, p. 215, cited in Leve, Rubin and Pusic 2012, p. 125; for a similar argument also see Braun and Kitzinger, 2001). Such accounts enable a construction of appearance as intricately bound up in health and psychological wellbeing, since appearance-related body work becomes the route to mental wellbeing and happiness. The scene is thus set for FGCS to be understood as the act of individuals agentially working towards greater health and not as one of the few responses available to the women considering labiaplasty who appear to be operating in social and cultural contexts characterised by unsupportive relationships and an appearance focused judgemental culture that does not tolerate normal diversity (Sharp, Tiggemann and Matiske, 2015).

Associations between health and FGCS are further enabled through constructing appearance concerns that affect sexual confidence as a psychological problem, solved with medical intervention. Braun's (2005) analysis of media and surgeons' accounts of FGCS showed a reoccurring pattern in which women's concerns about how their genitals looked made them tense and anxious in ways that impeded sexual pleasure, particularly to orgasm or to receive cunnilingus. Framed in this way, FGCS was constructed as a medical solution to 'good' (healthy/happy) sex that was impeded by psychological concerns regarding appearance. As Braun (2005) and others have argued, this places sexual pleasure at the level of the individual body, rather than a dynamic between people whose embodied experiences, actions and relationships are themselves located within wider sociocultural sense making. The outcome of this decontextualising of sex is that medical intervention becomes the answer to a psychological issue, presenting cosmetic surgery as a form of psychological therapy. The mind is 'constructed as impervious to change *without* surgery ... Cosmetic surgery is thus about changing the body to change the mind' (Braun, 2005, p. 416; also see Gill and Elias, 2014, and our analysis of the links between the orgasmic imperative, 'good sex' and health in Chapter 4).

The construction of FCGS as a medical solution to an individual problem absents social solutions and leaves structural inequalities in place. For women, this means that, through FCGS, attention is focused away from relationships and issues of love, trust and acceptance in sexual relationships, away from questions about gender relations and why women's natural bodies are rendered problematic and towards the business interests of seeding body anxieties as requiring costly 'treatment'. Individualist 'choice' and medical discourses legitimise FGCS, counteracting arguments that women who have FGCS are cultural dupes following fashion, or victims of patriarchy (unlike, for example, understandings around the 'husband stitch'); they also work to distance FCGS from FGM.

In reducing concerns about appearance, FGCS may enhance sexual pleasure⁸ but, as Braun argues, it 'is a freedom to enjoy sex within a very limited frame of reference' (2005, p. 418). In this limited frame of reference, FGCS is presented as enhancing a very particular kind of heterosexual sex, often with specific focus on coitus that leads to orgasm. What is absent then, is 'other ways in which sex could be more pleasurable – e.g. more fun, more intense, more relaxed, more intimate – were relegated to second place, if any, behind orgasm' (Braun, 2005, p. 415). Lesbian and bisexual women's experiences are often excluded in constructions of sex enhanced by FGCS and, while FGCS is tied to women's sexual pleasure, the focus of men's pleasure from women's bodies is not absent. For example, women's sexual pleasure is predicated on men liking the look of her genitals enough that she can feel comfortable to relax and enjoy sex. There are also more obviously sexist discourses associated with FGCS. See for example, FCGS surgeon David Matlock, who is reported as saying in his promotional videos that following a labiaplasty 'she is like a 16-year-old now' (Tiefer, 2008, p. 469, citing Spivak, 2006).

The limited shape and appearance of post-FGCS bodies also highlights the limits of the 'choice' discourse. The neoliberal self as a project is not a free self,

but one enmeshed in governmentality that works through norms and confession that structure the choices women make and the direction of their desires. FCGS creates a similar 'expectation' to which women should aspire, problematising the wide variations in clitoral and labial length, width, colour and wrinkledness (Lloyd et al., 2005). FCGS thus 'becomes a practice of changing women's diverse bodies to fit a certain (male-oriented) aesthetic of what women's genitals *should look like*' (Braun, 2005, p. 413, italics in the original), raising concerns that women are using 'technologies to conform to a narrow, restricted cultural ideal' (Elliott 2003, p. xviii, cited in Tierfer, 2008), a cultural ideal that emerges out of a long history of problematising women's natural bodies. To address this concern activists such as the NewView Campaign have attempted to raise greater consciousness over the role of the discourse of choice in hiding normative social influence, arguing that 'the argument is not choice versus protection, but choice in what context?' (Tierfer, 2008, p. 474). Their activities include calling for a ban on direct-to-consumer advertising of drugs, publicising conflicts of interest and campaigning to increase consciousness about the medicalisation of sexuality through range of actions from ridicule to arts-based practice.⁹

A different approach was taken by Sharp and Tiggemann (2016), who developed online photograph and video resources that exposed women to the variation in normal female genital appearance and raised an awareness of digital airbrushing of women's genitals. Another potential source of activism is to make the connection that FGCS surgeons work hard to avoid, which is the similarities between FGCS and FGM. FGCS surgeries are problematised when seen through the lens of legal bans of FGM, especially when the World Health Organization's definitions of FGM make it hard to distinguish between the two.¹⁰ Scandinavian law, for example, bans any surgical modification of external female genital organs, considering it to be 'sexual mutilation', regardless of consent.

Making the link between FGCS and FGM also allows analysts to explore the racist implications of laws against African FGM that are not mobilised in cases of western FGCS (Essen and Johnsdotter, 2004; Sheldon and Wilkinson, 1998). The challenge to FGCS also comes from first-person accounts of African women who draw similarities in how surgeons talk of FGCS ('nice', 'clean', 'neat', 'marriage saving') with the 'beautifying', 'husband pleasing', 'clean' terms used by African women conducting female circumcision/FGM as a cultural practice (Olujobi, 2009).

Distinctions between FGM and FGCS hang on issues of consent and choice. However, as we have seen above, discourses of autonomous consent are easily challenged when we consider the wider sociocultural and commercial context in which Western women make decisions. Thus, although we should not want to dismiss accounts of choice and liberation that some women experience through FGCS, we can also explore how discourses of choice and freedom that women use to make sense of themselves are part of wider neoliberal discourses of what it means to be a good person. If we take ideas of governmentality seriously, women's decisions making around FCGS must be understood in the context in which they

are encouraged to understand themselves in particular ways that increase the likelihood of seeing surgery as an individual solution to an individual problem.

Conclusion

The technologies explored in this chapter highlight the roles of normalisation and problematisation of the female body in how women come to make sense of health within a postfeminist sensibility. Not to be normal is a risky position (Davies, 2013). It is risky because we live in a context that encourages women to direct their desires in particular normative ways. It is also risky because the neoliberal cultural imperative to work on the body constructs those who do not transform their bodies as irresponsible and weak-willed failed subjects. These risks are important when understanding what we might consider the 'push' factors in women's decisions to have surgery.

But equally it is important to understand the 'pull' factors. Postfeminism is informed by neoliberal sense making which constructs the body as malleable and promises health and happiness with transformation. Furthermore, this does not happen only at an individual level, but is bound up in wider social structures and interactions. To construct oneself through bodily transformation, and so through structures of governmentality, means being recognised by others within the realms of intelligibility, and there are clear pleasures associated with being normal. Weight-loss surgery and FGCS provide women with an opportunity to have positive rather than negative appraisals by others of their most intimate body parts. In an individualist judgemental culture, it might seem easier and more fulfilling to change oneself than try to change culture (Tierfer, 2008, p. 474; Haiken, 2000; Raisborough, 2007; Riley and Scharff, 2013).

The postfeminist promise of transformation can be considered a form of cruel optimism, however. Transformation directs hope and desire towards what Ahmed (2010) calls 'happiness objects' that have limited potential to fulfil us. The freedoms of the postfeminist promise then, are limited freedoms, they are freedoms to conform to particular ideals and enjoy the acceptance that this conformity brings. Yet even conformity is not a risk-free option. The multiple discourses in any society mean that conformity may be celebrated through some discourses and critiqued through others. Women who undertake surgery are vulnerable to a range of critiques, including being constructed as cultural dupes (as was seen in early feminist analysis of cosmetic surgery) or uncritical or tacky followers of fashion (see, for example, the media critique of working-class women and vajazzling (decorating one's pubic area e.g. with rhinestones) in the UK reality entertainment show *The Only Way is Essex*). Moreover, the work is not complete once a technology (surgery or otherwise) has been applied to the self. Weight-loss surgery and FGCS technologies are presented to women as aids for a healthier, happier and 'better you', but they work on the premise that desire is never fully sated through consumption (Evans and Riley, 2014). In the market of vulva beautification, for example, an increase in FGCS, hair removal and other intensive treatments have created the

need for ‘vagacials’ (i.e. a facial for the vulva). The consumer context in which work is done on the self for health and appearance thus constructs health in terms of ongoing work on the self through an expanding set of technologies. Appropriate ‘health’ has to be constantly striven for.

A further issue with neoliberal discourses of the malleable, constantly transformable body is that narratives around surgery become minimising. Reality TV, the ‘before and after’ format of transformation and other mediated representations of surgery present it as an easy and straightforward option to ‘fix’ a range of social problems. But, as Negrin (2002) argues, the body is flesh and blood: it bruises, it gets infected and, ultimately, it is not possible to transcend the body. The way the use of cosmetic surgery instrumentalises the body creates an alienation from our bodies, as we seek to control, conquer and transcend; attempts that must ultimately fail with the inevitability of age and death (Bauman, 1992). One option is of course to work harder at control and develop technologies further, but another is offered through thinking about Foucault’s concept of normalisation.

Brown and Stenner (2009) argue that Foucault was familiar with two ways of thinking about normalcy. The first has since been developed by Rose (e.g. 1990, 1996) to form part of governmentality as outlined above. The second is informed from the work of Canguilhem, a biologist who examined Foucault’s PhD thesis who considered the capacity for normativity as the ability to be attuned to a range of possible norms (Canguilhem, 1966/1989). From this perspective, healthy people are those who can adapt and shift between different norms so that they can respond to the challenges of, and changes in, the environment flexibly (in contrast, ill people are not adaptable). This standpoint suggests that humans have many possibilities that intersect with the contemporary discourses of the time to produce particular ways of making sense of ourselves. The solution to contemporary concerns from this perspective is to ask what are our other capacities that we are not focusing on when we understand ourselves through neoliberal rhetoric?

Bodies in a neoliberal rhetoric are individualising and objectifying. For example, feminist analysis of the body has demonstrated the way bodies are treated in parts, with women’s bodies compartmentalised and objectified in the context of cultural inequalities. In Moran and Lee’s (2013) analysis of FGCS websites, for example, and in our own discussion of fetus photographs in Chapter 5, the body is seen as separable, distinct and isolated. What if we were to reimagine these technologies? For example, in seeing the image of the fetus as intimately bound up in the body of the pregnant woman? We know from our experience of our bodies that they are not fundamentally self-contained. Sweat, for example, demonstrates that the boundary of the skin is not as contained as many of us like to think. Our skin is also absorbent. As Haraway (1991, p.178) has pointedly asked, ‘[w]hy should our bodies end at the skin, or include at best other beings encapsulated by skin?’.

Such a view might be afforded for us through Tiefer’s (2008) suggestion that technologies be used alongside a heightened understanding of bodily relationships

and our capacity to care and connect. Through a focus on the connectedness of body, we might be able to develop more the boundary between the normalising discourses we culturally live by and the possibilities of alternative constructs. In doing so, we might also want to construct different notions of what freedom is, beyond postfeminist, consumerist and individual constructs of a self-serving freedom, but where we might practice ‘freedom to make oneself through a continuous exposure – to put some holes in the “skin” stretched between the various technologies that afford selfhood’ (Brown and Stenner, 2009, p. 173). Through this framework, we might be able to imagine technologies of production less through a Foucauldian pessimism (trapped in discourse, unable to escape the symbolic or the realms of intelligibility) and more through an affirmative exploration of ‘what the body can do’ (Fox, 2016).

Before we develop this account further, however, we want to take some of the ideas presented above with us into the next chapter. The role of technologies of production and self as tools for normativity that direct us to ‘healthy’ subjectivities that are befitting a market economy are also important for understanding sex and sexuality. As the site of intense surveillance, monitoring and disciplining, sex has been understood as a central mechanism in shaping good life narratives and postfeminist promises of the normative, healthy and happy life, seemingly set free from the restrictions of feminist critique due to developments in more equitable relationships. A healthy sex life has become imbued in medical and healthism discourses. It also becomes an important construct around which postfeminist sensibility orients, through notions of the free, liberated and sassy twenty-first-century woman.

Notes

- 1 ‘no one is marched off for electrolysis at gunpoint, nor can we fail to appreciate the initiative and ingenuity displayed by countless women in an attempt to master the rituals of beauty’.
- 2 <http://news.bbc.co.uk/1/hi/health/3454099.stm>
- 3 www.nhs.uk/news/2012/08august/Pages/gastric-bypass-surgery-up-fivefold-in-six-years.aspx
- 4 www.hscic.gov.uk/article/6095/More-than-half-of-inpatient-bariatric-surgery-procedures-performed-on-adults-aged-45-to-64.
- 5 see ‘Vicky’s story: My gastric band surgery’ www.nhs.uk/Livewell/loseweight/Pages/My-gastric-band-weight-loss-surgery.aspx
- 6 www.bbc.co.uk/news/health-24942981
- 7 www.nhs.uk/conditions/labiaplasty/Pages/Introduction.aspx#risks
- 8 And at first glance FGCS seems to work. Patient satisfaction appears high. Veale et al., (2014), for example, conclude that labiaplasty appears effective in improving genital appearance and sexual satisfaction. However, possible biases in the sample suggest a need to be careful with this finding. Of the potential 112 women approached who received labiaplasty, only 49 agreed to take part, which reduced to 23 who did the final follow-up that occurred between 11 and 42 months, with the dropout rate partly attributed to a bias of women who did not want to answer intimate questions. Other studies

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have retrospective design problems, no comparison groups or do not use standardised measurements (Veale et al., 2014). Tiefer (2008) also warns that we should interpret research that finds high satisfaction for FGCS against the backdrop of limited forms of short-term assessment and the refusal of many surgeons to publish research on their work because of commercial interests.

9 <http://newviewcampaign.org/vulvagraphics.asp>.

10 The WHO defines FGM as 'Female genital mutilation (FGM) includes procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons'.

4

SEX

Liberating women

Postfeminism celebrates women as adventurous, sexually liberated and knowledgeable (Evans, Riley and Shankar, 2010; Evans and Riley, 2014; Harvey and Gilland, 2011), allowing new sexual subjectivities to emerge, such as the ‘sexual connoisseur’ and ‘pleasure pursuer’ (Evans and Riley, 2014). Within postfeminism, women are expected to know and meet their sexual needs without shame and to use their ‘erotic capital’ (Hakim, 2010) to get ahead. Women might enjoy porn, own sex toys and seek to be remembered as an amazing lover. While, an active sex life is now part of living a healthy life, tying sex with psychological and physical health.

The celebration of female sexual agency within postfeminist sensibility was built on twentieth-century second-wave feminist challenges to previous cultural idealisations of passive female sexuality. Postfeminist sexuality is also tied to consumerism and an increased cultural visibility of sex evidenced in the availability of porn, ‘lads’ magazines, ‘hypersexual’ women’s fashions and advertising, and greater reference to women’s sexuality across a range of media and social media (Gill, 2008b; Tolman, 2012). Tied into a neoliberal discourse of self-transformation, twenty-first century sex became part of the project of self, something women should take pleasure in and work on in order to understand themselves as healthy, productive, and empowered (Braun, 2005; Evans and Riley, 2014; also see Chapter 3).

From one perspective then, postfeminist sexualities are evidence of women’s sexual liberation, a liberation that we might trace from Victorian prudishness, to twentieth-century passivity, to twenty-first-century agency. But, in *The History of Sexuality*, Foucault (1978, 1990) questions the idea that previous eras were sexually repressed or restricted. Calling this the ‘repressive hypothesis’, Foucault argued that thinking about previous eras as less sexually liberated masks the various material and discursive practices that repress us. In his second volume of *The History of Sexuality*,

Foucault (1990) takes us back to the Ancient Greeks and suggests an ‘art of the self’ that was much less concerned about sexuality than we are today. Foucault’s work on sexuality was, in part, a response to the 1960s being labelled as a sexual revolution, but we can also draw on his thinking to consider the way postfeminist celebrations of women’s sexual agency might reduce women’s capacities for action.

In this chapter, we therefore draw from Foucault to provide a theoretical framework for thinking through some contemporary issues around sex and women’s health. We apply this framework to provide an analysis of ‘sexperts’ advice and associated sex apps; contemporary representations of female organism; and the medicalisation of sex, as seen in the development of ‘pink Viagra’. In so doing, we build on our previous chapters’ analysis of norms, confession and disciplinary power to consider further the role of monitoring, self-surveillance and expert knowledge in postfeminist sensibility. In our analysis, we highlight the way that sex is a central organising feature of women’s subjectivity within postfeminism, and argue that this works as a form of ‘regulation through empowerment’ that is market oriented and differently experienced across the lifespan and across intersections of class and ethnicity. We ask, what happens if we start to think of sexual empowerment as the vehicle through which women are regulated and disciplined?

Inventing sex

Postfeminism celebrates women’s sexual agency as empowering for women. And some analysts saw a new equality in postfeminist sexual subjectivities. But, across a range of academic, political and public forums, and liberal–conservative divides, such optimistic notions of the contemporary sexually liberated woman were questioned. Concerns were raised, for example, about the way that within postfeminist sensibility notions of sexual empowerment folded women back into an understanding that their social value was in being sexually attractive and pleasing to men (e.g. Harvey and Gill, 2011; Evans and Riley, 2013, 2014).

Research showed that many young women made sense of themselves through new sexual subjectivities, but that sex within a postfeminist sensibility seemed limited. For a start, there seemed to be clear limits as to who counted as sexy: usually women who were young looking, slim, toned and voluptuous, white or pale skinned and normatively attractive (Evans and Riley, 2014; Gill, 2007b,c, 2008b; Holland et al., 1998). White, middle-class, conventionally attractive, straight women were thus privileged within postfeminist sensibility in their ability to take up new sexual subjectivities. But this privilege was masked by the individualism of postfeminist sensibility, seen, for example, in postfeminist maxims such as ‘be yourself’, ‘this girl can’ and ‘girlpower’, which implied that possibilities were open to all who worked hard enough.

The postfeminist celebratory discourses of the sexually active woman thus run alongside historical discourses of women that intersected along sexist, classed and racist ideas that associated working-class and/or black and ethnic minority women’s sexuality with excess, disgust and/or the exotic. These discourses frame women’s

attempts to take up postfeminist new sexual subjectivities should they want to. The outcome is that many women tread a fine line between being understood as a twenty-first-century liberated woman who engages in sex the way she wants and being labelled a 'slut', tasteless, unrespectable or oversexed (Bailey, Griffin and Shankar, 2015; Evans and Riley, 2014; Griffin et al., 2013; Jensen and Ringrose, 2013; Riley and Evans, 2017; Rice, 2014; Ringrose and Walkerdine, 2008; Skeggs 2005).

Critics also argued that postfeminist new sexual subjectivities focused on pleasing men. Within postfeminist sensibility, women's sexual agency was celebrated, with its implications for sexual freedom and experimentation, that also tied into wider discourses of inclusivity and equality. Yet, what emerged from this was a normalisation of heterosexuality and a focus on expanding sexual practices with view to how it would be appreciated by men (Diamond, 2005; Holland et al., 1998). Thus, while lesbian sexuality had greater exposure across a range of media, it was often represented in heteronormative terms or in other ways that limited its radical potential, for example in highly polished, glamorous forms (Jackson and Gibertson, 2009). Postfeminist sexuality is thus contradictory. Women must love their bodies and have sex the way they want it as liberated women, but this sex needs to be recognisable as sexy for men in a conventional way.

Pleasing men, did not mean, however, thinking about sex as relational. Instead, the individualism of postfeminist sexual subjectivities positioned sex as part of a project of the self. Taking up postfeminist sexual subjectivities required women to work on themselves (such as developing new attitudes towards sex) and their bodies (Evans and Riley, 2014; Frith, 2015b; Harvey and Gill, 2011). The outcome was that, within postfeminism, sex was performative rather than, for example, experiential. So that sex became yet another aspect of (neoliberal) life to be worked on, and a 'good' sex life became another form of 'cruel optimism', creating a sense of never feeling fully complete or secure in one's performance of sexual subjectivities (Evans and Riley, 2014; see Chapter 5 for more on cruel optimism).

A separate set of concerns regarding postfeminist sexual subjectivities came from government and conservative oriented analysts who articulated a moral panic regarding the 'sexualisation of culture'. This 'sexualisation of culture' was a reoccurring trope in the first decade of the twenty-first century, although it later lost its usefulness for critical psychologists by being too all-encompassing (Gill, 2012), while losing its momentum as a moral panic within more conservative circles. But, in the late 2000s and early 2010s, 'the sexualisation of culture' was used to describe the cultural visibility of sex within which postfeminist sexualities flourished. Sexualisation of culture discourse created a luminosity of concern around certain figures, such as the porn-watching fatherless teenage boy unable to take up positive masculinities, the emotionally damaged woman seeking self-worth in sexual desirability, the sick and predatory 'dirty man' of recent and repeated high-profile sex scandals and the young girl contaminated by a highly sexualised and sexualising culture (Attwood, 2007; Evans and Riley, 2014; Egan, 2013).

The sexualisation of culture dominated academic, government and public discourse in the early twenty-first century, creating the impetus for policy documents

such as the American Psychological Association's Task Force on the Sexualization of Girls, the UK Home Office Sexualisation of Young People Review, the UK Department of Education's Letting Children Be Children and the Australian Senate's Sexualisation of Children in the Contemporary Media Inquiry. In the light of recent sex scandals highlighting systematic sex abuse of girls and young women in the UK and elsewhere, such reports might seem justified, but our critique lies in how these reports failed to engage with the complexities of girls' and women's experiences and absented their voices. Without these considerations, sexual vulnerabilities were cast as psychological rather than social problems. For example, it was argued that such reports overlooked how girls and women might operate with agency within contexts not of their own making that included societal structural inequalities around gender, ethnicity and socioeconomic status (Attwood et al., 2012; Barker and Duschinsky, 2012; Duits and van Zoonen, 2011; Evans and Riley, 2014; Jackson, Vares and Gill, 2012; Macleod and Vincent, 2013; Tolman, 2012).

In such responses to the 'sexualisation of culture', women stood as the figures of the sexual health of the nation, while bearing out cultural fantasies of ideal femininity as pure, clean, moral, unpolluted but 'pollutable' (Egan, 2013). Valenti (2009), for example, argued that such fantasies can be seen in the rise in chastity movements and abstinence-only education schools in America. In such communities, young women (not young men), make a public pledge to their fathers to remain virginal until marriage. Valenti's (2009) analysis of these movements suggests that they are not in opposition to the sexualisation of culture, but a core part of it, since they reproduce an understanding that women's social value is located in their body and in sex (whether sexually active or not). She concludes that such anti-sex movements are damaging to women's sexual health and wellbeing. Here, we also note that the moral panic embedded into sexualisation of culture discourse constructed women's poor sexual health in terms of bad choices made by vulnerable individuals, which ties into both the individualism of neoliberal healthism and a cultural pathologisation of femininity (see our discussion in Chapter 1).

The above review highlights how the new sexual subjectivities emerging out of postfeminism and the new visibility of sex were framed in contradictory ways, as either heralding an era of sexual empowerment or as new forms of oppression or vulnerability. It also highlights the way postfeminist sexual subjectivities framed ideas about women needing to sexually please men in terms of female empowerment, creating a complex and contradictory coalition of ideas about good sex and women's role in it. Key actors in the circulation of these ideas were those who presented themselves as experts, and able to offer advice for a good sex life. It is to their articulations of good sex that we now turn.

The rise of the sexpert

Expert contributions to our understanding of sexuality are not new. In *The History of Sexuality*, Foucault (1978) argued that, drawing on medical and scientific discourses, the Victorians attempted to create an ordered system of knowledge of sexuality,

though which they could 'know' sexuality and thus manage it. But, creating this system had the opposite effect, since it made sex more visible and produced new ways of understanding sexual practices, desires and categorisations, that had previously not been 'known' in this way. Thus, rather than repress sexuality, for Foucault, the Victorians produced sexuality, creating an explosion of language with which we could name and explain sex and sexuality, and from which medical interventions could be imagined and enacted.

In the nineteenth century, this system of knowledge included categories like the homosexual, heterosexual and nymphomaniac, as well as other categories relating to biological sex, such as hermaphrodite. Further categories were defined, including zoophiles, zooerasts, auto-monosexualists, mixoscophiles, gynecomasts, presbyophiles, sexoesthetic inverts and dyspareunist women (see Foucault, 1978, p. 43 for a full discussion).¹ By 1952, the introduction of the very heavily psychoanalytically and psychobiologically inspired *Diagnostic and Statistical Manual of Mental Disorders* made 'sexual deviance' a classified and medically recognised problem, which required intervention, treatment and cure. Sexual dysfunction here was defined out of a failure to live up to the norms of gender roles and social expectations. For example, a woman could be expected to have sex with her husband and, if sexual desire was found lacking, the woman could be diagnosed with frigidity, locating the problem within the woman's psyche and not within the pressures of social expectations and violence of gender norms (Angel, 2010).

Sexual practices were thus made visible and knowable in new ways through discourses of psychological health, science and medicine. But for the medical and health industries to create a meaningful language through which to categorise sex and sexuality, people also needed to learn to understand themselves through these terms (Hook, 2010; Foucault, 1978). As Hook (2010, p. 36) argues, these new sexual categories came to have a strong subjective effect because they provided a new language to speak about and therefore understand the self, because it named what a person is and does. For example, a man who had sex for pleasure with another man was now provided an identity of being 'a homosexual', which offered particular ways to understand himself.

Through the processes of confession and normalisation discussed in our previous chapter, the language of sexuality allowed people to define themselves in new ways. It also allowed people to consider that they might need expert help to guide them towards their most 'beneficial' outcomes. Intersecting with the emergence of psychology itself as a discipline, sex thus became an industry in its own right, with sizeable advice literatures, sources of information from the health, sexological and psychiatric disciplines, and dissemination into popular culture and through consumer items. Thus, a network of dispositif, or as Rose (1990, p. 11) calls them, 'experts of the soul' emerged to address issues of sexual practice, identity and disorder, evidenced in, for example, the range of available sex manuals, online advice, women's magazines and the newly emerging practices of self-tracking health apps.

Analysis of contemporary sex advice highlights the norms of sex and sexuality circulating within our current context. Across a range of expert advice, patterns

emerge in which notions of experimentation, liberation and choice often took place within a limited framework of 'good' sexual practice. For example, despite wider discourses of diversity and individual agency, contemporary sex advice normalised the heterosexual, monogamous couple while troubling same sex 'experimentation'. For example, Gill (2009b) noted how women's magazines constructed women's experiments with sex with other women as shameful and to be regretted.

In Gupta and Cacchioni's (2013) analysis of popular American sex manuals published between 2000 and 2010, they showed that most of these manuals either assumed monogamous heterosexual coupledness or constructed this relationship as desirable. With few exceptions, the intended audience was also predominantly white, middle class and cis gendered, evident in the pictorial representations of couples. Affluent, consumer oriented people were also constructed as the norm, since these manuals constructed sex as part of a larger project of self that through time, money and work on the self would lead to a healthier and more fulfilling life. These sex manuals thus drew on biomedical, healthism and neoliberal discourses to construct work on one's sex life as part of a normative attitude to working on the self for optimal living by a freely consuming subject (Bauman, 2000). Such sense making ignored how time itself has become a commodity, with few people able to live up to an expectation to work on their sex lives as if they had unlimited time or resources. The norms of sexual practice articulated in these manuals can thus serve to undermine their readers, with the potential to create a sense of failure or exclusion for those who do not have the resources to participate or who do not see themselves represented. As Barker (2012, p. 2) notes in relation to the importance of sex 'Get it right – we are told – and we could achieve the ultimate happily-ever-after ... Get it wrong, however, and we risk being seen as we are and found wanting'.

Similarly, limiting patterns can be identified in sex advice for those engaging in sex outside of monogamous coupledness. Postfeminist sexual subjectivities can be contrasted against historical practices that constrained women's sexuality and sexual desires. Thus, within postfeminism, casual sex, with its connotations of sex unfettered from relationships or procreation, might be celebrated as evidence of women's liberation. But, as Farvid and Braun's (2014) argue, the growing advice literature around casual sex combines notions of sexual liberation and equality with more traditional discourses that locate casual sex as problematic for women.

Traditional discourses are evident, for example, in advice on casual sex that draws on essentialist assumptions to argue that women find it harder to disassociate sex from emotion and romance, and have a higher chance of low self-esteem and poor emotional wellbeing from one night stands or 'friends-with-benefits' relationships (Farvid and Braun, 2014). Within postfeminist sensibility, women are thus constructed as 'sassy', free, empowered and sexually liberated, while also emotional, sexually vulnerable and biologically programmed for motherhood and familial life (for further discussion of the latter, see Chapters 5 and 6).

In contemporary sex advice, such traditional discourses of female sexuality are articulated alongside ideas of women as empowered through their sexuality.

Research on such advice includes Farvid and Braun's (2014) analysis of three self-help books for having 'healthy' casual heterosexual sex (*The Happy Hook-Up: A Single Girl's Guide to Casual Sex* (Sherman and Tocantins, 2004), *Brief Encounters: The Woman's Guide to Casual Sex* (Dubberley, 2005) and *The Game: Penetrating the Secret Society of Pickup Artists* (Strauss, 2005)). In their analysis of these texts, Farvid and Braun (2014) showed that women's engagement in casual sex meant becoming a skilled sexual subject and as having to act as the gatekeepers for men's more adventurous sexual preferences. For example, in one extract of sexual advice from Dubberley's *Brief Encounters*, women were advised that they should want 'a guy to leave your bed believing you're the best lover in the world' and could do this through a range of practices including 'a sex toy show, dressing up, striptease, anal sex or even fisting'. This advice draws on a performative discourse that focuses attention on how women might please and impress men (and not, for example, how sex might be mutually produced or that women might expect men to want to impress them). It is also contradictory, since women were also advised not to do any activity where trust could not be assured. For example, they were advised 'anal sex and fisting aren't things to try with strangers'. Men were also positioned in contradictory ways, as sexual consumers expecting a performance aimed to impress them, but also as simply grateful for women's sexual attention 'so you won't be disappointing them if you don't pull out any porn star tricks' (*Brief Encounters*, p. 169, cited in Farvid and Braun, 2014).

The need for women to focus on men's needs and desires is a recurring trope in sex advice to women, but it is constructed in terms of the act of empowered liberated women. In Gill's (2009b) analysis of *Glamour* magazine, for example, sex advice was melded to a notion of entrepreneurial subjectivity, so that happy and healthy relationships were conflated with the woman's ability to measure, account, manage and in all ways treat sex as a business, the business of pleasing men. In this magazine advice, women were constructed as being responsible for managing their own and men's emotional needs. As with Farvid and Braun's (2014) analysis, Gill (2009b.) showed that deeply contradictory subject positions were constructed for men and women. Men were both sexual connoisseurs, impressed by only the most sexually adventurous women, and also relative simpletons, grateful for sex or unable to manage their own feelings. In contrast, women were constructed as empowered through their ability to engage in asymmetrical relationships whereby they managed both their own and men's feelings, and performed sexual acts that meet men's sexual desires.

Gill also showed how, despite the intimacies being discussed, the sexual satisfaction of women was relatively absent, with women's experience of sex treated as 'curiously *affectless*' (2009b, p. 353) as they planned and strategised eye contact, body language, feelings and emotions (including confidence and self-esteem), with the intended 'goal' of pleasing a man. Such sex advice thus offers very little mention of the sexual satisfaction of women. Women are therefore still expected to perform sex and sexiness with men in mind and to be the object of men's fantasies, with women's pleasure being located in being a sexual object. These ideas of good

sex are reproduced in women's sense making. Holland et al. (1998), for example, highlighted the way young heterosexual women experienced sex through the 'male in the head' since their experiences were structured by how they imagined their male lovers might enjoy their sexual performance. Similarly, in our own research, we saw how young women, identifying with postfeminist sensibility, sought to take up a subject position of 'sexual connoisseur'; that is, someone who was sexually knowledgeable and who could, in the language of *Brief Encounters* described above, perform 'porn star tricks' (Evans and Riley, 2014).

Gill (2009b) argues that this unequal state of affairs is enabled by the language of empowerment, which creates a contradictory notion whereby successful, self-minded and autonomous femininity is evidenced in women's ability to maintain asymmetrical relationships with men. Postfeminist media thus legitimise advice to women that might otherwise be understood as evidence of unequal gender relations (such as strategically repeating the words a partner/boyfriend says back to them to give them the impression that they have a natural affinity with each other or performing sexual 'tricks' aimed at impressing male sexual partners rather than experiencing sexual pleasure).

Such advice is further legitimised by being tied into postfeminist imperatives of self-monitoring and transformation, in which ideal femininity is demonstrated through work on the self and body (Gill, 2009b; also see the Prologue of this volume). Postfeminist rhetoric of 'freedom' and 'choice' also makes inequality even more difficult to pinpoint because it hides behind the rubric of equality (Ringrose, 2013). This rubric of equality masks class inequalities, postcolonial histories and constructs of the fat female body that make it harder for women who are not white, slim, economically stable and urban to take up new sexual subjectivities without being interpreted through discourses that construct their sexuality as unclean, unruly, unattractive or excessive (Skeggs, 2005; McClintock, 1995; Hartley, 2001).

Foucault (1978, 1996) argued that sexual liberation does not bring happiness or freedom, but new forms of regulation. In the discussion above, we have highlighted the way that postfeminist sexual subjectivities described in contemporary sex advice produce norms that regulate sexuality. In these norms, women's sexuality is directed towards monogamous, heterosexual sex that is focused on women pleasing men and which forms part of a strategic approach to intimate relations that allows women to understand themselves as, for example, a sexual connoisseur. As we discussed in Chapter 3, normalisation works with confession, since people learn to understand themselves through norms and by 'confessing' how well they meet these norms (Foucault, 1978). Here, we consider how sexual norms also need to be confessed.

Historically, a person to whom one confesses is defined within community roles, such as police officers or pastors. As modern power has developed, psychologists and the health-related disciplines have increasingly participated in the 'shaping of the private self' by both providing norms and rules to follow (not unlike police officers) and schemas of self-transformation and guidance (in a similar way to the pastor) and, in doing so, it is the psychologist who comes to define what is normal and acceptable (Dean, 2010; Rose, 1990). As Foucault (1978, p. 60) states, 'the obligation

to confess is now relayed through so many different points ... that we no longer perceive it as the effect of a power that constrains us'. This confession also forms a panoptical kind of power.

The panopticon was Foucault's metaphor for modern power. Originally a prison design developed by philanthropist Jeremy Bentham to produce more functional and effective ways of rehabilitation, it included a cylindrical prison building with a central watchtower. In the watchtower sat the guard, who could not be viewed from outside the watchtower, while around the walls of the cylindrical wall the prisoner cells were placed. The idea of this prison design was that the prisoner did not need to know that the guard was there. Instead, with the belief that they were always being watched, the prisoner would internalise the gaze, turning it in upon themselves – and so becoming better prisoners. Confession acts in this panopticon by creating a heightened sense of self-awareness by asking the subject to be always checking on itself, in a state of constant reflexive self-surveillance. In Chapter 3, for example, we saw how the normalisation of how genitals should look creates a heightened self-awareness, including fear and anxiety about one's own genital appearance, and thus a desire to change them. For Foucault (1977), this prison system spoke to the way that power works in modern societies. As Bartky (1990, p. 65) stated, in 'the perpetual self-surveillance of the inmate lies the genesis of the celebrated "individualism" and heightened self-consciousness which are hallmarks of modern times'.

One example of the way panoptical power works in relation to the expert is in the rise of health and self-tracking apps. There are general self-tracking apps and also efficiency self-monitoring technologies that allow the user to measure success, motivation and goal-oriented outcomes. For example, Beeminder is a self-tracking app where the user is allowed to input a self-directed target, such as weight loss or the number of fruit and vegetables eaten per day. The app then asks you on a daily basis to input data, in a quantifiable measurement of the target. Every time the user meets or overachieves their target, the app rewards them with a place on the 'yellow brick road'. Every time the user misses their target, they have to pay a fine.

Self-tracking technologies work with the promise of improving the subject and include a range of measurements such as heart rate monitors, body heat and pace of walking. Lupton (2013a 2017) conceptualises these new forms of 'mHealth' (mobile health) within notions of the panopticon, arguing that mHealth technologies make sense within neoliberal notions of the self as a responsible, self-knowing, entrepreneurial, economic subject who is involved in constant self-surveillance with view to transformation. As in our previous discussions of power and health, mHealth technologies create a 'productive' bio-citizen, who is engaging in hypersurveillance under the guise of improving life. Previously, experts metaphorically held the role of the guard, offering the vision of ideal subjectivity to which the prisoner/expert advice consumer could aspire. With mHealth, the user, as the prisoner, is asked to engage in a form of participatory surveillance, whereby the expert of the self is now also the subject. mHealth thus blurs the guard/prisoner distinction. mHealth also requires a hypersurveillant subject who constantly monitors, reviews and measures

their activities on a daily basis with view to attaining self-knowledge and mastery. See for example, Lupton's (2013a) critique of the 'quantified self' movement, which sees self-tracking as the route to knowledge of the body by making internal bodily processes visible and intelligible (e.g. quantifiedself.com).

Lupton's (2015) review of self-tracking apps related to sex and sexual relationships notes the range of apps that people can engage with, from sexual health (sexually transmitted diseases, managing illness and coping with the personal implications and their impact on wider relationships), sexual pleasure (sexual positions, guides and manuals) and hook-up sites that make use of geolocation technology (such as new dating apps like Tinder and Grindr). Of particular interest to Lupton (2015) is the way these apps often include a self-tracking function as a means to measure health issues such as fertility, ovulation and reproduction, with platforms that measure bodily functions like menstruation, as well as counting the number of sexual partners, thrusts per sexual interaction, the levels of noises and sounds, and duration. Lupton (2015) argues that these apps provide a new way to do surveillance, as part of the 'post-panoptic' or participatory surveillance society, where people become responsible for their own self-monitoring and where modes of confession are no longer limited to the police, the pastor or the church, but to a much wider social and digital community (see Caluya, 2010; Albrechtslund, 2008; and Best, 2010; cited in Lupton 2015).

Part of Lupton's critique of the quantified self is that the reliance on numbers in these new forms of self-monitoring practices permits a sense that the confession, in the form of inputted data, creates 'truth'. Self-tracking comes with the assumption that numerical data reveal scientific facts. Self-tracking apps thus work through discourses of legitimate knowledge, so that 'good' sex becomes a quantifiable fact – measured in the number of thrusts, for example. Sensation, emotion and pleasure are set aside and, instead, the statistical output from people's data becomes a measure of what counts as meaningful, intimate sexual interaction. The self-tracking sex app is therefore performance driven. Furthermore, there are assumptions made within these about what constitutes 'good sex' that articulate normative constructions of gender and sexuality. For example, apps directed at men are concerned with basic measurements such as time, loudness, and number of sexual partners as indicators of sexual prowess, whereas apps that address women tend to be more concerned about monitoring health, risk and reproduction. Far from the postfeminist rally call of sexual freedom, liberation and experimentation, what these apps do is make reproduction and sexual risk the concern, primarily, of women. We would read this alongside the re-traditionalisation of gender roles in postfeminist sentiment that is underpinned by biological essentialism (see Chapter 5 for further discussion of re-traditionalisation).

In such apps, it is clear that the sex expert has shifted to expand beyond the authors of sex manuals and magazine advice to technology developers and the algorithms within particular technologies. This range of technologies of subjectivity determine what 'good' sex means and often constitutes good sexual health as monogamous, heterosexual, penetrative and reproductive. This seems to sit in

diametric contrast to notions of postfeminist sensibility that celebrate women's sexual pleasure, empowerment and autonomy. Did postfeminism not celebrate women having sex on her own terms, whenever, wherever and with whomever she wanted?

As well as being tied to traditional gendered norms, the construction of healthy sexuality identified in sex expert advice also folds into neoliberal subjectivity, making sexual health the outcome of the responsible, self-monitoring citizen. Here again, we see the language of empowerment being used to frame practices that might otherwise be understood as disciplining and oppressive, in this case that self-monitoring leads to self-knowledge and mastery. But we are reminded of Foucault's analysis of the Victorians approach to the measurement of sexuality – measurement did not produce mastery, but new subject positions from which people could be 'known' and acted upon. We explore this further below, by examining representations of the female orgasm within postfeminist media and their associations and imbrications for women's sexuality.

The big 'o'

There have been times when women's orgasm was constructed as a 'disease' of the unclean and unruly female body (contrasted against respectable, virtuous and pure femininity; Maines 2001). But as the orgasm became incorporated into the scientific, health and psychoanalytical discourses of the early twentieth century the idea that healthy sex was orgasm-oriented became a dominant way of understanding sexual pleasure. For example, both Freud and Reich viewed the orgasm as important in the psychological development of the subject, so much so that Reich (1968) stated that 'psychic health depends on orgasmic potency' (p. 28, cited in Potts, 2000). For these theorists, the female virginal orgasm was essential for female psychic development.

Early sexologists measured the biological and physiological components of female orgasm, keen to demonstrate that it existed and, in doing so, they tied the emotional and pleasurable aspects of sexual interaction with this bodily response (Masters and Johnson 1966). These ideas continue to this day, so that despite survey results indicating that many women do not reach orgasm during heterosexual intercourse (Jargose, 2010), contemporary media discourses celebrate women's orgasm, constructing it as synonymous with peak experience and as ultimate liberation (Potts, 2000). Orgasm is also tied into consumer culture; it sells product and product is sold to facilitate it. Below, we explore how orgasm is represented within contemporary advertising to consider the dynamics between autoeroticism, empowerment, self-monitoring and re-traditionalisation within postfeminism.

In 2010, Durex released an advert for Play O Gel, which featured a range of women's faces appearing to reach the point of orgasm. Each woman's face formed an exaggerated facial expression, a big 'o' of the lips and eyes rolling to the back of the head, all accompanied by Mozart's *Der Hölle Rache kocht in meinem Herzen*, an operatic piece involving a female singer vocalising a lot of 'o's. The representation of the

orgasm in the Play O Gel advert articulates well-known contemporary assumptions about the pleasures of orgasm and how it is made visible. And as Frith (2014) argues, such representation forms the way we understand orgasm as a knowable object. In her analysis of female orgasm, Frith (2014) argues that an exaggerated visualisation of the female orgasm is used as evidence of it having happened. The curled toes, rolling eyes and the o-shape of the mouth are thus necessary visual syntax when the viewer cannot really know the reality of the felt bodily experience. The visual representation ‘attempts to solicit what it can never be sure of: the out-of-control confession of pleasure, a hardcore “frenzy of the visible”’ (Williams, 1989, p. 50).

Frith (2014) suggests that the visual articulation of orgasm attests to the history of women’s bodies as unknowable and thus to be mistrusted. The expectation that women’s bodies (and minds) are unknowable can be seen, for example, in Freudian insistence on the mystery of women and Freud’s proclamation that ‘the great question that has never been answered, and which I have not yet been able to answer, despite my thirty years of research into the feminine soul, is “What does a woman want?”’ (cited in Jones 1955, p. 468; see also equally problematic statements by Freud’s contemporary, Lacan).² Thus, from psychodynamic theory to contemporary advertising, women’s orgasms are represented as being mysterious and often constructed through the dichotomy of the ‘real’ and the ‘fake’. For example, in another advertising campaign people are shocked to hear women having loud orgasms in public, only to discover that they are merely enjoying a shampoo.

The mistrust of women’s bodies can be seen in the contemporary cultural discourse of ‘faking it’, but others note that women report faking an orgasm as a strategy to bypass heterosexual men’s concerns about sexual performance (Braun, Gavey and McPhillips 2003). Women’s magazines, for example, suggest ‘faking it’ as a form of politeness (Roberts et al, 1995; similarly, see Kitzinger and Frith (1999) on the role of politeness and care of men’s feelings in women’s refusals of sex). The fake orgasm might therefore be less evidence of women’s ‘mysterious’ and unknowable bodies, and more a demonstration of the social norms and pressures of heterosex. Faking orgasm as an act of kindness suggests a form of emotional work that aligns with arguments that within postfeminism, the psychological labour of performing emotional work in paid forms of employment (e.g. smiling when not happy; Hochschild, 2012a) has spread to new areas less traditionally economic (Frith, 2015b; see also the collection in Elias, Gill and Scharff, 2016). From this perspective, faking orgasms is an example of intimate emotional labour, with the particular set of repeated expressions and visual codes that are well known and recognisable (e.g. the ‘o’ shaping of the mouth), providing the script that women use to perform pleasure in heterosexual interaction.

The visual language of the orgasm means that the orgasm has become an act of performance, exchange and management. In a similar argument to Gill’s (2009b) analysis of the way *Glamour* magazine’s sex advice draws on discourses of entrepreneurialism to construct sex as work, Frith (2015b) concludes that representations of the orgasm in *Cosmopolitan* magazine are ‘Taylorised’ (referring to the scientific study of work and management). Frith argues that in *Cosmopolitan*’s Taylorised

discourse, orgasm is the key motivator and only reason for women to engage in sexual practices, especially penetrative sex. Penetrative sex for coital orgasm is, as in psychoanalytical notions of healthy sex, thus constructed as the normative desired outcome. Within this logic, masturbation is constructed as an opportunity to prepare for the event of penetrative sex, for example through a discourse of self-knowledge that constructs masturbation as knowing what turns you on to provide insights that can then be taught to male lovers (Frith, 2015b). This construction of female masturbation as facilitating heterosexual penetrative sex is across range of postfeminist literature, for example, in 'chick' flicks and television series which position vibrator ownership as essential for the in between times, while seeking out 'Mr Right' (Arthurs, 2003; Smith, 2007; Gill and Herdieckerhoff, 2006). Within postfeminist literature, the orgasm is understood not only as the prime motivation in sexual interaction, but also as natural and expected. And yet the work needed to achieve this expectation requires labour of both the mind and body, so that it becomes women's responsibility to work towards being orgasmic and having 'better' orgasms. Potts (2000, p. 56), for example, argues that women now experience an 'orgasmic imperative', with organism being a requirement of a healthy female subject. From a Foucauldian perspective, it is this compulsory aspect of orgasm that makes orgasm not so much evidence of women's liberation, as a new form of regulation.

Postfeminist media thus articulate an idea of good sex as orgasmic and orgasmic sex as difficult and requiring work on the self. This construction of good sex provides the context of *Cosmopolitan* magazine, for example, providing advice, tips and tricks for becoming self-knowing about one's clitoral and g-spot 'erotic real estate' (Frith, 2015b, p. 317) and recommendations for 'sexercise' techniques to strengthen muscles, practice techniques for prolonging sexual pleasure and teaching men how to engage in the same so that women can reach orgasm (Frith, 2015b). Such practices constitute what elsewhere we have called 'technologies of sexiness' (Evans and Riley 2014; also see Chapter 3 in this volume for a discussion of technologies of self and subjectivity).

Technologies of sexiness are practices that the self-regulating and disciplinary subject employ on themselves in order to take up desired subject positions such as the 'sexual connoisseur', or in more everyday terms – to understand themselves as a 'good lay'. Thus, while we might celebrate the possibilities for women to be more orgasmic, we note the implications of women's sexual pleasure being tied to work on the self. For example, our research suggests a form constant work in which sex is another form of performance to be rated and contrasted against others (Evans and Riley 2014). For Frith (2014, 2015a,b), the widespread cultural representations of the female orgasm reproduce an understanding about women's sexuality that becomes part of our 'common knowledge' of what healthy sex is, with the outcome that there can be no 'genuine' orgasm that is only experiential, since the orgasm is always already mediated. The advertisement for Play O Gel featuring women's orgasms, that we gave above, thus reproduces a performance of women's sexual pleasure that comes to stand in for what might otherwise be a range of pleasure responses. From a Foucauldian perspective, media representations of female orgasm

that seem like radical and exciting evidence of female sexual empowerment may be teaching women how to discipline their own sexual practices.

A similar critique can be directed towards the other apparently radical aspect of these advertisements, and indeed of postfeminism more generally, which is that the orgasming women in the Play O Gel advert are often alone. The image of healthy sexuality presented in the Play O Gel advert is thus the visual representation of the woman pleasing herself, which sits in contrast to much of the historical medical and psychoanalytical discussion of orgasm and the normalisation of hetero-penetrative sex in contemporary expert sex advice. In contrast, the Play O Gel advert aligns with postfeminist sensibility that celebrates autoeroticism and, in so doing, normalises women finding pleasure in their bodies. Given historical and contemporary discourses that tie female sexuality to shame (for example, in discussions of slut shaming; see Ringrose and Renold, 2012), the celebratory tone of women's masturbation in the Play O Gel adverts, is, well, one to be celebrated.

Postfeminist celebrations of female self-pleasure can be linked to second-wave feminist arguments that saw radical potential in the orgasm; see, for example, Koedt's (1970) proposal that virginal orgasm was an invention that tied female sexual pleasure to penetrative sex. But in a characteristic postfeminist move, postfeminist discourses of orgasm both draw on and refute second-wave feminist ideas (McRobbie, 2009). The Play O Gel advert celebrates self-pleasure but frames it in consumerist rather than political terms, celebrating women's ability to buy products designed to facilitate sexual pleasure. Within a postfeminist sensibility then, 'pink' marketing moves sexuality away from second-wave feminist politics while keeping connotations of women's sexuality as empowerment. This is a typical postfeminist move, in which consumerism and the ability to consume, rather than politically oriented social change, is constructed as the route to women's empowerment (Riley et al., 2017).

Pink marketing also unties historical links between sexual consumption and seedy masculine sexuality, by associating it with femininity, through girly and/or middle-class connotations (Gill, 2008b; Evans, Riley and Shankar, 2010). The outcome is, for example, 'pink', 'fun' and 'cute' vibrators being sold in open, public spaces as part of a billion-pound industry (Smith, 2007). Play O Gel is after all a brand and product, looking to sell pleasure in the intimate realm. Its use of classical music in its advertisement places the product as an item of class, taste and respectability. The advertisement works to normalise the orgasm, but also the idea that sexual pleasure, either by oneself or with a partner, is safe, respectable and classy. Within postfeminist sensibility that celebrates women's sexuality as a source of empowerment, women's orgasms are thus depicted in ways that reduce their radical potential by tying them back into the status quo. The orgasm is less political, and more as a combination of hedonic pleasure, work on the self and an opportunity for consumption; it becomes visually stylised, safe, normal, middle class and enabled through hetero-penetrative sex (with a male partner or penis-shaped vibrator).

Foucault (2011) argued that while the orgasm was an object of freedom in both Marxist and psychoanalytical accounts, its association with the scientific

studies of the sexologists implicated it in modern power and thus control through governmentality. Although Deleuze disagreed with Foucault on whether orgasm was bound to pleasure (Deleuze, 1999; see Jargose, 2013 for a detailed discussion of this difference), he was also concerned about understanding good sex as the climatic construction of the orgasm, since it limits people's capacity to understand their sexuality (Deleuze, 2001). For example, understanding orgasm in penetrative heterosex as the pinnacle of sex provides the conditions of possibility for people to construct Viagra as returning a 'dysfunctional' body back to its 'normative' state (Potts, 2004). In Deleuzian terms, the orgasmic body is thus a re-territorialised body, in that it returns it to some of its apparently normative functions and, for both Foucault and Deleuze, it is readily available 'to the psychologizing and medicalizing discourses of normalization' (Jargose, 2013, p. 6).

As we have seen above, representations of good sex in sex advice and other media make orgasms compulsory, individualised and consumer oriented. Women have to engage in self-work in order to facilitate this potentially difficult, but essential act of sexual pleasure. Such individualism is aligned with neoliberal logic that locates problems at the individual level, thus directing attention to finding individualist solutions (see also Chapter 3). This logic is also applied to sexuality. Should a woman 'fail' to take up new sexual subjectivities successfully, the solution is rarely located in addressing social inequalities that limit women's ability to enjoy the kinds of relationships she needs with her lovers or body to enjoy sex. Instead, as we discuss below, these problems are located in her as person and made sense of through individualised medical or psychological discourses. Below, we explore the implications for individualising sexual experience, particularly for older women who are only partly addressed by postfeminist new sexual subjectivities.

Sexual dysfunction and risky subjects: am I normal?

A key moment in the medicalisation of non-reproductive sexuality was the US Food and Drug Administration's (FDA) approval of Viagra in 1998. Although originally not developed for this purpose, it became celebrated as a drug that would effectively eradicate erectile dysfunction. Viagra was thus a biomedical individual solution that located sexual problems in the physiology of the individual. Viagra also tied into consumerist discourses that constructed consumption as the route to individual problems and was aimed at a generation of consumers who had witnessed medical, pharmacological and technological breakthroughs and who have been the target of powerful advertising campaigns. This generation of consumers was also located within discourses of concern around masculinity in the context of social change, such as the decline in men's traditional roles as 'male breadwinner' (Loe, 2001; Tiefer, 2001a; Vares and Braun, 2006). Viagra was thus tied into ideas of male sexuality that intersected across medicalisation, consumerist, individualist and crisis discourses.

This sense making around Viagra also came under critical reception. Concerns were raised about how the focus on a drug-based solution took attention away from

both the relational aspect of sex and from considering societal pressures that require men's performance and sexual prowess. Within this logic, sexual problems are solved with individual technological solutions, such as Viagra or, as we saw in Chapter 3, labiaplasty. Such individual solutions can be contrasted against practices that focus on the dynamics between people, such as couple counselling (Kaschak and Tiefer, 2014). The level of uptake, estimated to be around 50% of American males having used Viagra (Loe, 2001), also suggested that the drug could no longer be considered to be treating dysfunction but was treating 'normal' life. As such, Viagra represented a blurring of commercial, consumerist and medical discourses that was allowing a biomedical model to move into areas of private life, facilitated by neo-liberal discourse about self-responsibility and the use of experts to facilitate self-transformation if one's life was not normatively ideal. For although access to Viagra requires some consultation with a health professional (be it a pharmacist or doctor, depending on different countries' categorisation of the drug), how it was advertised and made sense of by its users suggests a shift away from a patient being treated for a specific condition (erectile dysfunction) to a 'consumer' seeking enhanced sex. In this sense, Viagra represents both a medicalising and demedicalising of sex. See for example, Fox and Ward's (2006) analysis of internet pharmacies and Viagra user's discussion boards, where both men and women talk of using Viagra to have 'better sex'.

Critiques against Viagra therefore focused on it offering an individual, technical solution to what might have otherwise be understood as relational issues contextualised within wider discourses of sex and masculinity; that it drove new norms and expectations of performative masculinity in older age; that it was another site where hetero-penetrative sex was represented as the pinnacle (if not the only) form of sex of value, limiting people's understanding of sex; and because it was an example of how people's desires and understandings of what was normal were being directed by significant commercial interests. It was these concerns that contextualised critical responses to the first conference on 'female sexual dysfunction' that was called shortly after the substantial commercial success of Viagra.

Concerned about a simplistic, individualist, consumer-oriented biomedical approach to addressing women's sexuality, Tiefer responded to this conference by warning against 'a vision of women's sexuality that standardises sexuality and neglects how social class, sexual orientation, religion, race, and nationality don't just affect, but literally co-construct, the meaning of genital acts and the experience of sexual subjectivity' (2001b, p. 627). For Tiefer, solutions for sexual problems needed to start with the person-in-relationship and in their social context. Instead, what followed were attempts to identify a drug for female sexual dysfunction, what became known as the 'pink Viagra' (Cacchioni, 2007; Tiefer, 2001a) and, for Tiefer, a sustained campaign against the medicalisation of sex.³

The successful contender for the pink Viagra was flibanserin. Originally an unsuccessful antidepressant, Sprout Pharmaceuticals rebranded flibanserin as a treatment for female sexual dysfunction (Roehr, 2015). Because of poor quality evidence of its effectiveness, minimal improvements in libido and significant adverse

effects, the FDA repeatedly refused to license flibanserin. However, after Sprout Pharmaceuticals organised a media and consumer campaign called 'Even the Score', which lobbied on the basis of equality for women in treatment for sexual dysfunction, the FDA finally approved flibanserin for hypoactive sexual desire disorder in 2015 (Jaspers et al., 2015; Moynihan, 2014). However, uptake was not as high as hoped, perhaps because, unlike Viagra, flibanserin needs to be taken every day, works on brain chemistry rather than blood flow, was approved for the treatment of low sexual desire rather than a reduced physiological response to sexual desire, doctors need to be certified to prescribe it and because women taking it cannot drink alcohol.⁴

'Pink Viagra' encapsulates sexual health dilemmas in postfeminist times. Clearly, women's sexual health should be considered important, and negative stereotypes, particularly of older women as uninterested in sex, have previously contributed to a neglect of this area of women's health. But focusing on sexual health raises questions about how to balance recognition of some women's desire for sustained sexual desire and function over their lifespan without creating new norms that pathologise and medicalise lower levels of sexual interest. This balancing act is made difficult within wider discourses that normalise heterosexual penetrative sex and cultural constructs of older women's sexuality.

Older women's sexual health and feelings of sexiness are often framed in terms of a 'problem', both medically and culturally. For example, in Vares' (2009) research on constructs of the 'sexy oldie', she notes the way that older heterosexual couples are either represented in the media in terms of companionship and declining sex or, if they engage in sex, are understood as humorous, disgusting or abhorrent. Research with older women shows a pattern in which older women themselves reproduced these limited discourses of sexuality, as well as feeling invisible in media representations of age and sexiness (Vares, 2009; Ussher, Perz and Parton, 2015). Indeed, Ussher, Perz and Parton (2015) suggest that the negative sociocultural constructions of the sexually active older women have an important part to play in older women's sexual experiences. For the women they spoke to, menopause created a range of responses, from feeling barren to a sense of sexual freedom. These experiences were produced through complex interactions between the women's own interpretation of their ageing, how intimate others constructed it, wider cultural discourses of older women's sexuality and the biological changes in their bodies. Perz and Ussher (2008) also showed that while women tend to draw on dominant notions of beauty and sexiness and associate menopause with ageing and loss of youthful appearance and attractiveness, some women could resist this culturally dominant narrative. Those who did articulated positive discourses of menopausal experiences including an increase in feelings of self-worth, confidence and wisdom that came with age. What this research suggests is that a biomedical approach misses the importance and influence of wider societal discourses on women's embodied experiences including their sexual experiences.

Hormone replacement therapy (HRT) provides another example of the complexities of thinking about the medicalisation of female sexuality within the context

of postfeminism. Although it is technically a medical intervention that replaces hormones that are produced in lower amounts during the menopause, it is offered in a context in which women are valued for their youth/beauty/sexiness and it is understood as extending 'youth'. From this perspective, such medical interventions into women's sex lives are not value free; rather, there is a dynamic interaction between biology, medicine and culture within which women's sexual subjectivities are produced. For example, Ussher, Perz and Parton (2015) argue that dominant notions of older women's deteriorating sexual activity are more culturally plausible through the introduction of HRT, even while 'the evidence for a direct association between hormonal changes and sexual desire, response or activity is unpersuasive' (p. 451). Yet this cultural association between menopause and female sexual dysfunction, and the capacity to medicate through HRT, reinforces the idea that older women should maintain heterosexual standards of femininity beyond menopause. The implication is that if you can 'treat' it, you should, making sexual activity in older age an imperative rather than a choice.

Addressing such concerns, there have been calls to consider non-sexual pleasures as distinct from dysfunction. In her research with women who were either medically defined or self-defined as having female sexual dysfunction, Cacchioni (2007) found that, for the most part, there was a repetition of the contemporary constructions of good/healthy sex as hetero-penetrative, culminating in orgasm. The women she interviewed considered their experience of pain or discomfort during this kind of sex as evidence of them not being 'real women', not normal and thus not able to have 'good sex', which was understood as integral to psychological and physical health. There were, however, examples of how women could 'queer' or challenge these constructions. For some, alternative non-penetrative sexual activity or non-sexual lifestyles (although none of the women identified as asexual) became more positive ways of practising sexual life and sexual subjectivity that existed outside or on the borders of the postfeminist obligations of compulsory heterosex. While this work points to alternative possibilities, overall, it highlights the restrictions in available understandings of what is good, normal or healthy sex.

Such limitations are also seen in the way that the normativity of heterosexual sex scripts (foreplay-intercourse-orgasm) structure the medicalisation of sex between women. Boyle (1993), for example, suggests that the assumption of value-free science masks the often heterosexist bias that lesbian relationships are composed of one 'butch' and one 'femme' partner, where the 'butch' partner becomes the 'penile substitute'. Similarly, within postfeminist sensibility, research points to the way that while sexualised kissing between women has become more normalised within a postfeminist sensibility as part of a sexually liberated framework, it is simultaneously folded back into heteronormativity, since this kissing is understood as primarily for men's voyeuristic enjoyment (Diamond, 2005; Riley and Evans, 2017). Thus, across media and medical constructions of women's sexuality, and the sense making of women – both those able to enjoy penetrative heterosex and those experiencing

sexual dysfunction – is a limited set of understandings about women's sexuality which highlight the limitations of the argument that postfeminism is characterised by liberated women having sex on their own terms.

Conclusion

The *vagina dentate* is a myth of a vagina with teeth that appears in various folk tales. The *vagina dentate* associates women's sexuality with danger, pain, death and/or emasculation (Leach and Fried, 1950). It is an example of a long-standing cultural fascination with women's sexuality in which women's sexuality has been constructed as something to be understood and yet unknowable, to be controlled yet also uncontrollable. These contradictory understandings crystallise in different ways at different historical moments, so that sometimes cultural ideals construct women's sexuality as passive and passionless and at other times as naturally full of passion (Laqueur, 1990). Within postfeminist sensibility, women are 'up for' sex. But, as our discussion of Foucault's analysis of sexuality shows, liberation may not a pathway to happiness or freedom, but instead folds us into new forms of power.

Every era has its own discourse about sex, through which sex is made knowable in particular ways, and through which it is controlled as people take up these ways of knowing and work on themselves so that they may take up desired subject positions. Within postfeminist sensibility, the desired subject positions orient around the sexually agentic and knowledgeable subject. Women interpellated by postfeminism must therefore work on themselves – employing technologies of sexiness – in order to successfully position themselves as the 'sexual connoisseur'. But what this chapter has shown is that such technologies of sexiness require a focus on the individual and an understanding of sex as performance. Sex becomes another thing women have to work on to understand themselves as living a good life. Yet, even those who work on themselves cannot be guaranteed success since sexiness is also tied into social categorisations that are less permeable, such as age, classed and racialised identities, body shape and size, and levels of disposable income and time.

Understanding sex as performance also makes sex an act to be viewed rather than experienced. This leads to questions as to who is the viewer. Analysis of expert discourses are ways of identifying the norms circulating about good sex and, in these, it is clear that the viewer is male. And through contradictory advice, women are sold the idea that they are empowered by this inequity. Sexual empowerment does indeed appear to be the vehicle through which women are regulated and disciplined. Furthermore, sexpert discourse normalises a heterosexual sex script of foreplay-intercourse-orgasm (Cacchioni, 2007), which further limits women's (and men's) capacities for experiencing sex. Dominant representations of good sex as orgasmic, and of good orgasmic sex as occurring in highly stylised ways, also limit women's capacities to understand sexual experience and pleasure in a range of ways. As we argued above, the compulsory aspect of orgasm

therefore makes orgasm not so much evidence of women's liberation as a new form of regulation.

Analysis of the female orgasms also allow us to see the ways that the potency of representations of female sexuality are reduced through consumerist discourses that must both sell female sexuality as exciting, but not so exciting that large numbers of consumers will find its associated products too radical to buy. Postfeminist sensibility constructs empowerment through consumption, allowing the consumption of, for example, sex toys, to be understood as a form of radical sexual femininity – a technology of sexiness. But, understanding sexuality through consumerism masks the vested interest in selling sex in ways that make money. Women's most intimate desires are thus structured through capitalism.

The focus on sex as an individual pursuit and project of the self takes focus away from the relational aspect of sex, the outcome being that when women experience problems with sex these problems are more likely to be located in the individual. Individual problems suggest individual solutions, providing the conditions of possibility for self-tracking apps, pink Viagra or HRT to be offered as technical solutions to problems that are only partly biological/medical, since research points to the social context in which women's bodily experiences occur as structuring some of that experience.

The focus on performative hetero-penetrative sex that meets men's needs absents women's desire (other than getting off on pleasing their men). Noting this absence, some feminist researchers have described a 'missing discourse of desire', which they argue is shaped by an even broader lack of gender equality that makes concepts of healthy female sexuality – with or without orgasm – difficult to imagine when the societal structure is not yet in place to facilitate this (Fine, 1988; Tolman 2012). Responding to this position, one set of arguments for widening heterosexual women's (and men's) understanding of sex, and thus increasing women's capacities for positive sexual experience, has been to develop sex education to consider sex as a pleasure occurring within a wider social context. The outcome is advocating for sex education that includes discussion on desire, pleasure and the role of wider social inequalities that structure how people can act together in intimate relationships (Macleod and Vincent, 2013). Such an approach could also be developed in sexpert advice aimed for heterosexual adult women (and men). Similar arguments have also been made for bisexual and lesbian women, whose sex education is structured around understandings of heterosexual safe sex (Grant and Nash, 2017).

Sex education that considers the context of desire stands in contrast to current sexual subjectivities within postfeminism that offer the promise of a 'good sex life' through practices of working on the self. As we have suggested, there seems to be very little in the way of an alternative sexual economy; for example, of sexual pleasure without penetration. Discourses of good sex offer, it seems, very limited and normative notions of a good life. In the next chapter we take up the idea of 'good life' promises through our consideration of pregnancy.

Notes

- 1 As Sedgwick (1990) notes it is interesting that of the entire medical 'inventions' of sexuality that emerged throughout the late nineteenth and early twentieth century, the ones that have stuck (heterosexuality and homosexuality) are most closely tied to gender-preference. All others, now exist on the borders of intelligibility. This, Sedgwick (1990) argues, ignores the whole range of possible ways of dividing up pleasure based on genital activity, which could conceivably be used to name and categorise something like 'sex' or 'sexuality'.
- 2 Lacan claimed that 'woman cannot speak of her pleasure'. Cixous (1981) has interpreted this as meaning that women are without power and so can not use language to talk about pleasure. See also Cixous and Clement (1996) for a fuller discussion on this analysis of both Freud and Lacan.
- 3 For details, see newviewcampaign.org
- 4 See for example: <http://trueviralnews.com/first-anniversary-of-fdas-approval-of-addyi-to-boost-womens-sex-drive-a-reason-to-celebrate/>; www.theglobeandmail.com/report-on-business/valeants-newest-problem-the-female-libido-pill-isnt-selling/article27291467/; www.forbes.com/sites/ritarubin/2016/08/21/first-anniversary-of-fdas-approval-of-addyi-to-boost-womens-sex-drive-a-reason-to-celebrate/#6ed5a8365af9

5

PREGNANCY

Snapping back into shape

In 1987, West and Zimmerman argued that gender is something that we do, not something that we are. They challenged the idea that masculinity and femininity could be mapped to male and female bodies, respectively, and instead theorised gender as a performance, a reoccurring practice, repeated until it feels natural and normal. Within this conceptualisation, gender also has a future orientation, in that to ‘do’ gender we must be read by others – either as congruent or incongruent – within normative expectations of masculine and feminine behaviours. We can also apply this framework to think about pregnancy. Pregnancy may be an embodied experience, but how women ‘do’ pregnancy, from absent-mindedly stroking the stomach to in-vitro fertilisation (IVF), is made sense of through a range of sociohistorical, political and technologically mediated discourses that have direct impact on what women can say, think and do, and on how others respond to them.

Pregnancy is experienced through the cultural sense making of its day. Not only does the pregnant body change as the pregnancy progresses, but so too have cultural understandings of pregnancy, making the pregnant body ‘doubly mutable’ (Hanson, 2004, p. 3). There are health issues connected to pregnancy, including abortion and postpartum depression (see Thoma, 2009, and Dubriwny, 2013, for analysis of postfeminism in relation to each respectively). These concerns are important, but they are not the focus of this chapter. Instead, we use this chapter to examine the multiple and often conflicting cultural understandings through which pregnant women, and the people they interact with, make sense of pregnancy. We show how these understandings intersect with discourses of gender, class, ethnicity and citizenship to produce particular ways of ‘knowing’ pregnancy that have profound implications for women’s experience of their embodiment, as well as their access to health care.

Pregnancy poses a radical challenge to individualism. But, this radical potential is lost when pregnancy is co-opted back into an individualist project, which has happened both historically and in the context of contemporary neoliberalism. Considering these issues, we examine the role of technology and psychological expertise in producing contemporary understandings of pregnancy. In the previous chapter, we showed how discourses of good sex offer limited and normative notions of a good life. In this chapter, we develop our analysis of living a 'good life' within postfeminist sensibility, by considering the way pregnancy becomes a postfeminist fantasy of living an ideal-yet-also-normal life. To develop this analysis of pregnancy, we draw on theories of cruel optimism and governmentality. In the process, we explore the historical disjunctures and mutations in ideas about pregnancy, examining how different interpretive frameworks emerge at different times, but also how some ideas continue through historical periods, if in mutated forms. For example, the way that women have had to hide the effects of pregnancy, which, within postfeminist sensibility, produces the requirement that women might 'snap back' into shape and their pre-pregnancy norm.

Mapping the pregnant body: historical connections

As we saw in Chapter 2, beauty, femininity and fertility are intricately linked. One outcome of these associations is a discourse that couples pregnancy with womanhood. This discourse has a long historical legacy and positions pregnancy as a normative expectation for women, and motherhood as essential to being a 'complete' woman. Pregnancy is thus an idealised state for women, symbolic of fulfilment and historically tied to women's primary childbearing role in society. Everyday understandings of pregnancy reflect this sense making. For example, pregnancy is linked to health through talk of the pregnant 'glow' and through religious discourses it is associated with the sacred, so that even in secular societies we talk of the 'miracle' of birth.

Despite these celebratory and positive constructions of pregnancy, the pregnant body is also located within a set of meanings that produce it as a highly problematic embodied state. Characteristics of a typically developing female body, such as menstruation, menopause and pregnancy, are often pathologised. These characteristics involve bodily changes, which are problematically contrasted with understandings of healthy men's bodies as stable and autonomous. In this context, the pregnant body, which is in a constant process of physical reshaping and which contains a double entanglement of both an existing and developing person, stands in stark contrast to notions of a normal, healthy body as stable and autonomous (Young, 1984; Tyler, 2001). Pregnancy holds the potential to challenge notions of the normal body as autonomous and stable, but viewed through a 'male-as-norm' framework, this challenge is undone and the pregnant body is positioned as disturbing 'other' (see for example, Tyler, 2009, for discussion of the pregnant body as object).

The construction of the female body as not-normal is evident in medical and psychological discourses that tie the pregnant body to the 'disease' of femininity

(see Chapter 1 for an account of the normalisation of pathological femininity). For example, medical accounts in the eighteenth century constructed pregnancy as the 'extreme irritability of the uterus', which was thought to leave 'impressions' on the unborn child that could create physical deformity or a disruptive child (Denman, 1778, p. 238, cited in Hanson, 2004, p. 24). Such accounts of pregnancy go back to Ancient Greek notions of the 'wandering womb', demonstrating a long genealogy of discourses that construct women's bodies as inherently pathological. Notions of pathology also intersect with fears of a monstrous pregnancy and associated cultural ideas of the alien or non-human baby. These fears enter into popular media, such as in the creation of the monster in Shelley's *Frankenstein* (Hanson, 2004) or the extra-terrestrial birth in the film *Alien* (Creed, 1993).

Further pathological constructs of the pregnant body occurred through (Judeo-Christian) religious associations that link sex with sin. Since the pregnant body was made through sex, it evoked a sex-sin discourse that positioned the pregnant body as shameful. This shame meant the pregnant body needed to be concealed as much as possible and it is only relatively recently that maternity clothes have drawn attention to the bump rather than masking it under voluminous material. Historically, high mortality rates of women in childbirth meant that pregnancy was also associated with death. The pregnant body thus symbolised a heady mixture of sex, death and freakish double embodiments, mapped over a discursive terrain of religious and cultural misogyny that also celebrated pregnancy as the idealised female state.

Cultural ideas about pregnancy, gender and health have also intersected with political, scientific, medical and health discourses that linked individual human reproduction to population reproduction and nationhood. The pregnant body is therefore part of a 'bio-politics' (Foucault, 1977), through which the nation-state comes to know and monitor its population (see Chapter 2 for related discussion of monitoring). For example, in the late eighteenth century, a political imperative emerged around the need to have a 'healthy stock' to successfully engage in war, especially in the growing Empires of Britain, Russia, Germany, France and Japan. This led to debates about the 'quality' of reproduction. One classic example of the political tension of these debates can be witnessed in the satire of Jonathan Swift's (1729/1969) *A Modest Proposal*. The implication of the proposal to sell Irish children so that their bodies could be turned into meat and clothing for others, thus making the children 'sound and useful Members of the common-wealth' (Swift, 1729/1969, p. 1), ridicules the nationalistic feeling and discourses of the time around Irish poverty and the value of their children.

Such eighteenth-century debates around reproduction became tied into Darwinian ideas of natural selection. The outcome was that pregnancy was located within eugenicist movements dedicated to producing a stronger 'race' (Hanson, 2004) and which often constructed poor people as needing intervention because they bred excessively and without quality. Early suffragettes also engaged with eugenic arguments. These first-wave feminists countered the argument that women were closer to nature, and thus inherently inferior to men, with a eugenic

standpoint that the solution to creating a stronger race was a society in which men could breed with equals; that is, intelligent, well-educated and non-enslaved women. These arguments, used to counter sexism, thus intersected with racist and classed ideologies that assumed the natural superiority of the colonising white subject and the educated middle classes.

The pregnant body's political significance is also seen in the history of feminist theory, where the pregnant body has been a site of heated debates. Some feminist scholars considered pregnancy the source of women's power, while others argued that pregnancy was the vehicle by which male power operates. For example, de Beauvoir (1953) argued that women needed to refuse pregnancy and motherhood if they were to have the same 'existential transcendence', or freedom, as men. In contrast, Kristeva (1985) and Young (1984) offer examples of those who argued for the possibilities of pregnancy for facilitating women's liberatory politics and/or embodied subjectivities. What all these feminist analysts had in common, though, was a concern for how pregnancy ties women into traditional gender roles that may limit their capacities to act. An example of this can be seen in the way psychological theory was used to reinforce traditional gender roles after the Second World War.

During the Second World War, women worked in what were previously men's jobs while the men were away fighting. That women did these jobs successfully challenged gender roles (Burman, 1994). But, post-war, a 're-traditionalisation' of gender roles was facilitated by psychological research that evidenced the importance of the mother on the psychological development of the child and thus the importance of women's caregiving roles. Harlow et al's. (1966) research, for example, in which baby rhesus monkeys chose cloth surrogate mothers over metal ones that provided milk, appeared to show that emotional care was more important than basics like food. Other research, including that by Bowlby and Ainsworth (e.g. Bowlby, 1969; Ainsworth, 1978) concluded that young children needed a primary caregiver (and one that could feed them, so limiting this role to women) or else they would develop into 'affectionless psychopaths'. Bowlby's own childhood experiences influenced his thinking and research. As an upper-class child, his primary caregiver was a nanny who left the family when he was four, and he identified similarly traumatic separations in young offenders from lower socioeconomic classes with whom he worked (van Dijken, 1998).

Bowlby's work placed responsibility for the psychological development of children on their mothers. His work remains influential to this day, despite, as critics point out, creating an understanding that absented both fathers and socioeconomic factors associated with development. One outcome of Bowlby's work was a focus on the responsibility of mothers for their children's psychological development. Bowlby's work tied women to traditional gender roles, directing attention towards individual women rather than the social contexts in which they mother, so that 'poor mothers [are constructed] as architects of their children's deprivation' (Edwards, Gillies and Horsley, 2015, p. 1).

Despite the continuing influence of Bowlby's theories (also see our discussion of 'intensive mothering' in the next chapter), the second-wave feminism that emerged

mid-twentieth century included calls for a blurring of traditional gender roles, with the expectation for men to be more involved in the pregnancy process, have an active role in parenting and participate in equal divisions of domestic labour, and for more transparency and protection for women in employment laws. A central concern for second-wave feminism was women's control over their bodies. This concern oriented around a range of issues including the choice to abort a pregnancy and a call for the reversal of the 'medicalisation' of pregnancy that devalued women's knowledge. Where historically women and midwives had facilitated the homebirth, the medicalisation of pregnancy saw birthing moved to the hospital space, facilitated by doctors, who at that time were usually male. Examples of feminist resistance to this included Ina May Gaskin's (2002) midwifery guide that celebrated community-based births and which also sought to reframe women's experiences of birth, for example, re-labelling 'contractions' as 'rushes'.

Such political concerns over embodied autonomy was met with new technologies. Perhaps the most significant technological development was the invention and subsequent availability of the contraceptive pill (1961 in the UK), which provided the women who took it with unprecedented control over their reproduction. Reproductive choice thus became a real possibility for women and mapped to the increase of women into the workforce, culminating into the early 1990s rhetoric of 'having it all', where delayed motherhood became an apparent option for the young, middle-class, successful female subject (Dubriwny and Ramadurai, 2013).

Understandings of pregnancy are thus not only located historically, socially and politically, but are also mediated through available technologies. The development of the stethoscope in 1819 is another such example. First used on the pregnant body to hear the 'splashes' of the fetus in the womb, the discovery of a distinct and separate heartbeat of the fetus shaped understandings of the nature of pregnancy, enabling a concept of the fetus as distinct from the mother (Hanson, 2004). The separate existence of the (future) baby's heart also made it possible to monitor pregnancy in new ways albeit 'within the strict constraints of modesty which framed the interaction between male doctors and pregnant patient in the nineteenth century' (Hanson, 2004, p. 4).

Subsequent technological medical developments enabled the fetus to be seen as well as heard, further facilitating an understanding of the developing baby and the pregnant woman as two separate individuals. This understanding was facilitated by individualistic discourses already prevalent in Western culture and by the way particular images that caught the public imagination were produced. For example, in 1965, *Life* magazine published what was to be a famous front cover image of a fetus. This photograph was one from images created by photographer Lennart Nilsson, whose technique for imag(in)ing the fetus in utero was to photograph aborted fetuses. Photographic techniques gave these fetuses the impression of still being alive and thus able to exist without connection to the pregnant woman's body. Nilsson's images thus facilitated a highly individualistic understanding of pregnancy and, as such, can be read as providing a kind of antidote to the challenge that pregnancy poses to notions of the normal body as autonomous and stable.

Such images map to individualistic notions of what it means to be human and direct attention away from the radical dependency of humans on each other that pregnancy might otherwise symbolise. One alternative example of understanding pregnancy, for instance, is the Japanese concept of *amae*, translated as a sweet, pleasurable (or indulgent) dependency that is represented by the symbol of a nursing baby at a mother's breast.

Our brief historical mapping of the pregnant body above shows pregnancy as both a celebrated ideal of normative femininity and something that is also understood as not-normal and pathological. This contradictory sense making occurs through multiple medical, religious and political discourses that position women's bodies and pregnancy as 'other' (in either special or weird ways). We have also shown how understandings of pregnancy are mediated through the available technologies of the time. The historical pregnant body is thus fascinating for its location within multiple interpretative frameworks that are facilitated by a range of experts (medical, political) and technologies.

Contemporary women also have to negotiate multiple understandings through which to experience their pregnant embodiment and subjectivity and to negotiate health care. Within postfeminist sensibility, pregnancy is both a choice and an expectation. We see an example of this contradictory 'choice/expectation' construction in the regular media reports that problematise 'delayed' motherhood. For example, in 2015, the British daily newspaper the *Daily Mail*¹ reported one of "Britain's top NHS fertility experts" saying that women who delay pregnancy 'risk never having children'. In such articles, delayed motherhood is constructed as a choice and motherhood as a normative expectation, but not having children early enough can result in infertility (and thus a lack of choice; Baraister and Tyler, 2010). Such understandings ignore women who feel they have to delay pregnancy to participate equally in the workforce; those who would like children earlier, but did not meet an appropriate father (see Tonkin, 2012, for research with women who are 'circumstantially childless/childfree'); or those who choose voluntary childlessness/childfreedom (Morison et al., 2015). There is also a classed and racialised element to this talk; just as with historical discourses of pregnancy, contemporary concerns around a lack of fertility are often, explicitly or implicitly, about white, middle-class women.

To explore how pregnancy is understood through the language of choice and expectation, and how this maps to wider discourses of gender, class and ethnicity, we consider three elements of postfeminist sensibility, namely, re-traditionalisation, biological essentialism and 'compulsory heterosexuality'. We argue that these elements create the conditions for desire of a life trajectory in which motherhood is understood as both normal and promising a perfect life. We theorise the impossibility of such 'normal-perfection' through Berlant's (2011) notion of cruel optimism. We then explore how these elements of postfeminist sensibility fold into wider neoliberal discourses that make pregnancy a risky position within neoliberal economies. We also consider how contemporary technologies enable particular ways of being in the world when pregnant.

'Expecting': the perfection of postfeminist pregnancy

One space where we can see how postfeminist pregnancy is constructed is in media discourses. Within a raft of postfeminist media, including those labelled as chick lit, hen lit, mum lit and postfeminist dramas and docu-soaps, pregnancy is constructed as an expectation, echoing historic discourses that associated pregnancy with ideal and normal femininity. This 'maternal turn' in popular culture is the most recent form of re-traditionalisation of women's gender roles and orients around a heterosexual feminine fantasy of finding 'Mr Right' and a subsequent idealised family life (Arthurs, 2003; Broekhuizen, 2018; Gill and Herdieckerhoff, 2006; McRobbie 2009). This 'good life' fantasy means that pregnancy is, for many, both an expectation and an aspiration. We explore this concept using the example of the film *The Back-up Plan*.

In *The Back-up Plan*, the central protagonist Zoe (Jennifer Lopez) is depicted in the opening credits of the film as a cartoon character. Zoe's cartoon version walks around an imaginary city space, where trains turn into toys, traffic wardens' whistles become dummies and bakers make babies. Oblivious to her own heterosexual attractiveness (as men fall down the subway stairs after her), Zoe is depicted as lost in a world driven by her 'biological clock' and pregnant with dreams of becoming pregnant.

By using the technique of an imaginary cartoon world, the ideal world represented in the opening credits is rendered a fantasy and is subsequently contrasted with the 'real' Zoe, who has no partner and is not pregnant. In the film, Zoe is caught in a 'Catch-22', so lost to the dreams of becoming pregnant that she fails to see the 'eligible bachelors' that chase her. Her lack of heterosexual partnership is constructed as a heterosexual failure to meet 'Mr Right', with Zoe telling her female friend 'I've dated hundreds of guys over the past five years. Not one of them's close to being the one'. The film thus sets up this contemporary female protagonist within traditional gender roles, biological essentialism and heterosexuality, since her inability to access the happiness that babies would enable is set within a context of a biological ticking clock and undone by the 'real' circumstances where Zoe is not in a heterosexual relationship. And, in a typical postfeminist storyline, this urban and comfortably wealthy woman demonstrates agency and choice by taking matters/her body into her own hands by seeking IVF.

However, Zoe meets 'Mr Right', Stan, on her way out of the clinic and Zoe's dream world in the opening credits becomes compromised as she tries to negotiate an IVF pregnancy and a new relationship with her perfect partner. The fantasy pregnancy that is easy and embedded within a relationship with the father becomes increasingly distanced from how she can live her life. In the film, the object that is made to stand in for optimism, the fetus, does not live out its promise until the end, when Zoe becomes pregnant for a second time, with Mr Right. Ultimately, then, despite various troubles on the way, pregnancy fulfils its promise of an ideal contemporary life of fulfilling family and work: with one child and a second on the way, Zoe and Stan open their own restaurant together, next to Zoe's already successful pet store.

The Back-up Plan highlights the incredible amount of expectation surrounding pregnancy that is evidenced in a range of contemporary pregnancy-themed films (Oliver, 2012). In a context where women have more economic power and reproductive technological assistance/control than ever before, they are embedded within a cultural fantasy that pregnancy within a heterosexual relationship is the gateway to a 'good life' that is both normal *and* perfect.

In her book *The Promise of Happiness*, Sara Ahmed (2010) argues that media and cultural discourses set up an expectation that traditional sexual, gender and ethnic relations are the route to happiness, so that our attempts to follow the path to happiness in fact fold us back into established power relations that might actually limit us. In films such as *The Back-up Plan*, pregnancy within a heterosexual relationship is an example of a happiness promise; despite the separation between the fantasy of pregnancy and its reality that creates the plot line of the film, ultimately Zoe achieves her dream. Ideal pregnant subjectivity thus becomes tied into traditionalism, conservatism and conventional desire that we see in notions of 'maternal bliss' and the 'happy family' (see Ahmed, 2010, for a critique of the latter).

We relate this postfeminist re-traditionalism to Berlant's (2011) notion of 'cruel optimism'. Berlant considers the spaces that represent our dreams of 'the good life', exploring how we become attached to cultural ideas of what will make us happy. These attachments represent a form of optimism, since we expect the object of our attachment to make us happy. But, this optimism is 'cruel' because it is unattainable or bad for us. A postfeminist framing of happiness through pregnancy can be understood as form of cruel optimism because the possibility of maternal bliss as a continuous, normative aspect of everyday life is a fantasy, yet it is understood as normal and attainable. The outcome for Berlant is a 'violence of normativity' (Berlant, 2011, p. 28) in which we are damaged by our attempts to live normal lives that represent a 'good life'. McRobbie (2015) applied this thinking to Peaches Geldof's response to motherhood. Before her death from a heroin overdose in 2014, Geldof became a proponent of attachment parenting based on Bowlby's attachment theory. She wrote a column for *Mother and Baby* magazine in which she regularly described the bliss of perfect pregnancy and motherhood, which her tragic death showed she was unable to maintain. The concept of cruel optimism draws attention to the impossibility of normal-perfection and the significant damage it can do to women who attempt to make sense of themselves through the postfeminist promise of pregnancy.

What we see in postfeminist pregnancy discourses is thus a resurgence and repetition of pregnancy as the ideal of femininity, as well as attachment theory and traditional gender roles of women as caregivers. A factor in enabling this shift is, Gill (2007c) argues, biological essentialism, in which women's psychology and social roles are understood as produced through their biology. Biological essentialism is a characteristic of postfeminist sensibility. But with pregnancy, we argue, it is particularly easy to take for granted because of pregnancy's inherent effect on the body and its historical associations with nature. The narratives of living a perfect life, of wanting to be lost in pregnancy and of dreaming of pregnancy (such as those

represented by *The Back-up Plan*, high-profile pregnant women and mothers, and other contemporary media representations) imply a pregnant subjectivity that is the result of hormones, natural 'biological clocks', feminine maturity and/or natural/healthy life-stage narratives of growing up, settling down and making a home.

Biological essentialism takes place alongside a media panic about an impending 'fertility crisis', where women are leaving pregnancy 'too late', an example of which we gave above from the *Daily Mail*. The media panic about women leaving it 'too late' can be understood as a triple bind. First, pregnancy is seen as an assumed embodiment: if you are a woman, at some point you will be (or will want to be) pregnant. This closes down any options for childfree existence, where non-pregnancy is a 'choice' and not an issue with a woman's fertility. Second, the media discourse of a fertility crisis locates the 'problem' of delayed motherhood with individual psychology and physiology – as a women's choice that goes against her biology – closing down questions about workplace practices that still discriminate against pregnant women and which may inform women's reasons for delaying motherhood. Third, feminism is often constructed as the mechanism behind women's refusal of their natural maternal instincts (Fixmer-Oraiz, 2014), closing down possibilities for women to engage in collective activism against androcentric working practices.

Postfeminist pregnancy combines both a re-traditionalisation of gender norms and biological essentialism with compulsory heterosexuality. Compulsory heterosexuality is a term used to describe the way that heterosexuality is normalised within postfeminism, creating an expectation for women to work on their appearance in order to look heterosexually attractive while also understanding that this appearance work is empowering – something they do for themselves and not for the approval of men. As analysts of postfeminism have argued, postfeminism combines the contradictory expectations to be whatever you want to be and to love your body, but to also desire to work on yourself so that the body meets very limited cultural beauty ideals (Gill and Elias 2014; Ringrose and Walkerdine, 2008; Evans and Riley, 2014). Pregnancy does not exclude women from this requirement. This is evidenced in pregnant celebrity cover shoots, featuring smooth skin and a perfect round belly on otherwise unchanged bodies that present the pregnant body as fashionable, chic and sexy (Harris, 2004; Oliver, 2012; Tyler, 2001). We see these discourses circulating, for example, in the media coverage of Beyoncé's pregnant body and her subsequent return to prepregnancy size and weight; and in the breadth of popular and highbrow media discussions of Kim Kardashian's weight gain and 'trashy' performance of pregnancy, which can be contrasted to media celebrations of Kate Middleton's 'classy' slim-embodied pregnancies (Allen et al., 2015). The expectation to remain heterosexually attractive can also be seen in the range of postnatal diets that encourage the idea that women might 'snap back' into shape, in ways that emphasise the pregnant body's elasticity and create unrealistic ideals of postpartum appearance (Seagram and Daniluk, 2002). Pregnant women are thus not allowed to 'go with the flow' of their biologically unfolding state, instead, pregnancy is 'reconfigured as a ... "body project" to be directed and managed, another site of

feminine performance anxiety and thus ironically a new kind of confinement for women' (Tyler, 2011, p. 29).

A further concern with postfeminist pregnancy is how it masks inequalities around class and ethnicity. Chatman (2015), for example, argues that the embodiment of culturally admired figures such as Beyoncé is oppressive for ordinary women. Constructed through the apolitical lens of postfeminism, famous women's body successes are attributed to personal effort and empowerment in ways that ignore the material barriers and disempowerment that women experience through socioeconomic and racial inequalities. Representations of Beyoncé's return to work, for example, mask an assemblage that includes a historic lack of maternity leave provision that disproportionately affects black women, the need to be seen as an economically active citizen and the way in which work produces subjectivity, a self that should not be 'lost' to the demands of motherhood. The 'snap back into shape' discourse also erases the embodied experiences of pregnancy; the leaky, saggy, stretch-marked postpartum body is hidden by representations of the taut, toned, work-ready, sexually appealing postfeminist body.

Pregnancy is thus incorporated into the transformation imperative of postfeminist sensibility, where women's bodies are constructed as malleable and women's worth read in their ability to work on their bodies in order to transform them into the slim, toned ideal (Riley and Evans, 2018). The potential for pregnancy to disrupt postfeminist sensibility is thus lost and, with it, the potential for pregnancy to disrupt the highly individualised ideal of neoliberal citizenship, in which the ideal subject is understood as autonomous, rational, risk managing, and thus a person who can work on themselves so that they may transform into what they desire and who is not reliant on others (particularly the state) to do so. The interconnected, doubled embodiment of pregnancy might challenge such an individualised concept of the person, but instead, as we argue above, re-traditionalisation, biological essentialism and compulsory heterosexuality enable pregnancy to become yet another project of the self. The pregnant body, like other bodies, becomes understood as malleable and produced through self-scrutiny and body work.

Pregnancy does not sit entirely comfortably within neoliberalism, however, which we argue, makes pregnancy a 'risky' subject position. Part of this risk comes from the fundamental conflict between pregnant subjectivity and the ideal neoliberal citizen, who is economically productive, independent and self-reliant. Pregnancy troubles neoliberal concepts of the self, as it is fundamentally relational and co-dependent. It also often means time out of full-time, paid employment. Yet neoliberalism is predicated on a citizen who is autonomous, financially independent and who does not require state welfare or support. This economic citizen model problematises women who do not return to paid employment at a level that allows them to live without state support (Harris, 2004).

Pregnancy thus puts women within a nexus of contradictory expectations: attachment theory sets up the mother as the primary caregiver, with re-traditionalisation positioning this role as one associated with choice, pleasure and feminine fulfilment, while biological essentialism challenges decisions to delay

motherhood. On the other hand, neoliberal economic citizen discourses define citizenship through economic participation that requires women not to stay at home, while androcentric working practices derived from a male-as-norm framework mean that early breaks or part-time working practices are likely to be detrimental to women's career opportunities. Outlined in such a way, notions of 'having it all' seem far from the lived experiences of many women contemplating pregnancy. Instead, these arguments challenge the notions of 'choice' that are so embedded within postfeminist sensibility.

Indeed, the notion of 'choice' itself makes postfeminist pregnancy risky. Postfeminism both draws on and refutes feminism. This 'double entanglement' with feminism can be seen in how the discourse of 'choice' is applied to pregnancy. As we saw in our historical discussion, 'choice' was a central motif for second-wave feminism. Within postfeminism, the discourse of choice in relation to reproductive bodily control remains, but it is conceptualised in the individualistic frameworks of neoliberalism, so that pregnancy becomes constructed as a lifestyle choice. But constructing pregnancy as a lifestyle choice fails to account for (or indeed it works to mask) the context in which women make choices. In the context of pregnancy, women can feel pressure to 'choose'. For example, research with women participating in IVF highlights the way some women feel that having the technology available means that they have "no choice" but to try it' (Nahman, 2008, p. 76). Such accounts echo the choice/expectation discourse we described earlier, which, in this context, is enabled by the assisted reproductive technology of IVF.

Much like the way Nilsson's photographs of the fetus masked its fundamental dependency on its mother's body, neoliberal and postfeminist individualism masks how 'choices' are made within wider unequal social structures and available technologies. The outcome is that inequalities in the kinds of 'choices' women can make are hidden by discourses of individual consumerism (Dubriwny and Ramadurai, 2013). For example, major new technology industries such as the companies of Facebook and Google offer their female employees a monetary reward/payment for freezing their eggs as part of their employment package. This remuneration is accounted for within the discourse of 'choice'; it allows women to decide when they want children. But, the risk is that women who do not 'choose' such assisted reproductive technologies are understood as failing to participate appropriately in work organisations, and pregnancy becomes risky.

The discourse of 'choice' also draws attention away from considering the wider context in which reproductive health and technologies resources are mobilised. Nahman (2008), for example, notes that in the context of low success rates of IVF with ova donation, the 'spin-offs' of this form of IVF include 'developing new techniques, generating more research papers and developing new pharmaceutical associated with reprotch' (p. 67).

Assisted reproductive technologies are widely seen as a way of increasing women's control and choice in the face of later motherhood, infertility, cancer treatment or relationship breakdown (Martin, 2010), but these technologies are located within wider economic conditions that limit choice. Access to such

technologies are limited for women considered medically overweight or too old, or who have limited finance or are in the wrong geographic location (for research on inequalities and restrictions for people seeking assisted reproductive treatment, see, for example, Donchin, 2010, and Whittaker, 2011). Similarly, there are concerns that economic inequalities mean that women who donate eggs and who are exposed to the associated health risks may not feel that they have much choice (Donchin, 2010; Nahman, 2008; Whittaker, 2011).

Given the problematising of notions of choice within postfeminism, Nahman (2008) suggests that we focus instead on how desire is mobilised for all the actors involved and the economic, sociohistorical and political contexts in which these desires operate. From this perspective, thinking about women's decisions to undergo IVF or to sell eggs requires us to consider those in the pharmaceutical industry, fertility researchers, people from comparatively wealthy states seeking ova, the women from poor states who sell theirs, the doctors, nurses, and clinic managers involved, as well as neoliberal markets and globalised consumer culture (that enable, for example, the pleasures of being able to participate in consumer culture with money from egg donation, as well as the expectation to participate in IVF experienced by wealthier women with infertility problems). Nahman (2008) also considers the legal and philosophical discourses of bodies and rights that are drawn on by a range of actors, including activists making sense of 'reprotech' and localised historical legacies that might impact on women's decisions (for example, the Romanian egg-selling participants had a cultural memory of the limited reproductive control earlier generations of women experienced under Ceausescu's Soviet-era reign).

The limits to the choice discourse are also evident when we consider the way women's class, gender and ethnicity are used to bestow il/legitimacy on their decisions to engage in assisted reproductive technologies. One example was the response to the multiple IVF pregnancy of Nadya Suleman's octuplets in 2009. The birth of Suleman's octuplets was greeted at first with approval. Multiple births have been celebrated in the United States in reality TV programmes such as *19 Kids and Counting*, *Raising Sextuplets* and *Kate Plus 8*. But information about Suleman emerged that differentiated her from these traditional American two-parent families. She was a single mother of Iraqi/Lithuanian heritage, in receipt of welfare, and already had six children. She attracted intense criticism on the basis of all of these deviations from 'appropriate' motherhood, but she and her doctor (who was later disqualified from practising medicine in California) were deemed especially irresponsible for undertaking the risk of transferring multiple embryos because of her lack of financial stability. Suleman was thus pathologised through neoliberal discourses of economic citizenship, risk and responsibility, and further vilified when, with TV deals failing to materialise, she earned money through appearances in nightclubs, a Playboy photo shoot and a pornographic film (Fixmer-Oraiz, 2014).

The vitriolic media response to Suleman's status as both a recipient of welfare and a working-class sexualised mother is an example of what Tyler (2008) describes as a 'class disgust' that is reserved for young working-class mothers who are constructed as failing to meet normative standards of feminine purity, morality

and decency. In her analysis of the figuration of the ‘chav mum’, Tyler argues that working-class pregnant women are constructed within discourses of apparent concern that enable the articulation of disgust (also see Egan, 2013, in relation to class, youth and sexualisation). We offer an example from a 2015 *Daily Mail*² headline that reads: ‘Prepare to pay! Jobless couple dubbed “Britain’s fattest scroungers” lose 13st between them ... and are now expecting their FOURTEENTH child’. Such accounts create an aversive affective response by tying discourses of weight, excess and reproduction to economic citizenship and neoliberal ideals of the self-reliant individual.

Similarly, teenage pregnancies are represented as bad life decisions. In parallel with historical discourses around nation and fertility, contemporary media discourses construct the pregnant teenager as a figure of all that is wrong with the nation: poor personal choices, laziness, incompetence, inappropriate risk taking, failed femininity and the vehicle by which the next generation of failed citizens who make poor decisions are produced (Harris, 2004; McRobbie, 2009). These discourses reproduce concerns over the reproduction practices of the poor and working classes that we saw in our historical analysis, echoing the call of the eugenics movement for the ‘genetically fit’ to reproduce and strategies to restrict the fertility of the genetically inferior lower classes. Now, though, such concerns are more likely to be voiced within neoliberal discourses of economic citizenship, rather than Darwinian evolution, but their function is the same: the social exclusion of those not white and middle class.

Contemporary classed and gendered discourses around pregnancy also intersect with those of ethnicity. For example, Tyler (2008) argues that in a range of reality television shows, white working-class mothers, often surrounded by children, who are themselves often ‘not-quite-white’, comes to represent an excessive sexual femininity and a ‘whiteness contaminated with poverty’ (p. 25). For those not British, Tyler (2013) highlights how UK government policies aimed at managing historical legacies of colonialism that might otherwise bestow British citizenship to those born on British soil mean that children born in Britain to non-British migrant women receive their mother’s citizenship. The outcome is that the migrant woman’s pregnant body becomes a state border so that ‘increasingly birth is associated not only with the breaching of bodily borders but with the invasion of territorial borders’ (Tyler, 2013, p. 110). Tyler also shows how media stories about ‘health tourists’ and policies shaping forms of citizenship position the pregnant migrant woman as an immigration problem that threatens national collective health resources, despite evidence that many pregnant women seeking asylum in the UK are too scared to visit National Health doctors for fear of being reported (Waugh, 2010, cited in Tyler, 2013).

Postfeminist pregnancy is located within this discourse of choice, but, as we have argued above, ‘choice’ is a problematised construct which masks the contexts in which women make decisions about reproduction. The outcome is that attention is taken away from this complexity, as well as from structural inequalities in access to health care, employment practices that disadvantage the younger mother and

public discourses that devalue (if not vilify) women who do not seek motherhood within limited parameters (not too young, not too old, with a partner, financially independent but also the primary caregiver to the child). As we saw in the discussion in Chapter 2 of governmentality, the rhetoric of choice is part of the way that neoliberal regimes work; people consider themselves as having freedom to choose, despite social exclusion of those who fail to choose ‘appropriately’. As such, governmentality works through exclusion (and the desire to avoid being excluded) and normalisation (the desire to meet cultural definitions of what it means to be a good person). In the next section, we return to governmentality in relation to postfeminist pregnancy.

Governing postfeminist pregnancy

In his account of the ‘governed soul’, Rose (1990) suggests that the social space of the family produces a specialised form of governmentality and management of the people. We would extend this idea to include pregnancy, as the fundamental starting point of any biological family. By ‘governmentality’, Rose (1990) refers to a specific form of modern power that works through psychology to shape people, so that decisions that people make feel like their own, but are also aligned with wider social norms.

We may like to think about this concept in terms of an emphasis on the word ‘mentalities’. If governing is about shaping societies (different perhaps from dictating or totalising), then ‘governing mentalities’ would mean shaping the ways people are able to think. One way to do this is through the promise of a ‘better life’, where, for example, taking the stairs instead of the lift, eating five portions of fruit and vegetables a day, drinking less, not taking (the wrong kinds of) drugs and abstaining from smoking are understood as extending life and thus a good thing to do. And, by extension, doing ‘good’ things allows people to think of themselves as ‘good’ people or, in Foucauldian terms, ‘ethical subjects’. This constitutes a ‘productive’ form of power, in which power is the process by which ideas become accepted as normal and taken for granted, so that people feel that they employ these ideas through their own volition.

Productive power is diffused rather than top down. This means that although government departments might encourage certain behaviours (for example, the Department of Health might issue nutritional advice for pregnant women), much of the way in which taken-for-granted knowledge becomes distributed is through various semi-autonomous ‘*dispositifs*’: institutions, bodies of knowledge, disciplines, organisations and agents, who constitute a diverse ‘ensemble’ – a network of ideas – that work more or less consistently to make things ‘true’. For example, pregnant women might come to understand what is good for them to eat through magazines, blogs, routine appointments with health professionals and conversations with friends, through which these ideas circulate. Governmentality thus requires the sharing of ideas about what it means to ‘do’ pregnancy well. These discourses construct ways of being in the world that represent a ‘good’ pregnancy and the

subject positions associated with good pregnancy. In this way, pregnancy – like the family – ‘remains intensively governed ... through the promotion of subjectivities, the construction of pleasures and ambitions, and the activation of guilt, anxiety, envy, and disappointment’ (Rose, 1990, p. 213).

Discourses of pregnancy make visible certain ways of seeing the world. Deleuze (1992) talks about governmental *dispositif* as lines of light, which crisscross over an object and make it visible. In their visibility, these objects become easier to manage, control and ‘govern’, so that with visibility also comes forms of surveillance. Consider, for example, the social sanctioning of pregnant women who publicly smoke, drink alcohol or, as in the Kim Kardashian example in our earlier section, gain weight or fail to look conventionally sexually attractive during pregnancy. However, a key feature of governmentality is that social sanctioning is rarely needed, because people do it to themselves. Just as with Zoe in *The Back-up Plan*, they compare their own life to the culturally shared understanding of the ‘good life’ and seek actions to address any gap between the two, often with the help of experts and technology.

A proliferation of new ‘experts of the soul’ have emerged to facilitate postfeminist pregnancy. These specialists, experts, advice gurus and professionals constitute a new arrangement or assemblage of *dispositif* that concern the management of pregnancy in line with postfeminist discourses of choice, autonomy and consumerism. These address the pregnant woman as the manager of her own pregnancy and position pregnancy within wider lifestyle consumer choice discourses. But, as some analysts argue, the outcome is not so much freedom through choice but through intense forms of self-monitoring and self-discipline. Below, we explore this in relation to new mobile media technologies, using the app *The Bump* as an example.

The Bump is a freely available digital media health app allowing the pregnant woman to monitor, day-by-day, her pregnancy. The app includes a range of advice pages, including suggestions on fashion, how best to sleep, what to ask the doctor or midwife and how to interact with the coming-baby’s father. Throughout the various pages, all forms of address are directed to the woman, not the couple. There are no responsibilities or lists of requirements for men to fulfil and, equally, no subject positions are available for pregnancies outside normative couples, for instance in surrogacy. Subscribers to *The Bump* are sent weekly updates on the size of the fetus relative to different fruit and vegetables, as well as information on the fetus’s development. For example, at week 19, users are told ‘Your baby is as big as a mango’ or at week 33 that ‘He’s keeping his eyes open while awake. He’s also starting to coordinate breathing with sucking and swallowing’. As with our outline of postfeminist pregnancy above, the app conforms with the privileging of an idyllic and leisurely embrace of pregnant embodiment, where health advice becomes indiscernible from forms of consumption that are only available to the good citizen consumer. Links to advice on ‘Baby Showers’ and ‘Maternity Fashion’ sit alongside those for ‘Miscarriage and Loss’, as if these were comparable aspects of pregnancy. As another example, content under the advice tab ‘Nursery Ideas’ includes advice on home improvement that makes assumptions about disposable income and taste: ‘Treat the

nursery like you would the rest of your home; if you love modern design, go for it. Don't feel the need to fit some old fashioned criteria. Otherwise, your child will grow up to have terrible taste in décor'.

Coleman's (2010) analysis of the Weight Watchers online platform suggests that new media technologies enable forms of temporality (keeping time, seeing time pass, imagining a future) that create new modes of governmentality. Apps like The Bump similarly allow for intense forms of self-monitoring and self-disciplining dictated by time – with lists of activities, which include making the pregnancy bump visible through documenting its growth week-on-week, emphasising the women's body parts rather than the whole pregnant women, and instructions on the various appointments with experts that need scheduling (e.g. antenatal visits, touring the maternity ward, birthing plans, labour exercises). And like wedding forums (see Broekhuizen, 2018), the app also caters to future concerns after pregnancy, with additional advice and active community to address postnatal health and consumption practices.

The Bump therefore enacts new forms of power, and more so given its intensely personal, intimate forms of address that map to contemporary cultural concerns. In Åström's (2015) analysis of 'new momism', she draws several parallels between contemporary pregnancy health advice and Victorian literature, noting that where the Victorian advice was concerned with inciting the fear of child fatality, current pregnancy and parenting advice concerns issues relate to psychology and appearance (e.g. obesity). The Bump, for example, includes a range of advice on weight and weight management during pregnancy, with a focus on the 'right' kinds of food to consume; 'step away from the Oreos and grab an apple instead', 'are you getting the proper nutrients for your baby?', 'Are you eating your super foods?'

The development of such new media technologies takes place within a context of heightened concern with monitoring pregnancy. Pregnant subjectivity has become the site of intense medical and legal intrusions (Longhurst, 2000). While apps like The Bump emphasise neoliberal forms of 'good life' consumption alongside day-to-day medical and health concerns, they do so while rendering invisible the bodily intrusions and forms of monitoring that are practised during pregnancy. As we outlined in the historical section of this chapter, pregnancy is often understood as a risk. This risk necessitates forms of governmentality, ensuring that the pregnant body comes into line with 'normality', so that '[m]edicine's self-identification as the curing profession encourages others as well as the woman to think of her pregnancy as a condition which deviates from normal health' (Young, 1984, p. 46).

One of the ways that pregnancy is made to deviate from 'normal health' is in the many antenatal tests pregnant women routinely undergo. As well as regular checks on weight and blood pressure, and set times for ultrasound, pregnant women may also be expected to undergo a series of urine and blood tests and internal examinations (Lupton, 1999). In the context of such heightened medical scrutiny of the body, the governance of pregnancy through apps like The Bump may inform 'softer' forms of power, which normalise the intensity of the procedures and medical scrutiny of the woman's body, making it appear pleasurable, normal and

safe.³ Taken together, the postfeminist reframing of pregnancy and its governance through new technologies, both mediated and medical, work to make pregnancy a closely observed, surveyed and monitored embodied transition, in need of careful management by the pregnant woman herself and those around her. We would also suggest that it allows for an internalisation of forms of surveillance, imposing new kinds of pregnant subjectivity that also absents others (e.g. surrogacy, unwanted pregnancy, single motherhood, LGBT* parenting) and overlooks a global market that has developed around pregnant bodies (see, for example, Riggs and Due, 2017, for a detailed discussion of these issues relating to surrogacy).

Conclusion

In this chapter, we have conceptualised pregnancy as something that women 'do', as an embodied experience made sense of at the intersections of a range of sociohistorically located discourses. We explored the ways that pregnancy is constructed as an ideal female state, both historically and within postfeminist sensibility, but also how pregnancy positions women as 'other' because their doubled embodiment stands in stark contrast to the unchanging ideal adult male body and to neoliberal ideals of autonomy and individualism. We have shown that, whether as an ideal female state or as a challenge to masculine norms and neoliberal subjectivity, pregnancy is a risky position.

As an ideal female state, postfeminist pregnancy holds an expectation of normal-perfection, a vision of the good life that is unattainable and which may cause significant psychological damage as women attempt to live out an expectation for their everyday life to be perfect. For this reason, we drew on Berlant's concept of cruel optimism to think through the good life narratives of postfeminist pregnancy. We also drew on Foucauldian concepts of diffused, disciplinary power and normalisation to consider the ways that postfeminist pregnancy ties together intense forms of medical and mediated forms of surveillance within a narrative of pleasure and consumption. And we considered who is excluded from postfeminist pregnancy subjectivities. Individual pregnancies come with a range of contextual, personal and sociocultural issues that shape how pregnancy is experienced. But postfeminist pregnancy narratives exclude those who are not white, middle class, consumer oriented and with disposable incomes, as well as the woman who is unable to get pregnant, becomes pregnant outside notions of 'choice' or who is pregnant because of wider social, economic and global market demands for reproduction (see Twine, 2011). Pregnancy as an ideal state is thus only available to a limited number of women, who must also understand themselves within postfeminist elements of biological essentialism, re-traditionalisation and compulsory heterosexuality.

Our discussion of compulsory heterosexuality also highlighted other ways in which pregnancy is risky. Within postfeminism, women must work on themselves to meet cultural ideals of heterosexual beauty, while understanding this work as their choice. In the context of pregnancy, this means a celebration of the pregnant body (seen, for example, in photographs exposing the bump) that, contradictorily,

also hides other embodied aspects of pregnancy (such as a stretched stomach). A changed body, particularly one that is not understood as immediately heterosexually attractive, risks contempt. Following pregnancy, women must thus work on their bodies to return them to their pre-pregnancy, unchanged 'norm'. In the media, this means that 'celebrity' women's bodies are intensely scrutinised. But in the lives of non-celebrity women, women's ability to remove the signs of having been pregnant is also a marker of success. Postpregnancy is thus characterised by an imperative to work on the body, an imperative that potentially takes time away from enjoying the interconnected experience of bonding with the baby (Suzie Orbach, personal communication).

The tying together of pregnancy, health and consumerism that occurs within postfeminist pregnancy encourages a form of regulation that we theorise through the lens of disciplinary power. Within postfeminist sensibility, a good pregnancy is constructed as one that involves constant scrutiny and application of guides, often mediated through new technologies. Our analysis of the app *The Bump* supports arguments for considering Foucauldian notions of panoptic power as useful in making sense of contemporary self-surveillance. It also shows how constructions of what is a good pregnancy tie in consumption with health regulation, so that from the colour of a nursery to the type of vitamins taken, health, lifestyle and consumption are brought together through online advice. Such apps offer the appearance of a good friend taking you through the important choices that allow for a healthy and happy pregnancy, but we contend that the outcome is often one of limits and anxiety. Limitations in the kind of mother you can be (a consuming one) and anxieties about doing it right, since consumer cultures are predicated on judging people by their consumption and on desire never being satisfied for long.

Within a postfeminist sensibility, the pregnant body is a risk that is managed through consumption, healthism and neoliberalism. But the pregnant body holds within it a genuine challenge to neoliberalism. Feminist readings suggest possibilities for thinking differently about the pregnant body, offering directions for health activism that challenge individualism, 'good life' capitalism and normative relationships. The pregnant body is a body that can produce other bodies; as such, it offers the potential to conceptualise a relationship-oriented subjectivity, where the communicative power between mother and fetus stands as a metaphor for a more relational, interconnected and permeable understanding of subjectivity (Blackman, 2012).

Such critical analyses of pregnancy give us a fundamentally interconnected view of subjectivity, a perspective that is also facilitated by new technologies. For example, research on assisted reproductive technologies has identified a process of fetal microchimerism, in which both the baby and the surrogate mother share cells through the process of pregnancy even while they are genetically unrelated. This interconnectedness has the potential to challenge contemporary discourses of individualism and autonomy. It also points to the utility of bringing together Foucauldian and Deleuzian ideas, so that we might resist seeing individuals as bounded entities and instead see them as complex sets of interconnected relations.

As the work of Nahman (2008) showed, a Foucauldian–Deleuzian approach would also facilitate an analysis of the flow of desires and how desire is mobilised for all the actors involved and the economic, sociohistorical and political contexts in which these desires operate.

In this chapter, we have shown how postfeminist sensibility directs women's desires towards a normal-perfection expectation of pregnancy that can undermine rather than support women's capacities to act. In the next chapter, we explore how their subsequent childcare is also tied into a form of postfeminist perfection, whereby discourses of choice, autonomy and empowerment are again tied to biological essentialist arguments to justify a romanticised re-traditionalisation of women's roles that legitimises further intensive scrutiny of mothers.

Notes

- 1 www.dailymail.co.uk/news/article-3104023/NHS-chief-warns-women-not-wait-30-baby-country-faces-fertility-timebomb.html
- 2 www.dailymail.co.uk/femail/article-3144367/Prepare-pay-Jobless-couple-dubbed-Britain-s-fattest-scroungers-lose-13st-expecting-FOURTEENTH-child.html
- 3 As an aside, we would also note that despite its cheerful address, many of the reviews of the app give it negative scores, not for the advice within the platform, but because the community forums within the platform are perceived as 'bitchy', 'cruel' and 'vile'. For example, one review reads 'App is okay, however some of the frequent posters in the forum are rude, aggressive and unfriendly ... ON ALMOST EVERY POST!!! Don't join, find an alternative without bullies'. Although we haven't engaged with the forums, such complaints demonstrate the opportunities within communities of pregnant women to engage further in judgemental forms of postfeminist rhetoric.

6

INTIMATE RESPONSIBILITIES

The good mother

Ulrich's (1990) *A Midwife's Tale* tells a story from the diary of Martha Ballard, who worked as a midwife in eighteenth-century New England until her death aged 77. Ballard farmed, cleaned, cooked, wove fabric, made clothes for a large extended family and engaged in 'emotional labour', managed the relationships between daughters and sons-in-law, fostered her children's romantic relationships, provided childcare and supported her husband, managing the family finances when he was jailed for debt. Ballard's diary gives not just an insight into eighteenth-century life, but also evidence that a woman juggling home, work and children is not a modern phenomenon. From this perspective, perhaps there is more similarity than one might first assume between Ballard writing 200 years ago and, for example, the autobiography of twenty-first century glamour model, business woman and mother, Katie Price (Jordan).

But what distinguishes Ballard from Price is that Price may be made sense of through a postfeminist sensibility that encourages women to work on themselves as if they were a project. Postfeminism draws on discourses of choice, autonomy and empowerment and, in this chapter, we explore how these discourses are tied to biological essentialist arguments to justify a romanticised re-traditionalisation of women's roles, locating women's pleasures and senses of self in the domestic sphere. We explore the way in which re-traditionalisation works with an ideology of 'intensive mothering', neoliberalism and healthism, to hold mothers accountable for the healthy development of their child. This accountability legitimises intensive scrutiny of mothers, creating impossible spaces for them to occupy since women must be self-focused enough to be an appropriately consuming economic citizen, but also child focused, dedicating all her time and energy to her child or children.

A range of *dispositifs* facilitate the construction of women's intimate responsibilities, including government, commerce and media, which often inform each other, circulating ideas that locate responsibility for health with women. The outcome is that government responsibilities towards the health of its nation has become focused on the scrutiny and education of women, a practice they can outsource to business. Such public–private partnerships facilitate greater reach of health promotion, but do so in ways that tie good mothering to consumption and, in countries that need it, fail to contribute to the development of health infrastructure, such as clean water, that would have greater effect on the health and mortality of children.

This chapter explores the way government, commerce and media articulate a set of regulatory discourses that create a luminosity of a particular mother figure, which validates a form of white, middle-class motherhood, while also making it an anxious, unstable position. Yet within women's 'intimate responsibilities', women's responsibility for the health of their children may be experienced as empowering. We explore health promotion as one mechanism by which women gain knowledge that allows them to act in new ways and take up valued subject positions, particularly that of the 'good mother'.

We finish this chapter by considering breastfeeding, an issue that crystallises the way that 'intimate responsibilities' are mobilised around subjectivity and what it means to be a 'good mother'. Through breastfeeding, we explore the themes of this chapter, of how individual risk and responsibility discourses are validated through neoliberal healthism and how they intersect with women's traditional caring role and commercial investments in this role in ways that have significant effects on women's subjectivity, their health and the health of their children. In so doing, we expand our intersectional analysis of postfeminism to consider the classed and racialised aspects of postfeminist motherhood and develop thinking around postfeminist sensibility as a globalised address facilitated by commercial investments in female subjectivity.

A woman's place: caring, postfeminism and re-traditionalisation

Discourses of 'choice', which include delaying motherhood or being childfree, make different embodiments of femininity possible. But such apparent choice is shaped by the needs of the market and workforce, and coexists with more traditional feminine responsibilities as romantic partners, homemakers, carers and mothers. As we saw in the previous chapter, women's reproductive role sets the context for intense surveillance and monitoring, where postfeminist pregnancy is an expected performance, requiring constant body work, transformation and a normalisation of (impossible) perfection. The resurgence of ideals of femininity relating to appearance, domestic and family responsibilities is a form of postfeminist 're-traditionalisation' in which essentialist arguments are used to construct women's desires as biologically driven. Such arguments construct women's juggling of home, work and children as a modern and problematic phenomenon brought on by feminist demands to enter

the public sphere that go against women's natural biology. Re-traditionalisation represents a nostalgic turning back, of finding pleasures in traditional female roles of child care. For example, in the UK, Persil recently produced a nostalgic advert, that under the question of 'What is a mum?' showed historical footage of families and Persil adverts with a voiceover that tied motherhood to self-sacrifice, care and love before concluding that 'a mum is someone who uses Persil'.¹

Re-traditionalisation is often interpreted through evolutionary and biological arguments that construct women as programmed to choose and find fulfilment in traditional female concerns such as childcare and appearance. Postfeminism thus requires women to understand themselves as autonomous and agentic, and to direct that agency towards traditional feminine pursuits of appearance concerns, relationships, domestic responsibilities and child rearing.

There is rhetorical power in biological and evolutionary arguments – it is hard to argue against science. But in public debates around gender roles biological essentialist arguments fail to engage with issues of context, plasticity, adaption or complexity that are part of a more scientific discourse on evolution/biology. Instead, biological essentialist arguments function at the level of myth, offering contradictory, unfalsifiable and simplistic stories of human thinking and behaviour (Men are from Mars, Women from Venus!). In Deleuzian terms, biological and evolutionary arguments used to support re-traditionalisation limit women's capacities to act by reinforcing an already existing patriarchal and heterosexist order. For example, successful career women's intellectual, professional or public selves are often constructed as at odds with an authentic, biological, feminine nature (see, for example, our analysis of the *Bachelorette* in Chapter 1).

Traditional feminine pursuits are understood in new ways within postfeminism. They are not undertaken to please a man or because women do not have choice. Rather, women are constructed as having choice and, in a free world characterised by equal opportunities between men and women, women choose to work on their appearance and care for their family. This 'choice' is supported by consumerism that offers a range of products and practices for this work, as seen in the figure of the 'yummy mummy' who "knows her Gap from her Gucci" (Fraser 2006, p. xvii, cited in Littler, 2013; also see McRobbie, 2006; O'Donohoe, 2006). The outcome is that at a time when women have significant access to economic and public life and operate in contexts where equality discourses dominate legislative and everyday sense making, pregnancy and domestic bliss are positioned as women's happiness objects.

Rather than a biological inevitability, we see re-traditionalisation as a form of nostalgia for a simpler time (Evans and Riley, 2014). We link the desire to return to an (imagined) simpler time to the impossible spaces that women occupy within postfeminism (Griffin et al., 2013). In the 1970s, women might have been asked to rise to the challenge of being 'superwoman', but her juggling of home and work meant that she could reject some of the more intensive feminine arts (see Conran's infamous statement 'Life is too short to stuff a mushroom'; 1975, epigraph). In contrast, twenty-first century femininity is a vision of 'postfeminist perfection'

that combines participating in the intensive, insecure working practices of neoliberal economies with a simultaneous engagement with beauty practices and hyperfeminine behaviour (McRobbie, 2015; Blum and Stracuzzi, 2004).

Rather than the vision of *Having it All* (Brown, 1982), women are doing what Hochschild (2012b) called 'the second shift', creating the kinds of tensions portrayed in the film *The Back-up Plan*, where Zoe's 'happily ever after' is running two businesses as well as having a family (for our analysis of *The Back-up Plan* see Chapter 4). The cultural changes that led to normalising women's paid employment, lifetime careers and expectations of independence and economic success has thus occurred without women losing their traditional ties to domestic and emotional labour within their intimate relationships (Pavalko and Wolfe, 2015). And if a woman finds it difficult to meet these demands, neoliberal notions of self-improvement and striving direct her towards working on the self, becoming better skilled, working harder or taking prescription drugs to fix herself; while re-traditionalisation discourses construct her struggles as evidence that 'having it all' is an impossible feminist fantasy and the solution is a return to the domestic sphere. What is absent in these constructions is a structural analysis and a challenge to androcentric, neoliberal organisational structures that make work–life balance such a challenge.

The re-traditionalisation of domestic bliss as the site for women's happiness ties health concerns of the family to the mother, creating a burden of caring – what we term 'intimate responsibilities'. Intimate responsibilities extend beyond pregnancy and towards the expectations of care and responsibilities for the wellbeing of the family, in both health, as we discuss in this chapter, but also in sickness (see for example Gregory, 2005). The practices involved in carrying this 'burden' may elicit positive affects, such as pride and pleasure for those who demonstrate capability. Equally, guilt, shame and anxiety are outcomes for those who internalise postfeminist motherhood, yet fail to attain what are effectively contradictory constructs of the 'good' mother: one who is *child focused* (in line with intensive mothering that includes a discourse of self-sacrifice for the benefit of the child – see below) and also *self-focused* in terms of contributing to the public sphere through employment and working on the body to produce oneself into a polished vision of femininity (Bryce, 2014; Evans and Riley, 2013; McRobbie, 2009; Sims-Schouten, 2000).

Intensive mothering is a contemporary ideology that constructs ideal motherhood in terms of self-sacrifice and child-centred parenting that treats childrearing as a project (Hays, 1996). With links to Bowlby's attachment theory, intensive mothering idealises consistent nurturing by the mother as the primary caregiver, reinforcing traditional gender roles, and locating women's happiness in their child caring. Butler (1990) proposes that gender is performative rather than innate and biologically essential, so that femininity is 'done' through the repetition of particular practices and discourses. Intensive mothering provides a discursive regimen through which certain practices (e.g. breastfeeding) are understood as the performance of good mothering. Intensive mothering binds the practice of good mothering to subjectivity, so that to perform actions in line with intensive mothering definitions

of a 'good mother' is to be a good person. For example, in her interview study with Canadian mothers, Knaak (2010, p. 349) described how 'for many of the mothers ... breastfeeding emerged as a key marker (to self and others) about who they were as mothers, about how they mothered and about what they stood for'.

Intensive mothering offers a particular norm for mothering. As we discussed in Chapter 3, norms are mechanisms through which people make sense of themselves. They are not therefore experienced as something external that may be chosen or rejected, but as the fabric through which people weave their subjectivity (Davies, 2013). This means that norms around mothering appear natural, as arising out of, and fulfilling, women's own desires. Women's subjectivities are thus not only produced through their own individual health practices, but are also formed through the ways in which they care and are perceived to care for their children.

The extended reach of women's responsibilities to their children can, within postfeminist sensibility, be understood as an interaction between neoliberalism, healthism and traditional gender norms. In Chapter 1, we discussed how contemporary discourses construct the self as a project, a form of neoliberal sense making that creates an imperative of self-improvement that is felt particularly intensely for women when tied to older discourses of femininity. We discussed older discourses that associated femininity with psychopathology. Here, we suggest a similar pattern that links the neoliberal self-improvement imperative to older discourses of motherhood and femininity. We also argue that these discourses are further intensified by healthism, the medicalisation of everyday life that ties health to individual responsibility, creating identities around health citizenship (for healthism see Chapter 2). The outcome is that neoliberal expectations for understanding and improving the self are, for mothers, expanded beyond the self, legitimising the regulation of mothers, who are held accountable for optimising the development of their child's psychological and physical health.

According to attachment theory, for example, a breakdown in a mother's caring and nurturing responsibilities poses a risk to children's healthy development, which then affects those children's abilities to form and provide secure relationships in adulthood. Mothering practices are thus seen as the foundation of a civil society and thus a legitimate focus of governmentality (Lawler, 2000; Murphy, 2003; Rose, 1999). With the expectations for economic participation alongside this role as primary caregiver, women's responsibilities soon stack up – ensuring domestic bliss and a healthy family, being the primary caregiver, achieving in a professional career, safeguarding the happiness of others, and maintaining feminine beauty practices.

Intensive mothering is wrapped up within discourses of emotional rewards, and the idealisation of the self-effacing, self-sacrificing mother. In such ways, women's value is measured in terms of their services and usefulness to others, regardless of the impact upon women's own health and wealth (Nomaguchi and Wilkie, 2003). But intensive mothering has significant emotional and material costs, involving self-sacrifice, potential loss of income and consumption (Hays, 1996). Women's health-related and caring responsibilities contribute to a significant economy of informal care that is estimated at A\$60.3 billion in Australia (Carers Australia, 2015)

and US\$522 billion in the United States (Chari et al., 2015). The personal, professional and emotional costs of these activities are not included in the calculations, yet they are significant. Women's uptake of paid employment is affected directly and indirectly, with women's lower salaries in the UK, for example, being attributed to their caring responsibilities (Shackleton, 2015). In terms of mental health, caregivers experience worse mental health than non-caregivers, and women report higher levels of depression, anxiety and other mental health problems than caregiving men, a difference attributable to women's experience of caregiving, which involve greater levels of time, 'hands-on' intensity, burden, role conflict, concurrent household labour and lower levels of support and support seeking than men (Yee and Schulz, 2000).

A range of *dispositifs* circulate ideas around motherhood that validate intensive mothering and consumerism, including parental guidebooks and memoirs that reproduce the idea that mothers' parenting dramatically affects the outcomes for their children (see, for example, Chua's, 2011, *The Battle Hymn of the Tiger Mother*, which describes a disciplinary approach to childraising that received significant media coverage; Afflerback and et al., 2013, including the controversial take up of the book's title by British politicians).² But, as with all discourses, there are alternatives, and the media is as important a medium for circulating alternative discourses to intensive, consumer-oriented motherhood as it is for supporting them. Locke (2015, p. 143), for example, reports on an article in Glasgow's *Daily Record* newspaper, 16 August 2012, of 'martyr mum', a woman who is unnecessarily tired because of her choice to participate in intensive mothering, 'Martyr mum hasn't had a proper night's sleep in 10 years. If she stopped co-sleeping with them before they got their adult teeth she'd have less to complain about. All these years she's been either breastfeeding, feeding on command, exploring baby-led weaning or making gluten-free, vegan packed lunches'.

Media alternatives to intensive mothering offer a chink of respite for mothers since they suggest perfection/self-sacrifice is not possible nor desirable, but they also further destabilise the 'good mother' subject position since a proliferation of conflicting discourses means that all the options open to mothers are contested and open to criticism (O'Key and Hugh-Jones, 2010; Pescud and Pettigrew, 2014). In Chapter 5, we showed how postfeminist sensibility works through contradictions and, here, we give motherhood as another example. As with so many postfeminist subjectivities then, postfeminist motherhood is insecure, with no clear right way, yet responsibility, judgements and identities are based on doing it right.

Postfeminist mothers must be child centred, self-focused and financially independent, creating contradictory demands. For example, mothers must spend significant time with their child/ren but also have significant financial resources (which for most women will require paid employment) in order to consume appropriately according to standards set by medicine, psychology, media and commerce (e.g. safe car seats, organic baby food, baby slings or extracurricular tuition; O'Donohoe, 2006). Both poorer and wealthier women who work outside the home are caught in a dilemma. Paid work may enable them to be recognised as legitimate economic

citizens and provides money to spend on their families, but their parenting is open to scrutiny and criticism in terms of qualities such as attachment, time, care and devotion. The contradictory expectations of postfeminist mothers thus orients around women meeting their individual, child and societal needs. This leads Akass (2011 p. 137), in her review of media discourses on motherhood, to ask ‘is it possible that the agenda behind mothering advice is ... more an instruction manual on what suits society than what is best for our mothers and children?’.

Poorer women, particularly if they are young, single and/or working-class, may have less choice as to the kind of parenting they can do. Often with fewer resources, such mothers are disadvantaged in their attempts to ‘perform intensive mothering in the absence of larger social supports for their children’s upbringing’ (Elliott, Powell and Brenton, 2013, p. 351) and are also stigmatised through cultural constructions of good mothers as middle class, white and in a heterosexual relationship (Locke, 2015; McRobbie, 2006; Tyler, 2008). Thus, while mothers in general are subject to scrutiny, legitimised through an assemblage of intensive mothering, healthism, neo-liberalism and postfeminism, such scrutiny occurs through intersections of class and racialised positions. Below, we consider the range of dispositifs, including government, media and commerce, involved in this regulation of mothers.

Responsibility and risk: government, media and commerce

In 1854, Dr John Snow traced an outbreak of cholera to a standpipe in Soho, London, confirming his theory that cholera was a waterborne disease. His discovery led to the closure of the contaminated water pump and marked the beginning of the science of epidemiology and modern government involvement in hygiene and public health. The subsequent development of clean running water and sewage systems brought about a decline in infectious diseases – cholera, typhus, tuberculosis and diarrhoea – and their associated mortality (Aiello, Larson, and Sedlak, 2007; Mbali, 2002). In so doing, the Victorian British government took responsibility for public health in the provision of sanitation and clean water, opening up debates over health, responsibility, hygiene, illness and poverty that continue into the present.

In the mid-nineteenth century, British government officials, economists and reformers debated whether poverty or poor hygiene and sanitation were to blame for high rates of infectious diseases such as cholera and typhus that kept life expectancy for working-class people in industrial towns well below the national average of 40 years. Some reformers advocated economic approaches to health promotion through the elimination of poverty, but an influential civil servant, James Chadwick, supported a focus on individual behaviour since ‘filth leads to disease and that disease, in turn, leads to a loss of income and poverty’ (Mbali, 2002, p. 7).

The outcome of the ‘poverty vs. dirt’ debate allowed a shift of responsibility away from government and on to the individual, supported by wider Victorian discourses about blameworthy subjects, gender roles and morality, as summed up in Victorian proverbs such as ‘cleanliness is next to Godliness’ (Duschinsky, 2013;

Moodley, 2013). So while government schemes included the building of sewers and public baths, and a reduction in taxes on soap (Aiello, Larson, and Sedlak, 2007), the beliefs that underpinned subsequent public policy constructed hygiene and health in terms of individual responsibility. A key resource for implementing these policies in both Europe and North America, was women, who were recruited to disseminate health information.

The first health visitors in the 1900s were middle-class women, but soon health visitors were conscripted from the target poor communities. Both sets of health visitors were unpaid and focused their interventions on the mother (Ramirez-Valles, 1998). Since the mother was defined as the immediate cause of high infant mortality and low birth rate, the solution was to teach 'mothercraft'. The caring practices of motherhood thus interconnected with government interventions, producing a new configuration of official scrutiny of mothers that can be traced back to Plato (Ramirez-Valles, 1998).

Turn of the century public health programmes hooked on to women's domestic responsibilities at a time when women's engagement in public life was limited, as was their access to formal education and their role as producers of valued knowledge. Yet despite significant shifts in gender relations, contemporary health promotion intervention programmes have much in common with their Victorian counterparts. Both privilege the role of information in health behaviour change, giving scientific knowledge to the rational person who will then act upon it (Lupton 1995, 2014b). The gendered nature of health promotion also remains, seeking to harness women's caring roles and domestic responsibilities so that women remain the target of much of this health promotion. And similar to their Victorian counterparts, women in contemporary peer-based health promotion education programmes often remain unpaid, justified through a discourse of empowerment through education, concern about costs, and because peer education requires close ties to the community which might be broken should the woman be elevated through paid work, but which critiques argue creates another form of unpaid female domestic labour (Mbali, 2002; Ramirez-Valles, 1998). We see women's participation in these programmes as a form of governmentality, managing the conduct of conduct in ways that permit positive forms of subjectivity, such that participants understand themselves as 'good' and 'knowledgeable', but one which also reproduces certain sexist and colonial discourses, as we argue below.

Contemporary women remain the primary vehicle for health promotion, both passing on their expertise and receiving information on how, for example, to keep family houses clean from dirt and provide healthy food for their partners and children (Allen et al., 2015). The female hosts of the makeover show, *How Clean is Your House?* (Channel 4, 2003), for example, take up a subject position of feminine domestic expert, whose knowledge and skills enable them to create a safe, as well as respectable and aesthetically pleasing, home environment. Despite profound changes in women's roles outside the home and some take-up of domestic activities by men, such television shows position women as responsible for the family home, legitimising moral judgements on women who fail to maintain standards

of domestic cleanliness. Advertisements also often construct women as having primary responsibility for family care, often evoking guilt and anxiety to promote their products (LaBarge and Godek, 2006).

The focus on women is also evident in health promotion interventions across the globe (Mbali, 2002; Ramirez-Valles 1998). For example, in 2015, the UK's Conservative–Liberal Democrat coalition government cited the Healthy Start programme as evidence of their initiatives for healthier families, but the programme document and associated website only mentioned mothers and women.³ Similarly, the front cover of UK's *Healthy Child Programme: Pregnancy and the first five years of life* (Shribman and Billingham, 2009) featured images of mothers and babies, setting the tone for the woman-oriented focus on developing healthy children. The focus on maternal behaviour is also evident in the UK's Change4Life campaign; despite visually representing a carefully gender and ethnically indeterminate four-person family, the voiceover referred to the need for 'mum' to limit the children's consumption of high-sugar drinks.⁴

Change4Life is a public health programme concerned with increasing healthy eating and physical exercise. Funded against the backdrop of government concerns over rising obesity, Change4Life is an example of neoliberal health promotion. Neoliberal health promotion is predicated on 'small government', where government interventions into its citizen's lives are constructed as inappropriate paternalism, making the role of government interventions that of providing information for individuals to make informed choices (for a more detailed discussion on neoliberal health policy, see Chapter 2)). More direct government interventions are justified only when individuals make 'inappropriate choices' that draw on public resources (see, for example, neoliberal government drug policy that targets drug users with health service or criminal justice implications (Riley, Thompson and Griffin, 2010). An exception to this approach is motherhood. Rose (1999) argues that understandings of the family as a site of production of social order and healthy citizens, and conversely of disorder and delinquency, have warranted the involvement of the state in how families, and particularly mothers, care for the health and wellbeing of their children (Bruch and Touraine, 1940; Lawler, 2000). Mothers are thus targeted for health interventions through a combination of traditional gendered discourses of mothers being held responsible future generations' welfare and contemporary neoliberal discourses of health as a process of making informed choices. As such, contemporary neoliberal health promotion and its Victorian predecessor share an individualist standpoint that sits alongside an ideology of the woman-carer.

An ideology of the woman-carer makes mothers a legitimate target of contemporary public health programmes policies. This creates a paradox, since women are constructed as natural carers, but also in need of being taught how to care. Within neoliberal governance, this paradox is circumnavigated in two ways. First, a therapeutic culture understanding whereby all subjectivity is in the process of transformation, facilitated by experts (see Chapter 1), is applied to motherhood. Thus, despite the purported naturalness and instinctiveness of motherhood, intensive mothering can be understood as requiring the guidance of experts (Hays, 1996).

Second, the ‘natural, but needs teaching’ contradiction is managed by constructing those who fail to meet cultural standards as individual failures. And this occurs despite, as we note above, the requirement of time/money in intensive mothering that makes social economic status a factor in how women can mother. The outcome is that low-income, working-class and many other women outside the ‘ideal’ middle-class mother are problematised as individual mother failures. For example, the Healthy Child Programme described above identified high-risk groups as those living in social housing, with a young mother or young father, where the mother’s main language is not English, where the parents are not co-resident and/or where one or both parents grew up in care.

From one perspective, identifying who needs help is important in the context of limited resources, and many mothers value support when offered. But, Ramirez-Valles (1998) draws attention to the way that this approach to health promotion creates categories of women along classed and racialised lines, so that poor and non-white women are positioned as potentially ignorant, unhealthy and oppressed (e.g. by men, religion, governments and others) and that these things alone account for their caring practices. Ramirez-Valles gives an example of how Hispanic women in the United States are positioned as ‘other’, and as ‘oppressed, childlike and victim of patriarchy, religion, poverty, and diseases ... [compared with] the standard female as non-oppressed, independent, and educated woman’ (1998, p. 1751). White, middle-class women become figured as the educated, modern, healthy, free of oppression, liberated ‘first-world’ women, whose healthcare practices are based on value-free, scientific health research (and not superstition or religious practice). The globalised health interventions that Ramirez-Valles reviews thus become a form of tacit colonialism. It is interesting to note how this works alongside other health discourses; for example, in relation to our discussion of female genital cosmetic surgery (see Chapter 3), where cosmetic genital surgery is normalised through a discourse of choice for wealthy white Western women. What this means is that non-white, poor and working-class women are constructed as deficient and excluded from Western discourses of empowered, postfeminist femininity. Simultaneously, the vulnerabilities of white middle-class women, for example, in relation to domestic, symbolic or cultural violence, go unnoticed.

The categorising of mothers along racialised and classed lines is evidenced across a range of *dispositifs* including developmental psychology which, in its reproduction of middle-class norms and aspirations, marginalises working-class mothering by constructing it as risky in terms of health and child attainment, and as a burden on the state (Walkerline and Lucey, 1989; Rose, 1999). Media discourses also marginalise working-class mothers, with the figure of the ‘chav mum’ in the UK used as a derogatory term to construct young white working-class women as impure, unfeminine and of low social class, education and taste (also see Chapter 5). News stories also regularly construct multi-racial families around classed, racist and sexist constructs of hypersexuality, irresponsibility and socially delinquency (Allen et al., 2015; Tyler 2008). And when not denigrated, working-class women are absent, rarely appearing in media representations of good mothering. For example, advertising for nappies

and infant formula predominantly employs images of white, well-dressed mothers in clean, well-appointed homes, that symbolically tie middle-class mothers with an ability to make healthy choices for their babies (Feltham-King, 2015).

As Tyler (2008) suggests, the image of the 'chav mum' not only works to demonise the white working-class mother, but also highlights the 'reproductive responsibilities' of the middle classes to breed (see Chapter 5 for discussion of concerns over young white women who put their careers ahead of caring). But despite the idealisation of middle-class motherhood, such mothers are also the object of discourses of risk and responsibility, so that health promotion alerts all mothers to the possible harm that they could cause or advantage they could bestow (or fail to bestow) on their children. Neoliberal health promotion thus draws on traditional gender role discourse to construct women as the guardians of family health. The centrality of women in public health discourses and practices is exemplified in national and global campaigns such as International Handwashing Day, a global public-private partnership between the World Health Organization (WHO) and Unilever to encourage women to facilitate their family's personal hygiene by teaching them to wash their hands up to five times a day (and in the process, expand the soap market, which, in the rural areas targeted, was predominately used by working-class men; Moodley, 2013; Warin, 2009).

Such partnerships between corporations and health agencies are coherent with neoliberal policy that constructs market forces as a legitimate driver of policy and an understanding that 'businesses do it right'. The logic is that corporations can be harnessed to better do the work previously done by government departments and charities. Global corporations like Unilever, for example, can take on the task of raising awareness of health issues, offer expertise in social marketing and have a wide reach. But these partnerships must offer opportunities for both parties and the corporations benefit from associations with respected and often trusted non-profit organisations such as Unicef and WHO. Huge marketing possibilities at a relatively low cost are also enabled by the positive media coverage of such programmes, where the campaign becomes the advert. Government agencies and state media outlets advertise global campaigns for free and bring them to the population through community outreach programmes. Thus, it is not just the campaign that is brought to the population, but marketing of the company and its products, creating a contemporary twist on a long history of commercial interest in reproducing ideologies of the ideal mother. For example, twentieth-century advertising responded to the increasing numbers of women in paid employment by shifting its representations of women as traditional homemakers to women as mothers, accommodating changes in public gender roles without challenging the construction of women as having primary responsibility for cleaning, shopping, cooking and childcare (Neuhaus, 2013).

Social marketing partnerships between global corporations and health agencies allow corporations to articulate the message that good mothering equates to consumption in more subtle and insidious ways since the message is delivered through health promotion materials that are supposedly designed to support women. For

example, Feltham-King's (2015) analysis of health promotion material sponsored by Pampers given to women in antenatal clinics in South Africa showed how health education material and pictures of doctors were interspersed with product information, creating an association between disposable nappies, healthy babies, medicine and health care (to which the women actually had limited access). The literature also subtly used classed and racialised markers to reproduce heteronormative, middle-class aspirations as key to health and happiness. These commercially sponsored information leaflets thus produced the subject position of a good mother as one who consumed, marginalising poor women without economic resources required for consumption and absencing other kinds of good mother discourses. Linking consumption to good mothering also has other costs, for example, environmental issues regarding disposable nappies.

Women in low-income countries represent market expansion possibilities for consumer lifestyle oriented products. The market expansion possibilities through public-private health promotion partnerships are thus significant and, in an increasingly globalised address, products such as Lifebuoy soap or Jik disinfectant are advertised as part of preventative health practices that construct responsible citizenship and motherhood through appropriate consumption (Mbali, 2002; McRobbie, 2009; Moodley, 2013). In 2006, for example, Proctor and Gamble marketed their disposable nappies, Pampers, in South Africa in collaboration with Unicef. Proctor and Gamble benefited from the reach and trustworthiness of Unicef and, in return, donated money from each sale (with the slogan 1 pack = 1 vaccine) to Unicef's tetanus vaccination programme (Cryder and Lowenstein, 2011). This campaign thus promoted their product both in South Africa and in countries such as the UK, where mothers buying Pampers could imagine themselves supporting other mothers in countries with less developed health care.

Such corporation-health organisation partnerships generate resources such as vaccines. But many argue that making such resources available should be the work of governments and should not be predicated on corporate marketing strategies. The focus on consumption also locates the burden of health on individuals and families, particularly women, taking a focus away from high-cost, state level infrastructure changes that are not undertaken by these public-private partnerships, but which would bring about the greatest reductions in illness and death from conditions such as cholera and HIV/AIDS (Mbali, 2002, 2009; Moodley, 2013). For example, although handwashing is an important infection control measure, constructing personal hygiene as a major contributor to cholera infection sidelines the greater importance of the public sanitation infrastructure that produced the eradication of cholera in Europe and the United States (Aiello, Larson, and Sedlak, 2007; Mbali, 2002). Contracting out the work of health to businesses and charities means that wider social determinants of health such as access to clean water supplies, basic sanitation and medical services remain unchanged. The outcome is a de-politicisation of health, as governments take less responsibility for their citizen's health and corporations commodify health within capitalism (Brown, 2006).

Social and eco-feminist perspectives on recommendations to use soap and bleach, and to boil drinking water also highlight the disproportionate financial, health and labour burdens that these injunctions place on poor women. For example, the collection and burning of firewood damages the environment and smoke from domestic fires is linked to serious respiratory health problems for women and children in low-income countries (Po, FitzGerald, and Carlsten, 2011). Poor, minority women suffer most from the gender inequality that exists in every society, and when the burden of domestic, caring, and affective labour is added to the forces of sexism, racism and poverty, it creates a cycle from which women struggle to escape. Health promotion that focuses on individual behaviours thus fails to take full account of women's embodied experiences in the context of wider social, governmental and economic inequalities (Kiguwa, 2004). Instead, the logic of individual responsibility perpetuates a culture of blame and shame, marginalisation and stigma, which is experienced disproportionately by women who have the greater responsibility of care (Raisier and Cohn, 2005). The inseparability of socioeconomic forces and women's health means that improvements in maternal and child health are unachievable unless gender inequality, poverty and disadvantage are also addressed (Langer, Horton, and Chalamilla, 2012). Yet the mediation of health through consumerism converts health into a shopping opportunity.

Close relationships between commerce and health organisations also reduce governments' capacities to limit marketing that has negative consequences for the health of mothers and babies. For example, milk formula companies frequently violate international marketing codes in their advertising of breastmilk substitutes in low-income countries, where it is estimated that the deaths of approximately 800,000 children under five could be prevented by successful breastfeeding (Hidayana, Februharty, and Parady, 2016; World Health Organization, 2017), figures that are glossed over in the neoliberal consumer and advertising discourses of choice, responsibility and aspiration. The involvement of multinationals such as Unilever in health promotion thus completes a cycle of re-colonisation as large corporations develop markets for their products in low-income countries, reproducing the discourses of individual responsibility for health and hygiene that took place in Victorian Britain and sidelining attention to the tackling of wider, structural determinants of health (Feltham-King, 2015; Mbali, 2002).

The outcome is that, across both the global North and South, government and non-government organisations, commerce and media circulate an understanding that mothers bear the risk and responsibility for child health. Mothers' connection to their children is understood as a source of happiness, pride and fulfilment, but it is also used to produce a sense of accountability for their children's health that can be used to promote products over mothers' and their children's psychological and physical health needs. Fear, guilt and awareness of risk have become inseparable from women's experience of caring for family and are particularly salient in practices of infant and child feeding (Persky et al., 2015). Perhaps nowhere is this more strongly shown than in health promotion around breastfeeding.

Breast is best?

Breastfeeding is an intimate, embodied practice, situated at the beginning of maternal relationships and subjectivities. But it is also located in an assemblage of postfeminist sensibility, neoliberal healthism, discourses of maternal responsibility for child health, science and medicine. Like evolutionary arguments, biomedical arguments are rhetorically powerful because they are located within a valued framework for knowledge generation. And at first glance, the biomedical literature appears to show a clear health advantage for breastfed babies in comparison with their formula-fed counterparts. This has led to government and non-governmental organisations (NGOs) such as the WHO implementing health programmes aimed at encouraging mothers to breastfeed, and to breastfeed exclusively and for longer, with the WHO recommending exclusive breastfeeding for the first six months and continued breastfeeding for up to two years of age or beyond (World Health Organization, 2017).

Biomedical and health promotion literature suggests a wide range of benefits from breastfeeding, from higher intelligence quotient (IQ) to better physical and emotional health, which in turn contribute to a healthy, productive society, thus reducing the burden of ill-health from conditions such as coronary heart disease, cancer and obesity (Meyer and de Oliveira, 2003; Dykes, 2009). Breastfeeding is associated with fewer infections, lower mortality and better health outcomes in babies in low and middle-income countries (World Health Organization, 2017). In high-income countries, formula-fed babies have more gastrointestinal infections than breastfed babies, but these babies do not experience the worse mortality and health outcomes seen in lower-income countries (Binns, Lee and Low, 2016). Thus, although research consistently points to breast milk as healthier than formula, with overall worse health and higher mortality of formula-fed babies globally, for women in high-income countries, a 'broader contextualisation of risk reveals that the magnitude of these health/nutritional differences [between breast and formula] is relatively small' (Knaak, 2010, p. 348). What this means is that the risks associated with formula or breastfeeding is different for babies born in higher- and lower-income countries.

Babies of women in low-income countries particularly benefit from breastfeeding. But it is these women who are the target of international marketing of formula/bottle feeding by companies such as Nestlé in a context where government and NGO breastfeeding campaigns have less traction. Drawing together our analysis above of public-private health campaigns with the empirical support for breastfeeding, we are left with the conclusion that many mothers in low- and middle-income countries do not have access to information in ways that allow them to make an informed decision, and that their babies are made life-threateningly vulnerable because of vested commercial interests in their use of formula.

In contrast, women who use formula in high-income countries where breastfeeding is highly promoted are made psychologically vulnerable through an understanding of themselves as 'bad' mothers, when the associated risks are relatively

low. For relatively wealthy women in high-income countries, breastfeeding campaigns, such as 'breast is best' have morphed from education into persuasion 'characterised by informational biases, moral overtones, and a restrictive construction of choice' (Knaak, 2010, p. 346). For example, breastfeeding promotion frequently reports that breastfeeding increases IQ (Caspi et al., 2007; Unicef, 2017). Such social marketing elicits fears about children's intelligence and economic attainment far into their futures, evoking anxiety in mothers (Douglas, 2010; Labarge and Godek, 2006) and implying that mothers who bottle feed are failing to provide the best care (Dyke, 2009; Meyer and Doliveira, 2003). The breast is best campaign thus becomes a form of governmentality, hooking on to subjectivity and acting as a technology of self (a vehicle by which mothers could experience and demonstrate themselves as good mothers), so that being a good mother is synonymous with breastfeeding. It is in such a context that, when interviewed about why they intended to breastfeed, Knaak's (2010) Canadian participants described breastfeeding as both a choice based on a deeply felt, personal conviction, and not a choice, since not to do was to be defined as a bad mother. Breastfeeding was thus 'a key marker (to self and others) about who they were as mothers, about how they mothered, and about what they stood for' (p. 349). In line with so many aspects of postfeminist sensibility, women were free to choose breastfeeding but only if they chose appropriately. And while taking up this norm was associated with feelings of pride, empowerment and pleasure, for those not able to establish their breastfeeding practice the result was a sense of inadequacy and failure, as one of Knaak's participants stated, 'you feel like less of a person less of a mother less of a woman' (p. 350).

This sense of failure is in part produced by the way health information and advice construct breastfeeding as a choice based on a woman's understanding or lack of understanding of its health benefits (Kukla, 2006). Breastfeeding promotion is supported by national and international organisations. For example, in the UK, the National Childbirth Trust (NCT) offers information and advice about breastfeeding that draws on discourses of empowerment and naturalness, which is contrasted against a disempowering medicalisation of pregnancy and childbirth. As such, the NCT is an example of organisations that have led a sustained campaign to have women's experiences and voices valued in pregnancy and child care in the context of medicalisation that devalued this knowledge (for further discussion, see Chapter 5). But, in celebrating breast milk as the natural and healthy product of women's bodies in contrast with the scientific 'formula' of breastmilk substitutes, such organisations produce a natural versus medicalised dichotomy which reinforces 'bad mother' discourses for women who do not breastfeed (Crossley, 2009).

In high- and middle-income countries, government and NGO health promotion constructs breastfeeding as both a moral issue and a rational decision. This cognitive, morally weighted framework ignores the physical, economic and social factors which influence breast and bottle feeding. Physically, breastfeeding mothers may experience difficulties such as nipple and breast pain, infections and latch problems. Economically, breastfeeding is often constructed as free, but it takes up significant time, equipment if the mother is pumping for future use and, as Metz,

Kirkland and Kirkland (2010, p 88) point out, is only free if the mother's time and labour is assumed to be 'without cost'. Social factors can also negatively influence women's take up of breastfeeding. For example, breastfeeding can be responded to with disgust and anger, seen for example in the regular reports in UK media of women being asked to cover up or not breastfeed in public⁵ (although we note, in line with intensive 'natural' mothering ideologies, these reports often side with the woman).

Psychoanalytical interpretations of negative responses to breastfeeding suggest that breastfeeding is symbolically contradictory, since the potentially sexual breast is employed in a mutually exclusive practice of nursing. Disgust or anger are produced from an experience of the nursing breast as abject (Kristeva's psychoanalytical notion of the horror produced when symbolic distinctions are blurred), since the contradictory associations of sex and nursing are combined with a leaky lactating body that blurs boundaries. Significant tensions thus lie in the multiple understandings and signification of women's breasts, in 'the encoding of the breast as a maternal organ and of breast milk as an infant nutrient, on the one hand, and the competing interpretations of the breast as sexual fetish and of breast milk as abject bodily fluid' (Reeve, 2009, p. 65). Thus, although women's right to breastfeed in public is enshrined in European anti-discrimination law, the harassment or public shaming that can happen to women who breastfeed in public means that, socially, women find many public and work places uninviting, difficult and problematic for breastfeeding (Crossley, 2009).

The impact of social mores on breastfeeding can also be seen in differences between countries or regions that have stronger or weaker emphasis on breastfeeding. Perrine et al. (2012) report from a large US study in which over 85% of mothers planned to breastfeed exclusively, but only 32% of them met this goal. Despite mothers' early preferences for and medical discourses advocating breastfeeding, in Perrine et al.'s study, 40% of babies received formula in hospital on the advice of medical and nursing staff. In countries and regions with stronger breastfeeding promotion, there are higher rates; for example, Knaak (2010) reports data from Canada that showed that 85% of mothers initiated breastfeeding. In Europe, longer periods of maternity leave and follow-up from midwives and health visitors are available than in the United States, where limited maternity leave may help to explain the lower rates of continuation of breastfeeding. These findings hint at the complexities of wider sociocultural and economic factors that influence breastfeeding, despite the focus of health promotion on influencing individual behaviour through providing information on health risks and benefits.

In their presentation of the benefits of breastfeeding, social marketing campaigns reinforce similar norms to those of commercial advertising, encouraging identification with the message of individual responsibility and absencing other factors that negatively affect breastfeeding, such as poverty, insecurity, lack of social and healthcare support, lactation problems, lack of medical and social support, demands of paid employment, the marketing of bottle feeding and low acceptance of breastfeeding, particularly in public places (Glaser and Basch, 2013). Illouz (2007) argues that

'institutions build cultural coherence not so much by trying to establish uniformity as by trying to organise difference' (p. 48) and, certainly, pro-breastfeeding arguments set up a binary opposition between breast and bottle feeding, and position women who bottle feed as excluding themselves and their babies from those benefits. Metz, Kirkland and Kirkland (2010) highlight the language of comparison and risk that characterises campaigns such as the National Breastfeeding Awareness Campaigns in the United States, which imply that formula feeding is not only inferior to breastfeeding, but is an actively risky practice. Online breastfeeding information, such as that provided by NHS Choices,⁶ list benefits of breastfeeding ranging from bonding to reduced rates of obesity. While such campaigns aim to make breastfeeding acceptable and accepted rather than to denigrate bottle feeding, the logic of these arguments positions bottle feeding as unnatural and not-healthy, with negative implications for parents who bottle feed their children. Critical analysts question not only the research basis of these claims, but the ethics of assuming and exploiting mothers' responsibility for and anxieties over their children's health (see, for example, Wolf, 2007).

Polarised discourses of breast and bottle feeding offer troubled maternal subject positions for women on both sides of the debate. The promotion of breastfeeding and the assertion of women's rights to breastfeed in public elicit terms such as 'breastapo' that articulate a criticism that pro-breastfeeding campaigns shame parents who bottle feed their babies. 'Breastapo' has an obvious link with 'feminazi' terminology that constructs both supporters of breastfeeding and feminists as extreme and aggressive, oppressing not only men, but women too. Organisations and activists trying to negotiate this emotive landscape thus have to break down the oppositional relationship between breast and bottle feeding, but also the focus on women as idealised carers and/or the source of negative judgements. At the time of writing, interesting developments show the difficulty in this task, as we have seen changes in the online advice of the Breastfeeding Network⁷ and activist organisations that shift along these different dichotomies of mother–parent and breast–formula. For example, the online and community group Fearless Formula Feeder's ISupportYou campaign moved from raising awareness of the complexities and challenges of infant feeding within an inclusive mother and father address to focusing their address more on mothers through a more hard-line 'fearless formula feeder' position that challenged breastfeeding promotion.⁸

The organisation of difference continues to dominate a range of media and health promotion around infant feeding and is used by commercial enterprises as a vehicle through which to advertise. One example is Similac's 2015 advertising campaign 'The Mommy Wars', which includes a commercial, *The Mother Hood* and an accompanying behind-the-scenes documentary.⁹ The advert begins humorously, with warring groups of judgemental mothers (including working, stay at home, breastfeeding and bottle-feeding mums, plus a group of dads) who come close to a fight, but then, in an emotive finale, join forces to save a baby in a runaway pram. In the documentary, mothers talk about their attempts to breastfeed and reasons for using formula, which include having treatment for breast cancer

and being a single working mother. Breastfeeding mothers then confess to and renounce their judgemental attitudes towards bottle-feeding mothers. The campaign website, 'support for moms', includes information about and coupons for formula and related products, and a 'Similac Feeding Expert' helpline. Similac's 'Mommy Wars' advertising was thus a mix of public service, information and product placement, ostensibly promoting activism against criticism and negative judgements of mothers while supporting the use of formula and facilitating a non-judgemental attitude towards formula (Elliot, Powell and Brenton, 2013). Thus, as with the health promotion–commercial partnerships described earlier in this chapter, consumption of product is the take-home message.

Aside from the clear benefit to formula manufacturers of non-judgemental attitudes towards bottle feeding, the campaign also undermines its purported aim of supporting mothers. It identifies women as the origin of critical attitudes towards mothers, and in so doing it reproduces a 'mean girls' discourse in which the norms of femininity and motherhood legitimise division and judgement (see Chapter 1 for a discussion of representations of mean girls into adulthood). Breastfeeding mothers are presented as particularly judgemental and, although the aim of the campaign is to increase acceptance of bottle feeding, the mothers who use formula all say they have tried breastfeeding and appear to need 'good' reasons for not continuing to do so that align not with choice but with factors out of their control. The advertisement and accompanying documentary also recreate narrow norms of good motherhood through its absencing of mothers who are not slim, attractive and middle class. Rather than celebrating sisterhood and diversity, we therefore see this advertising campaign as one that reproduces a range of discourses that devalue women and undermine women's choices.

The undermining of women's choices can be managed by setting up contradictions and dilemmas around infant feeding. In the Similac advertisement and documentary, dilemmas orient around negotiating extreme and judgemental breastfeeding mothers. Another example is the breastfeeding promotion campaign by the Paediatric Society of Rio Grande do Sul (SPRS) in Brazil, in which a series of posters show a breastfeeding baby held to its mother's naked breasts, but superimposed on the breast from which the baby is feeding, almost like a tattoo, are pictures of either a cheeseburger, a coke-style soda or a doughnut, with the implication that the baby is consuming these products. Reinforcing this idea, the slogan 'Your baby is what you eat' is written across the opposite breast. These posters ostensibly encourage mothers to eat healthily while breastfeeding, but there is a strong suggestion that the mother's unhealthy diet is transferred to the baby through breast milk, presenting mothers with a dilemma that could be solved by using formula. Nestlé Corporation, a major producer of infant formula, sponsored the campaign, illustrating the coming together of social and regulatory practices in the politicisation and commodification of breastfeeding and motherhood (Meyer and de Oliveira, 2003).

Breastfeeding is thus located in an assemblage of material and discursive affects, facilitated by government, media and commercial *dispositifs*, making for a complex

picture, where all choices and representations of these choices are questionable. Women's intimate responsibilities are an essential component to motherhood, yet offer an unstable set of fluid and contradictory forms of sense making from which women who are mothers must make sense of themselves. For thinking through (and perhaps 'out of') some of this complexity, we turn to Deleuze's notion of affect. For Deleuze and Guattari (1988), eating is 'a precise state of intermingling of bodies in a society, including all the attractions and repulsions, sympathies and antipathies, alterations, amalgamations, penetrations and expansions that affect bodies of all kinds in the relations with one another' (p. 90). This approach contrasts with simple, rational–cognitive models of eating and breastfeeding that health promotion and information offers, and perhaps provides more successful routes to activism than we have so far identified.

For example, Jess Dobkin's 'The Lactation Station Breast Milk Bar' was an interactive, performance artwork to explore sexual and abject aspects of breastfeeding. This work offered audiences/participants samples of human breast milk, while the artist, as bar tender, talked about the characteristics of the milk and related them to the interviews she had undertaken with the milk donors (Reeve, 2009). Springgay (2011) argues that such artworks create an affective analysis that 'disrupts a culture of blame and demands that we examine why and what we feel is disgusting' (p. 71). Broad injunctions to accept breastfeeding in public spaces, for example, leave disgust and abjection of breastfeeding unexplored and potentially unchanged. Acknowledgement and working through of emotions such as disgust open up possibilities for them to be reclaimed and a source of pride rather than shame (Springgay, 2011; Springgay and Freedman, 2010). Thinking with notions of affect provides an alternative to the power relations inherent in Cartesian dualistic thinking, which divides and privileges qualities such as rationality, reason and cognition over emotion and physicality. Affect relates to the body's capacity to act and be acted upon, and so forms the basis of an ethics in which positive or affirmative experiences are those that increase capacities to relate and act, while negative ones reduce these relations and capacities. Applied to infant feeding, Deleuze and Guattari's ethics would steer away from universal notions of what constitutes good and bad feeding, nurturing and mothering, in favour of an ethics which is local, embodied and personal. In effect, this shifts the question to – what enhances the capacities to act for this woman at this time? This approach can overcome the impasses of binary oppositions and dominant knowledge, and acknowledge the full complexity and uniqueness of women and parents' child-feeding practices.

Conclusion

In this chapter, we have explored how a range of *dispositifs* in both the global North and South evoke the figure of a mother who is naturally responsible for her child/ren's health. This responsibility is produced through neoliberal healthism that constructs health as stable and achievable through the management and prevention of risk (Crawford, 2006). For mothers, neoliberal healthism extends its reach

by tying together what is usually a discourse of individual health responsibility with traditional female gender roles that associate women with care. To make this association palatable for contemporary women, this extension of responsibility is justified within a postfeminist sensibility that marries discourses of choice with biological essentialism.

Neoliberalism and (re)traditional female gender roles offer the discursive context for technologies of subjectivity through which mothers make sense of themselves, and through which particular subject positions of the 'good mother' are produced. Understanding oneself and being understood by others as a 'good mother' is predicated on particular practices, of 'technologies of self' related to health, such as breastfeeding or handwashing, so that motherhood can be understood as a performance that produces subjectivity and which becomes visible through observable criteria such as breastfeeding.

To be understood as a good mother is a highly emotive and powerful subject position, so that we might imagine it always held affective power. The particular contemporary assemblages of motherhood that we have explored in this chapter of neoliberalism, healthism, postfeminism, consumerism and globalisation, suggest an intense, disciplinary focus on mothers, that, as with all regimes of power, open up some possibilities while closing down others. Education, choice and emotional bonding with children are, from one perspective, inherently valuable. But in their operationalisation, a limited vision of good motherhood emerges, one that works on difference and othering, marginalising women who are not middle-class, affluent and consumer oriented. Discourses of good motherhood are also riven with contradiction, dilemmas and uncertainty, yet the practice of good motherhood is often presented in health promotion as the result of easy, rational choices. Health and media discourses construct mothers as primary caregivers, with control of all aspects of their babies' lives, particularly what they eat. As such, women might appear powerful and agentic, making decisions and choices for their children. But the socio-cultural and moral context of childbearing and rearing produces institutions and practices that undermine and disempower mothers, leaving them full of doubt, anxiety and guilt about their mothering. Even when mothers recognise cultural standards of 'good motherhood' as unachievable, they still use these standards against which to measure themselves, and experience themselves as measured against them by others (Seagram and Daniluk, 2002). In this context, activism and health promotion are often pulled towards judgemental dichotomies, escaped only through the acknowledgement of complexity and affect.

An understanding of health as a manageable risk creates an illusion of mastery. The messages that derive from biomedical advice and attachment theories, for example, ignore the uncertainty of bodies and offer deterministic, simplified cause and effect logic, that invests mothers' smallest actions with significance so that 'everyday risks' become pathologised. Drinking alcohol before a woman knows she is pregnant, eating a limited diet because of morning sickness or food aversions during pregnancy, being unable to breastfeed or feeling stressed over her new role and responsibilities are all common experiences during and after pregnancy. But,

discourses of risk push women to understand these common experiences as deeply problematic. The outcome is a pathologisation of the normal that leaves mothers open to pressure, guilt and exploitation.

The address to mothers from commercial interests is particularly exploitative. In this chapter, we have explored the complexities of partnerships between health and commercial organisations, showing how advertising and social marketing often combine information and a celebration of motherhood with product legitimacy and consumption. This means that across lower- and higher-income countries women receive the same message, that they are the ones determining their child's future and that formula, disposable nappies and other consumer products ensure that they can make it a good one. This construction of good motherhood through consumption limits the way mothers can think about or enact their ability to love and care. This limitation in capacity to act is a significant issue for all mothers, but it might be made even more painful for poorer women with limited resources to act on this interpellation.

Intimate responsibilities represent mothers' take up of the neoliberal moral imperative to care for the self and extends its reach to the care of others. Discourses of responsibility and preventative risk management structure what practices are associated with good mothering. These discourses work to regulate mothers in a form of disciplinary power so that mothers work on their mothercraft, striving for perfection. As a form of governmentality, neoliberalism works because it works on psychology – as we said in Chapter 1, it governs our 'mentalities', structuring, in this case, a mother's sense of self. The power of norms means that the ability to understand oneself through normative discourses of good mothering can be associated with deep pleasure, even as they produce anxiety and fear of failure. However, not all women are interpellated by neoliberal discourses, indeed some actively resist them. To explore the forms that such resistance can take, in our next chapter, we look at when women resist the moral imperative of self-care.

Notes

- 1 <https://youtu.be/SJAxDeKgp0g> retrieved 29th July 2016
- 2 www.theguardian.com/lifeandstyle/2016/jan/12/david-cameron-amy-chua-battle-hymn-of-the-tiger-mother-parenting-abuse
- 3 www.healthystart.nhs.uk
- 4 www.nhs.uk/change4life/#7io1MZ2JP7Ajlfga.97
- 5 See, for example, www.theguardian.com/lifeandstyle/2014/dec/02/claridges-hotel-breastfeeding-woman-cover-up
- 6 www.nhs.uk/conditions/pregnancy-and-baby/benefits-breastfeeding
- 7 www.breastfeedingnetwork.org.uk/breastfeeding-help
- 8 Fearless formula feeder. ISupportYou: www.fearlessformulafeeder.com/2013/07/announcing-the-i-support-you-movement
- 9 See here for the advert <https://youtu.be/XYliyCxV2AE> and here <https://youtu.be/2K18y1W2Lek> for the behind-the-scenes.

7

PRO-ANA

Unhealthy transformations

As we have shown throughout this book, postfeminist sensibility presupposes an agentic subject seeking health citizenship through self-scrutiny and work on the body. This subject is expected to both embody normative notions of health and beauty (slim, toned, heterosexually attractive) and understand their bodies as the source of their personal identities. These notions interpellate women through an individualist discourse ('be who you want to be!'), but offer a generic pathway for this self-actualisation. This pathway is one of continuous scrutiny and work on the self and body to meet cultural ideals and the needs of neoliberal economies, while understanding this work to be a personal choice. That there is such a homogenised route for women to uniquely self-actualise is one of the many contradictions within postfeminist sensibility. These contradictions, as we have shown in previous chapters, create a range of unhealthy psychological and physical outcomes, as women strive to be 'good' within a context where being 'good' is often unattainable since it involves meeting contradictory demands. But what of the women who do not strive to be 'good' – who resist cultural ideals of health and beauty?

We finish our analysis of postfeminism and health by exploring an area where women appear to take up unhealthy subject positions. Among representations of unhealthy femininity, the self-starving young woman has particular dominance in popular media, psychological discourse and feminist theory. In part, this is because anorexia and related disordered eating are seen as representing the particularly pathological relationship women have with their bodies within postfeminism (Ringrose, 2013).

One particular response (and, arguably, resistance) to the pathologisation of the woman with an eating-disorder has been the emergence of 'pro-anorexia' or 'pro-ana', terms used to describe diverse communities of women who variously define

themselves as anorexic and who engage in the online production of information on the practices of self-starving. That these practices are produced online is particularly relevant for an analysis of postfeminist healthism, since, as we have shown throughout the book, postfeminist ideas about ideal femininity are mediated ideas, circulating across a range of media and through various technological developments.

In this chapter, we offer an analysis of pro-ana by mapping different historical and contextual approaches to understanding self-starvation. We show how shifts in cultural constructs of femininity and psychology led to self-starvation becoming a disorder with its own diagnostic psychiatric criteria and set of media representations that articulate concern over the damage caused by mass media to the psychological wellbeing of vulnerable, young, white, middle-class women.

Having demonstrated the way that history, media and psychology intersected to produce particular frameworks for understanding anorexia, we introduce the idea of mediated subjectivity as a way of thinking through the complexities of women's engagement with media. Located in a wider mediated context, the discourses surrounding pro-ana play out largely through the bodies of celebrities, where media texts participate in the ownership, surveillance and body shaming of celebrity bodies in order to claim their own ethical standpoint, as critics of the thin-ideal. These media texts fold into a wider discourse which assumes that young women's psychologies are easily influenced by the media, a 'hypodermic' needle model, which proposes a simplistic causal relationship between the consumption of images and women's understanding of themselves. We take an example from the less controversial fitblr communities, which focus on fitness. While reproducing many of the same practices as pro-ana in terms of measurement, self-surveillance, monitoring and disciplining, fitblr fits more neatly into neoliberal modes of healthism and the body-as-project. By mapping the mediated and digital emergence of pro-ana in contrast to fitblr communities, we offer an analysis that engages with the complexities of postfeminist-mediated subjectivities beyond taking either a simple hypodermic approach or, its corollary, celebrating pro-ana as a form of political resistance.

We conclude this chapter by considering alternative ways of understanding pro-ana communities, which neither fall into celebratory constructions of pro-ana as resistance (while ignoring the damage done to women's health), nor undermines the capacity of pro-ana communities as spaces of support in the context of an otherwise marginalised embodiment. To do so, we draw on Deleuzian thinking to conceptualise pro-ana communities as assemblages of becoming. We suggest that this framework provides opportunities for us to re-engage in feminist accounts of eating disorders in new ways that ask not what pro-ana is, but what it can do.

Anorexia in a postfeminist sensibility

Psychological distress is often associated with femininity. Freud's infamous case of Dora, Sylvia Plath's (1963/2009) *The Bell Jar*, popular autobiographies like *Prozac Nation* (Wurtzel, 1995) and media panics about 'Am I pretty or ugly' YouTube videos (Dobson, 2015), all tie together femininity with madness and pathology.

In Chapter 1, we explored this idea by considering historical representations of women's madness through the figure of Ophelia. Here we explore 'women's madness' further by considering its medical categorisation and treatment.

The relationship between women and madness is a key feature of many critical analyses of psychology and psychiatry.¹ And as a disorder foremost of the mind, anorexia is part of this narrative, with the most legitimised and dominant construction of anorexia today being informed by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) produced by the American Psychiatric Association. Considering recent versions of the DSM, in DSM-4 (American Psychiatric Association, 2000), the diagnostic criteria in the category Feeding and Eating Disorders for anorexia included: a refusal to maintain normal weight for age and height; a fear of gaining weight; distorted perception of the body and a 'denial' of how serious one's body weight is; and amenorrhoea (the absence or cessation of menstruation; American Psychiatric Association, 1994). In DSM-5 (2013), further changes to the diagnostic criteria of Feeding and Eating Disorders included the additions of binge eating, pica (repetitive eating of non-nutritious substances like hair or soil), rumination and avoidant/restrictive food intake disorder. The inclusion of binge eating was to recognise this disorder, while pica, rumination and avoidant/restrictive food intake disorder were included as a way of recognising that these exist beyond childhood (American Psychiatric Association, 2013). The logic behind including additional categories in DSM-5 was to reduce the number of patients classified as 'eating disorders not otherwise specified', with view to enabling better treatment (American Psychiatric Association, 2013). This move also broadened the number of people clinically diagnosable as 'disordered'.² In contrast to such additions, amenorrhoea was removed from the DSM-5 criteria of Feeding and Eating Disorders, as was the word 'refusal' from the first criteria (refusal to maintain normal weight for age and height).

The removal of amenorrhoea from DSM-5 reflected a growing number of men who share similar body weight symptoms, but it also tied into feminist concerns about representations of women in the DSM. Critics had argued that including amenorrhoea signalled a simplistic positioning of women with anorexia as desiring to remain child like, when interview research suggested that they were rejecting a more specific adult femininity linked with being out of control, emotional, sexual and vulnerable (Malson and Ussher, 1996). However, the removal of amenorrhoea may be problematised in other ways, since a way that clinicians can avoid engaging with problematic weight charts (see Chapter 2 for a critique of 'health weight' charts) is to use amenorrhoea as a definition of unhealthy weight. These complexities point to the inherent problems in conceptualising anorexia, which, as we show below, take on a different set of dilemmas when thinking about anorexia as a form of resistance to patriarchal societies. Similarly, the removal of the word 'refusal' in relation to maintaining a normal weight for age and height was done because it implied 'intention' (American Psychiatric Association, 2013), but notions of choice and agency are central to neoliberal citizenship and postfeminist subjectivities, an issue we return to below in our discussion of pro-ana.

Recent DSM versions represent a turn away from its original psychodynamic explanations towards a biomedical model of health. This shift reflects a desire to produce more reliable and objective definitions of mental illness. Critics argue, though, that contemporary versions of the DSM are also not objective, neutral or value-free, but represent the sociohistorical contexts of the psychiatrists who produce it (see, for example, Lafrance, 2007). Part of this context is capitalism, with various reports raising concerns about potential conflicts of interests between the DSM panel members and their associations with the pharmaceutical industry. For example, Cosgrove and Wheeler (2013) reported that 69% of those on the panel of DSM-5 disclosed strong ties with pharmaceutical commercial organisations, while earlier work on the DSM-4 panels suggested that 100% of the members of the panels for 'Mood Disorders' and 'Schizophrenia and Other Psychotic Disorders' and 83% of the panel 'Eating Disorders' had financial ties to pharmaceutical companies and industries (Cosgrove et al., 2006).

Other criticisms of the DSM orient around the way gender is constructed. Again, rather than see the DSM as objectively reporting types of female pathology, feminists have argued that it reproduces cultural mores and thus acts as a mechanism of patriarchal power. Within this argument, feminists have also taken issue with the gendering of particular 'disorders', including depression and eating disorders (e.g. Lafrance and McKenzie-Mohr, 2013; Cvetkovich, 2012; Ussher, 2011; Swenson, 2010).

By arguing that the DSM is sociohistorically located, feminist analysts point to the need to contextualise women's mental health and illness. Thus, in contrast to the DSM's definitive, static diagnostic criteria, feminist approaches have highlighted the psychic, cultural and social context of women's self-starvation (see Bordo, 1993 Chernin, 1994; Wolf, 1990). From this perspective, medical models ignore a range of contextual and gendered meanings given to women's bodies, and treat the anorexic woman as an individual who needs to be 'cured' without significant challenge to the cultural contexts that make women self-starve. From this perspective, it is important to consider the sociohistorical conditions of possibility for women's self-starvation (Malson, 1997).

Saukko (2006, 2008), for example, offers contextualised analysis of media reports of the illnesses of singer Karen Carpenter and Princess Diana, who were diagnosed respectively with anorexia and bulimia in the 1970s and 1980s. Saukko suggests that media reports on the life and death of Carpenter make sense against the backdrop of political conservatism of Nixon and Regan. For example, in the obituaries of her death, Carpenter, was constructed as the 'good but caged' woman in ways that conflated her personality with a pathological character of anorexia (perfectionism, overwhelming lack of control). Diana, who was treated for her bulimia by the feminist psychoanalyst Susie Orbach, was, by contrast, discussed in the media as a survivor and fighter in an otherwise patriarchal, aristocratic Royal family. Saukko (2006) suggests that the media reports of the illnesses of these high-profile women marked floodgate moments in bringing disordered eating (both anorexia and bulimia) to the attention of a wider public. The widespread discussion

of these two white, middle- and upper-class celebrity women allowed them to become 'iconic' in defining contemporary understanding of the anorexic/bulimic body. Part of this understanding involved locating anorexia as an outcome of feminism, the argument being that taking up public roles and participating economically causes stresses damaging to women's mental health (Riley et al., 2008; Saukko, 2006). The narrative retelling of these two high-profile cases in the media thus both reflected the sentiment of the times but also shaped how people came to know 'the anorexic' – as white, middle classed, privileged and successful, but controlled, and damaged by feminist-driven changes in women's roles.

Another example of the powerful effects of media representations comes from Saukko's autoethnographic work on her own experience of anorexia. Considering the impact of media representations on how women can understand themselves, Saukko (2008) described how medical and popular representations of eating difficulties that construct the figure of an anorexic woman as a middle-class 'good girl', made it difficult for her, coming from a working-class background, to name her self-starvation. We could draw parallels here with kleptomania, which brought together middle-class privilege with constructs of women's mental instability, medical science and new spaces of consumption in the department store, converting the act of theft that criminalised working-class behaviour into a psychological pathologised middle-class behaviour (Abelson, 1989, p.124; Hare-Mustin and Marecek, 1997). Similarly, in her historical analysis of important texts and popular accounts that helped define the diagnosis of anorexia, Saukko (1999) argues that all forms of eating difficulties can be understood through classed constructs. For example, representations of working- and middle-class people often distinguish the classes in terms of moral control – thus in contrast to constructs of working-class people as lacking moral control (see, for example, Chapter 5), the middle-class anorexic woman is represented as having an excessive morality demonstrated by her control over her body (Saukko, 1999; also see Malson, 1997, for a discussion of the contradictory ways in which anorexia is represented in relation to control).

Saukko's nuanced and contextualised analyses of media representations of disordered eating stands in contrast to the more dominant psychological and individualised 'hypodermic needle' model evident in a range of media and psychological texts. In the 'hypodermic needle' model, women are understood as passively internalising the thin ideal through their consumption of women's media and those who develop disordered eating are constructed as being particularly psychologically vulnerable to internalising the thin ideal, because, for example, they have low self-esteem or have some other psychological characteristic such as being very materialistic (see Blood, 2005, for a critique of this model). In contrast, Saukko's work³ offers an analysis of what we call 'mediated subjectivities', understandings of oneself produced through dynamic, and potentially agentic, engagement with a complex assemblage of sociohistorically located material and discursive practices of which media representations are a part.

In showing how media constructions of disordered eating create mediated subjectivities, Saukko's work is a response to feminist criticisms of the DSM's

construction of anorexia in individual, behavioural terms without considering the cultural conditions of possibility that produce these eating practices. Other feminist work focusing on the cultural contextualisation of women's self-starvation have conceptualised disordered eating as a politicised response to the limitations placed on women within patriarchal societies. For example, Orbach wrote that:

[just as the] political prisoner who embarks upon a hunger strike does so to draw attention to the injustice of her or his incarceration and the righteousness of his or her cause. The anorectic woman on hunger strike echoes these themes. Her self-denial is in effect a protest against the rules that circumscribe a woman's life, a demand that she has an absolute right to exist.

Orbach, 1986 p. 105

Orbach was writing from a psychoanalytical perspective where the anorexic or obese woman's body size was analysed as an unconscious protest against patriarchal society. For others, self-starvation was conceptualised as a conscious political act. For example, the early twentieth-century suffragette movement used self-starvation as form of protest against women's location in culture, since property rights at the time deemed the woman's body as owned by either her father or her husband (Parkins, 2000). Once the authorities' response of force-feeding these 'unruly women' gained significant negative press (see Orbach, 1986, for an account), the UK government brought in the Cat and Mouse Act (Purvis, 1995), which allowed imprisoned women to starve themselves to the point of becoming too weak to engage in political activism. These women were then released from prison, only to be rearrested at a later date. Both force-feeding and the Cat and Mouse Act reflect significant historical patriarchal practices that attempted to control and discipline the female body for being in a state of 'self-denial' (Orbach, 1986).

In conceptualising anorexia as a means by which women might escape from undesired and socially undervalued femininity, writers such as Orbach (1986) conceptualise anorexia as a form of resistance. But anorexia presents a 'coding problem' for feminists (Bray, 1996, p. 414), since, from different perspectives, it can be understood as either resistance or conformity to oppressive ideals of femininity. Self-starvation might be an embodied critique about culture, but it also allows women to conform to cultural ideals of femininity that orient around control, sacrifice, reduced consumption and the thin-ideal (Day, 2010; Day and Keys, 2008, 2009; Malson, 1997). Celebrations of anorexia as resistance are also somewhat less triumphant when we consider that anorexia has the highest mortality rate of any mental illness (Malson, 1997; see Ferreday, 2011, for further discussion on the importance of analysts recognising the health outcomes of anorexia).

Feminist analysts thus have to negotiate a range of troubling frameworks to make sense of anorexia. The hypodermic needle model locates anorexia as a form of cultural contagion where women passively absorb cultural norms of beauty; psychiatric accounts infantilise, pathologise and discipline women's bodies; yet feminist accounts of resistance celebrate an illness that kills women. One solution was

to draw on Bordo's (1993a) Foucauldian-inspired conceptualisation of anorexia as a 'crystalisation of culture', whereby anorexia was understood, not as a separate, unhealthy pathological state, but 'an intensifying amalgam of certain dimensions of the norm' (Malson, 2008, p. 30). It is from this standpoint that we consider discourses of anorexia within postfeminist media, using the intense media focus on the actress and model Kiera Knightly's body to illuminate our arguments, from which we aim to contribute new ways of addressing the 'coding problem' of anorexia.

Eat something

During the summer of 2014, Kiera Knightley addressed repeated questions in the media over her body and about whether she was anorexic. In an interview with *Elle UK Magazine*, she discussed such media scrutiny over her body that had gone on for several years, being most intense following her appearance in the 2006 London premier of *Pirates of the Caribbean: Dead Man's Chest*. Following the premier, Knightley made several public announcements responding to speculation over her body weight, stating that she was not anorexic. Despite her repeated insistence that her body was naturally thin, media reports continued to describe her as anorexic, including a 2007 *Daily Mail* article that claimed that as a self-starving woman, Knightley was a bad role model and implicated in the death of a young anorexic woman.⁴

Our interest in this issue here is that the attempts by the media to label Knightley as 'anorexic' demonstrate both the importance of the body as a marker of success and the surveillance and commodification of the female celebrity body in the post-feminist media. The intense scrutiny of female celebrity bodies in contemporary media is inherently ambivalent, creating further cultural anxiety and contradiction. One of these contradictions, for example, is the implication that the celebrity is both responsible for, and made vulnerable by, their public appearance (Ferreday, 2003). Knightley's appearance at the *Pirates* premier was celebrated as demonstrating her 'English rose' beauty, while also being tied to her failure as a good role model and her vulnerability as a young actress. This positioning of 'vulnerable woman' makes sense within wider cultural gendered, classed and racialised discourses around disordered eating that were highlighted in Saukko's work, whereby eating disorders become the cost of success for white, middle-class women. Where Knightley's representation differs from those of Karen Carpenter or Princess Diana is that, located within a postfeminist sensibility, media discourses of concern for Knightley can be understood as simultaneously critiquing and supporting the thin-ideal. As we discussed in Chapter 2, there has been a sustained feminist critique about the damaging effects of thin-ideal representations of women in media. Postfeminist media have responded to these, but not necessarily by rejecting the thin-ideal. Instead, the thin-ideal has been rebranded, for example, in blogs that reframe food restriction/dieting as eating healthily (Cairns and Johnson, 2015) or, as we argue below, reproduced within a discourse of concern.

As we have said throughout this book, postfeminist sensibility is riven with contradictions and the construction of Knightly as a vulnerable yet a bad role model highlights another, since it positions Knightly as both passive and agentic, as well as drawing on historical discourses of female pathology that we described in Chapter 1. Constructing Knightly as vulnerable also allows the media to engage in a new discourse of concern, while benefiting from understanding her as ill. Within women's magazines, for example, there is a regular demand that Knightley and other skinny celebrities should 'eat something'. The demand for these women to 'eat something' makes sense as part of the historical discourses that others own the female body and also makes sense in relation to DSM-4's criterion that anorexia is a 'refusal' to eat. But, in a further postfeminist twist, the demand to 'eat something' is also offered as evidence of the magazine's care and concern, of a wish for the celebrity to become healthier or for there to be more 'healthy' role models for other women, even though much of the rest of the magazine's content will be designed to elicit intense scrutiny of other women's bodies (and thus one's own in comparison) through articles structured by images of women that are deemed too thin or too fat (Gill and Elias, 2014; Riley, Evans and Mackiewicz, 2016). In the 'eat something' imperative, magazines can thus bring together both scrutiny and care (also see our discussion of plus-size model Tess Holliday in Chapter 2).

Calls in the media for healthy-looking role models for women articulate the hypodermic needle model of media, whereby eating disorders are attributable to the individual vulnerabilities of particular women who are considered to be disproportionality influenced by the thin-ideals they see in media representations of femininity. In contrast, poststructuralist-informed feminist work argues that anorexia is better understood within its wider social context, but struggles to reconcile an understanding of anorexia as potentially a form of cultural resistance, when it also validates the thin ideal and causes significant psychological and physical damage to women, even death. Here, we have argued that postfeminist sensibility adds further contradictions and complications, in which, for example, the scrutiny of women's bodies is both oppressive and located within a discourse of care. The outcome is that we do not really have appropriate frameworks for understanding anorexia as a feminist health issue. Added to this mix is that making sense of contemporary articulations of anorexia also requires consideration of digital technologies. In Chapter 5, we showed how the emergence of photography created novel ways of thinking about the fetus. Similarly, below we explore the emergence of digital cultures, in particular, pro-ana websites and their implications for understanding disordered eating and the pathological female.

Pro-ana

Emerging at the end of the twentieth century, pro-ana communities represent a diverse and divergent range of digital practices for those who self-identify as anorexic in online contexts (Dias, 2003). While largely defining themselves as supporting anorexia as 'a lifestyle choice', a brief taxonomy of pro-ana websites demonstrates

their heterogeneity, which is further extended if other pro-eating-disorder websites are included e.g. pro-mia (bulimia) or pro-EDNOS (eating disorders not otherwise specified). To give a sense of the range, some pro-ana sites can be categorised as 'hardcore'; these offer a range of 'commandments' and personal dedications that personify 'Ana' as benevolent and/or malevolent figure to be obeyed. Other pro-ana sites approach anorexia as a lifestyle choice or as a sub-culture, for example, by promoting the wearing of a red bracelet to signify membership to a wider pro-ana community. Others still, take a more activist stance (taking the 'pro' to stand for 'pro-active'). These sites position themselves as service providers, offering information on being anorexic, including support for those who have been fired for being too thin and descriptions of what happens to the body during fasting. The focus on 'human rights' in these activist sites precedes the development of the emergence of a further 'evolution'⁵ in the form of post-pro-ana sites, such as *Your Eatopia* and *We Bite Back*, whose primary purpose is to serve those in recovery (also see Riley, Rodham and Gavin, 2009, for an analysis of more traditional recovery site forums). Developments in technology also facilitated shifts in the digital articulations of anorexia within pro-ana communities; for example, improvements to the ease of uploading visual images led to a dramatic increase in visually oriented platforms (Ferreday, 2003).

Pro-ana communities are thus heterogeneous, serving multiple functions in relation to how they address their users. There is also heterogeneity in their use of different online platforms, from social media to websites. Sites sometimes contain forums and discussion threads and many have anorexic slogans (e.g. 'hunger hurts, but starving works') and 'thinspiration' images of thin bodies including those of celebrities, while others allow users to share online diaries. The structure of platforms therefore greatly shapes the way they are used. Blog sites, for example, are often used as a journal or diary of those suffering with anorexia and so provide a narrative history, often with an ambivalence that demonstrates a range of emotions and affects of everyday life that include both the narrator's individual struggles and wider issues of the anorexic body.

Despite the heterogeneity of pro-ana communities, they have been the focus of a sustained media panic that homogenised them as singularly dangerous. The *Salon* magazine's online article 'The Winner Dies'⁶ and *Time* magazine's 'Anorexia Goes High Tech'⁷ are examples of regular features that appear to 'reveal' pro-ana communities. These features follow a similar structure. For example, during the 2014 Eating Disorders Awareness Week, for example, the *Telegraph* newspaper published a 'special report',⁸ which claimed that the 'only way to understand this community – and lure them out – is to delve inside', through a mix of pro-ana accounts, 'survivor' stories and a series of experts from academia and psychiatry. Throughout all these discussions, there is a repetition of a few key modes of representation: namely that these sites 'promote' anorexia or treat anorexia as a lifestyle choice, therefore simplifying the range of more complex and nuanced differences within pro-ana communities.

A steady stream of discussion about pro-ana websites continues to dominate popular media, with one of the most recent media panics concerning the

sale of 'pro-ana' clothing and accessories. In March 2014, a wave of online print publications reported that the red pro-ana bracelets, discussed in the community ambiguously as either demonstrating awareness, support or belonging, were being sold on sites like Etsy and eBay. In 2010, the clothes shop Urban Outfitters came to attention for selling pro-ana clothing, pulling a line of t-shirts with the slogan 'Eat Less' because of pressure from commenters on Twitter and Facebook. The Hudson's Bay clothing company followed in 2014. Their 'Nothing Tastes as Good as Skinny Feels' t-shirt borrowed the phrase from Kate Moss, who in 2009, came under pressure for repeating the slogan that already appeared on many pro-ana websites. Following similar complaints to those received by Urban Outfitters, Hudson's Bay removed the t-shirts from their stores. Artist Ioana Urma and the company Spreadshirt.com were the subject of a Change.org petition in 2014 to remove their 'Alluringly Anorexic', 'Beautifully Bulimic' and 'Breathtakingly Boney' t-shirts. All instances incited retaliation from designers. For example, Hudson's Bay insisted that the 'design was not intended to be pro-anorexia but the opposite',⁹ while Philip Rooke, owner of Spreadshirt.com, responded by suggesting that the t-shirts were part of an art project and were meant to challenge the impossibilities of the fashion and beauty complex. These examples also evidence the discourse of concern we discussed in relation media scrutiny of Kiera Knightly's body, a discourse that enables the user to position themselves as concerned for women and against the mediated reproduction of the thin-ideal, while simultaneously reproducing that thin-ideal. Ethnographer Megan Warin (2009) documents a similar pattern in media requests to write about her work on women's experiences of anorexia, where she was asked for images of her participants 'to fuel their stories' (p. 181), with one journalist requesting only 'a really skinny one' (p. 9).

Critical commentary of pro-ana communities also developed across a range of social media platforms like Twitter, Facebook, Tumblr and Instagram – so that sites of pro-ana communities also became spaces of anti-pro-ana, seen for example, in the #antiana hashtag. As the line between social media and the traditional 'official' media and print press folded, digital media companies from the early 2000s onwards were put under pressure from a range of sources to censor or remove pro-ana websites that use their platforms. Yahoo! infamously deleted pro-ana related content from its servers in 2001. Others have attempted similar acts of removal. Instagram, for example, removes all content relating to pro-ana hashtags, while Tumblr and others provide warnings, with an 'Everything Okay?' pop-up message reminiscent of self-help calls to assess the self (see Chapter 1) and a link that directs the reader to the appropriate medical and official experts in the form of the National Eating Disorders Association. Pro-ana communities thus have to operate as closed communities, hiding their existence from outsiders and platform providers through the use of passwords and coded specialist language.

Pro-ana communities are thus forged within a wider context where others seek to make them visible, while also problematising, silencing or annihilating them. One outcome of this adversarial media critique is that, across pro-ana sites, members of these communities have to protect themselves from outsiders (Boero and Pascoe,

2012). What pro-ana communities share then, is a sense of community, produced both by an identification as 'ana' (which might occur in a range of ways) but also in response to wider cultural critique by those not in these communities. To defend against a range of outsiders that include 'haters' and 'wannabes' (Boero and Pascoe, 2012; Giles, 2006; Riley, Rodham and Gavin, 2009), as well as journalists and academic researchers, entry into pro-ana communities requires a demonstration of legitimacy of membership. To manage entry, pro-ana communities have created specialist language and discursive practices that demonstrate knowledge and understanding of anorexic life. Lavis (2014) discusses such specialist language as a form of Foucauldian biosociality, where these discursive practices demonstrate an understanding of the biological, physical and psychological criteria that can determine belonging to a pro-ana community (such as listing current and ideal weights or knowledge of the DSM criteria). Such discursive practices allow pro-ana communities to continue and to police their borders, sharing a range of content designed to facilitate disordered eating and validate an ultra-thin ideal.

As Dobson (2015) argues in her analysis of young women's self-sexualising digital media images, it is important to recognise the affective quality of such representations – shock or horror for example – but also to develop a more nuanced analysis for making sense of them. Similarly, in relation to pro-ana representations of self-starvation, it is important to recognise the affective qualities of the content on pro-ana sites – viewing images and content is often disturbing and distressing experience. But, we also need to consider the conditions of possibility that allow pro-ana communities to make sense to those who participate in them and think through the capacities for action that these digitally mediated subjectivities allow. Early work on pro-ana communities, for example, pointed to how such online communities provided much needed support for an often hidden and socially isolating illness (Dias, 2003). There are also affective bonds formed between members. For example, when the author of the Blogspot journal *Starve to be Perfect* stopped documenting her everyday experiences and anxieties around her body weight, readers of the blog posted messages of support and concern.

It is also important to develop a nuanced analysis of the mediated subjectivities enabled in pro-ana sites. Thinspiration images of women that are used to inspire self-starvation point to a hypodermic needle of media influence (Burke, 2006; Coleman, 2009; Dias, 2003). Yet how these images are presented differs across pro-ana sites, with some claiming bodies of celebrity women like Keira Knightley, the Olson twins, Kate Moss, Victoria Beckham and Nicole Richie as part of their own community (Ferreday, 2011). Yet in other instances, images of these celebrities' bodies are interspersed with images of the site member's anorexic body, intersecting the aspiration and glamour of celebrity with a range of embodied meanings, including pain, discomfort and failure.

Agency is also evident in the way images can be employed on these sites that suggests more intent allowed by either the hypodermic model or the DSM-V diagnostic criteria. For example, images produced by the No Anorexia and 32 Kilos critiques of the fashion industry's emphasis on thin models are now part of

the canon of thinspiration images on pro-ana websites. The anti-anorexia billboard campaign No Anorexia ran during 2007's Milan Fashion Week and featured anorexic model Isabelle Caro, who subsequently died aged 28 (see Ferreday, 2011, for an analysis of this campaign). In response to Caro's images and to heightening public awareness of pro-ana communities, photographic artist Ivonne Thein then created the series 32 Kilos, in which images of the photographer's friends were Photoshopped to appear the same weight as Caro in the No Anorexia campaign, appearing as bandaged fashion models in *Vogue*-esque poses. Both the No Anorexia and 32 Kilos images were created as critiques of the fashion industry's emphasis on thin models and the assumption that this industry promotes anorexia. The take-up of images produced in anti-anorexia campaigns on pro-ana websites thus demonstrates a complexity in pro-ana members' engagement with celebrity and the thin-ideal, as well as an active engagement with these images.

As well as sense of community (even if their community may differ from other pro-ana communities) and an active engagement with the thin-ideal, pro-ana communities draw on an understanding of vulnerability as power (Ferreday, 2003). As we discussed in Chapter 1, there is an historical association between femininity and mental vulnerability, which a postfeminist sensibility rewrites so that while femininity continues to be positioned as pathological, the female mind is understood as both capable of and responsible for fixing itself. Empowered postfeminist subjectivity is thus a self who is able to work on itself. In pro-ana, the importance of working on the self is also reproduced, but not to fix pathology. Rather, work on the self is used to support it.

Burke (2012) likens the aesthetics of pro-ana sites to the stylistics of grunge. Grunge fashion embraced the sense of hopelessness in the face of institutional powers, the crisis of social structures and social anxiety, reacting to 1980s glamour and following the challenge of the punk movement, it was 'characterised by a kind of despairing passivity in the face of mass consumerism and the mass media' (p. 39). According to Burke (2012), the 'the waif' embodied grunge aesthetic (see, for example, images of model Kate Moss from the 1990s). Many pro-ana websites and online forums borrow from the grunge aesthetic, deploying knowingly fragile and feminine objects (e.g. butterflies) and making use of contradictory symbols so that images of weakness and vulnerability are made to stand in for empowerment. Burke (2012) associates this aesthetic with the politics of postmodernity, where meanings become flexible and fluid. A repeated aesthetic across the sites is therefore located in the practice of symbolic distress as a signifying strategy, demonstrating agency by embracing a normative pathology (Burke, 2012). Understanding pro-ana in terms of embracing normative pathology also ties into analysis of postfeminist subjectivity. In her analysis of the media panic around 'Am I pretty or ugly' YouTube videos, Dobson (2015), for example, argued that the corollary of the successful postfeminist subject is the one who fails to fix herself and in so doing is unable to take up an autonomous, choiceful subject position. In asking the world 'Am I pretty?' the producers of these videos, Dobson argued, demonstrate a neediness for validation by others that positions them as both psychologically vulnerable and unable to fix

themselves, yet are agentic in their practices, thus symbolically rejecting postfeminist subjectivity and neoliberal citizenship that underpins it.

From this perspective, pro-ana communities might represent a crystallisation of culture in terms of illuminating a pathological, vulnerable femininity produced in the context of the thin-ideal and cultural locations of women's value in their appearance. But, they might equally be read as its reverse, and as part of a range of digitally facilitated mediated subjectivities that articulate resistance to neoliberal subjectivities. This resistance may also drive the wider public and media panic, in part because of our cultural commitment to neoliberalism. To develop this analysis, below we consider how pro-ana can be read as a rejection of healthism. We do this using the concept of abjection and also by contrasting pro-ana with its apparent corollary, sites that are linked, not to thin-spiration, but to 'fit-spiration'.

Pro-ana, healthism and mediation: 'those pics make me sick'¹⁰

One way we can make sense of the public reaction to pro-ana communities is through the concept of 'abjection'. According to Kristeva's (1982) psychoanalytical account of subject formation, 'the abject' are things we find disgusting. Kristeva (1982) suggests the things that make us feel physically sick are those that pass between the inside and outside of the body, such as excrement, blood, sweat, semen and, in the case of the anorexic, the sight of bones protruding through the skin. Disgust, for Kristeva (1982), is therefore not a matter of cleanliness of health. Instead, what we find disgusting are things that shatter our sense of bodily coherence and demonstrate how life is disordered, fluid and mutable. Disgusting things challenge our sense of a coherent self, a sense of the unique and individual 'I', by showing the borders of the body to be more indistinct than we might believe.

For Kristeva (1982), birth and death are the most profound experiences of abjection. Birth and death function for Kristeva as the psychic 'borderlands' between becoming a body in one's own right separate from the body of our mothers or the annihilation of the self in death, are thus feared and full of taboo and ritual. They represent our most intimate connection to the body of another and the fact that our bodies are not forever. Yet despite our sense of uneasiness and sickness at the sight of these apparently disgusting things, we are also fascinated by the abject. By looking, we locate the abject as other. Seeing dead bodies, for example, allows us to reconfirm that we are not yet ourselves dead. In terms of health, we could also suggest that seeing the unwell allows us to reconfirm ourselves as healthy.

Many have suggested a more sociological way of using the concept of abjection, taking it from its psychoanalytical roots and employing it to understand 'the mode by which Others become shit' (Butler, 1990, p. 182). For example, Ferreday (2003) suggests that the 'healthy' person's fascination at clicking on and viewing pro-ana content (or alternatively seeing emaciated celebrities and models in women's magazines) stems from the fact that the pro-ana body appears to exist in a liminal space between life and death. She also notes that abjection is often verbalised in online comments. For example, in one comment that we read in reaction to a news

story on the *Daily Mail*, one reader exclaimed ‘Those pics make me sick how can people admire bones!!!’. Ferreday argues that such reactions to pro-ana communities are forms of abjection and by reacting with disgust the person demonstrates belonging ‘to the healthy community and is not at risk of being incorporated’ (2003, p. 290). She also comments that there is an irony in the abject reaction to images of anorexics online since reconfirming the commenter as part of the healthy community (and therefore disgusted by images of anorexic women) means also declaring the need to vomit, thus re-enacting some of the practices of anorexia (and bulimia specifically) that are discussed in pro-ana communities.

The abject is therefore needed to restore order and normality, but the abject also incites a desire for change and/or deletion (Ringrose and Walkerdine, 2008; Ferreday, 2003; Tyler, 2008). Abjection can therefore be seen behind the demand that the anorexic body needs to be changed, censored or erased, such as in the proliferation of recovery stories in newspaper reports, the expressions of ‘eat something’ when faced with the thin celebrity, and calls for deletion of pro-ana websites and images that appear on them. Abjection thus explains the desire to look – for the journalist to need an image of a ‘really skinny one’ for their coverage of women who suffer from anorexia, as we described above, since by making the anorexic body hypervisible, we ensure confirmation of our healthy self (Warin, 2009). Within visual culture where a ‘scopic regime’ conflates the ‘seen’ with the ‘known’ (Jenks, 1995, p. 3), the focus on thinness within the visual grammar of anorexia makes the female anorexic body an object of fascination and spectacle (Warin, 2009). Social media tools provide the opportunity for the image to be repeated, so that it may be hyperlinked, re-pinned, hashtagged and re-blogged, by both pro-ana communities in the form of thinspiration and by the popular media, as a form of power-knowledge that helps designate some bodies as sick and others as healthy (Foucault, 2003). These forms of power-knowledge through the visual representation of the anorexic body also demonstrate the visceral and emotional power of such images (Bray and Colebrook, 1998). Read through the lens of abjection, the risk of incorporation and subsequent negation of the image is experienced affectively – ‘[t]hose pics make me sick’ – that forms an important component of our subjective relationship to the image of another. Media responses to pro-ana communities that then circulate on and offline can therefore be understood as a form of crystallisation of culture, an expression of cultural anxieties around health.

The abjection of the anorexic image in media coverage of pro-ana communities contrasts starkly when compared with other online representations of weight reduction, control and management, where practices associated with eating difficulties are tied to health, blurring the boundaries of ‘sick’ and ‘healthy’ even further. For example, Coleman’s (2010) analysis of the Weight Watchers online platform shows how dieting and scrutiny of current and ideal weights becomes tied to a neo-liberal focus on (life-long) lifestyle changes, success stories and the good citizen’s ‘choice’ to maintain a ‘healthy’ weight. Similarly, Szto and Gray’s (2015) analysis of the Twitter hashtags that circulated around *The Biggest Loser* (NBC, USA), showed the way Twitter is used as a way of disseminating ‘expert’ health advice on body

management. Placed alongside pro-ana communities, the bodily practices engaged with through Weight Watchers Online and *The Biggest Loser's* Twitter commentary demonstrate the same capacity for disciplinarity, except that they are acceptable because of their orientation to health and normalised, biosurveillance techniques. In a similar way, Ferreday (2003) highlights the way that airbrushing and digital manipulation of celebrity bodies are understood as normal and normative in the fashion, beauty and photography industries, but dangerous and deviant in others. We develop these lines of argument below with the example of the fitblr community.

'Fitblr' is a term used by many bloggers and Tumblr users to denote content dedicated to fitness and exercise. To date, the fitblr community has received little media attention, despite similarities with pro-ana communities with regard to disciplined regimens of bodily transformation and a heavy focus on 'motivational images' that could, in other contexts, be deemed part of the iconography of thinspiration (and are known within the fitblr community as 'fitspiration', or 'fitspo'). Within the fitblr community, there is an emphasis on forms of exercise that requires monitoring and measurement, restrictive diets (e.g. the 'clean diet', which excludes any processed foods) and normative notions of beauty. For example, an image that appears across a number of fitblr blogs is of a white, slim, pouting woman with full make-up and long flowing hair, dressed in gym clothes that show off her midriff, attached to the slogan: 'I don't want another's girl's body. I want my body. But leaner, stronger and healthier!'. Facilitated through Tumblr's visual format, images of slim, toned, white women dominate,¹¹ while its slogans refer to practices of transformation – 'you can't spell challenge without change', 'become the best version of you', 'work hard in silence, let the results do the talking' – as well as infographics that visualise the right way to perform particular exercise routines to achieve muscle or weight loss, or how to prepare and cook 'healthy' food recipes.

Despite articulating a transformation imperative that aligns with postfeminism (Riley and Evans, 2018), fitblr communities also emphasise body acceptance that fits in with a current media shift towards 'love your body' (LYB; Gill, 2007c; Gill and Elias, 2014). In their analysis of LYB advertising, for example, Gill and Elias (2014), argue that LYB discourses appear at first to counter a highly judgemental culture, where women's bodies are regularly critiqued for being saggy, flabby and/or wrinkled. But Gill and Elias (2014) are critical of extols for women to 'be confident', 'love yourself' and 'awaken your incredible', arguing that these create further disciplinary work for women. For example, Dove's Evolution video shows the processes involved in turning an 'ordinary' woman into somebody fit for a billboard advertisement, through a stop-motion technique which takes us from make-up through to Photoshop. The video ends on the note 'no wonder our perception of beauty is distorted'. These forms of body acceptance discourses are therefore predicated on a normative dislike and 'rely upon and reinforce the cultural intelligibility of the female body as inherently "difficult to love"' (Gill and Elias, 2014, p. 184). The LYB discourse also means that alongside the expectation to work on the body to achieve beauty, women are now also expected to work on their subjectivity – what Gill and Elias (2014) refer to as the 'labour of self-confidence' (p. 185). Thus, the LYB

discourse adds another thing to the list that needs ‘fixing’, reinforcing the very discourse it appears to challenge. Similarly, in the fitblr example ‘I don’t want another’s girl’s body. I want my body. But leaner, stronger and healthier!’ bodily integrity and authenticity are reconfirmed, since ‘my body’ is the only body ‘I’ want, while simultaneously constructing this body as requiring transformation.

In fitblr, ideals of female strength are also coupled with appearing slim and sexy, so that fitblr images are reassuringly feminine despite celebrating strong (and potentially masculinised) female bodies. Combining the stated desire to be ‘leaner, stronger and healthier!’ with an image conforming to cultural standards of the ‘sexy’, white, slim midriff (Gill 2009a, for example, ties masculine embodied ideals (leaner, stronger) to feminine embodiment. Within postfeminism, McRobbie (2009) argues that gender power relations are reconfirmed when women who take up apparently powerful positions do so in combination with exaggerated femininity, what she calls the ‘postfeminist masquerade’. We also see evidence of this dynamic between power and femininity in fitblr, as well as other research. For example, St Martin and Gavey (1996) showed how the strong female body is regulated in bodybuilding by being both strong and hyperfeminine. Similarly, in their analysis of Prozac advertising, Blum and Stracuzzi (2004) demonstrated how antidepressants are presented as producing a gender identity that is both able to fit in with the expectations of a masculinised workforce, while Prozac’s diet-aiding qualities help ensure this body is still within the realms of femininity.

The fitblr community also repeats key motifs of pro-ana, while distancing itself from its likeness with statements such as ‘strong is the new skinny’. Recent research on fitblr communities have also raised concerns around parallels between pro-ana and fitblr in terms of validating the thin-ideal, as well as objectification of women; the promotion of exercise and dietary regimens for the purposes of weight loss and guilt-inducing messages regarding weight that also stigmatise those with larger bodies (Boepple and Thompson, 2016; Boepple et al., 2016; Carrotte, Pritchard and Lim, 2017; Deighton-Smith and Bell, 2017; Tiggemann and Zaccardo, 2015). But such research has not contextualised fitblr within a postfeminist sensibility informed by neoliberal healthism (Riley and Evans, 2018). By contextualising fitblr and pro-ana within postfeminism, we can instead see how fitspiration both acknowledges some of the repertoires of pro-ana (e.g. ‘nothing tastes as good as skinny feels’), while also drawing on a subject position of a good bio-citizen, represented in health, strength and an athletic ideal. Similarly, self-control is highly valued among the fitblr community and is thus in tune with other constructs of ‘good’ neoliberal and postfeminist subjectivity, while also echoing the sentiments of pro-ana communities. Fitspiration thus interpellates a transformation that maps to cultural ideals of the healthy ‘fit’ feminine body, rendering some of the practices it shares with pro-ana as beneficial because it does not disrupt neoliberal healthism or the promise of postfeminist perfectionism. In contrast, pro-ana holds a liminal position on the borders of much bigger issues raised around women’s bodies and health embodied agency emerging from the affordances of online media that produce it through abjection.

Conclusion

In this chapter, we have considered the question, what of the women who do not strive to be good' – who resist cultural ideals of health and beauty? To do so, we explored anorexia. Disordered eating is historically located and, in this chapter, we have made a case that – in line with feminist and poststructuralist work – anorexia needs to be analysed within its sociohistorical context. In so doing, we have highlighted how postfeminism and neoliberal healthism provide the conditions of possibility for our understandings of anorexia and how they are represented online and in other media. In particular, we have explored how responses to these representations might tell us as much about wider concerns around abjection, health and death as they do about the issue of anorexia. In so doing, we have moved beyond hypodermic models towards mediated subjectivities and wider analysis of the cultural amalgams that make pro-ana possible. For example, we have shown how both pro-ana and fitblr communities share information that reaffirms historical constructs of femininity: thin and vulnerable in pro-ana and thin and sexy in fitblr, but also how they resist particular cultural expectations in terms of unhealthy starvation (pro-ana) or strong femininity (fitblr).

Postfeminist sensibility is not coherent, but a complex and contradictory set of intersecting discourses (Gill, 2017a; Riley et al. 2017). By locating our analysis of online representations of healthy and unhealthy bodies within postfeminism, we can therefore draw together an underlying rationality that brings these contradictions together. Locating pro-ana and fitblr communities within a postfeminist sensibility allows us, for example, to see how these online communities are informed and validated by postfeminist perfectionism, albeit in different ways. Neither community challenges postfeminist perfectionism, yet they both challenge passive femininity and the implication of merely being a 'cultural dupe' or someone whose individual psychology make them vulnerable to cultural ideals. But locating within postfeminism also facilitates developments for the 'coding problem' of anorexia, allowing us to offer new insights. What our analysis shows is the complexity of online representations of healthy or unhealthy femininity and the importance of making sense of this complexity through the lens of neoliberalism and postfeminism.

As Bray and Colebrook (1998) suggest, the 'coding problem' of anorexia creates an impasse for an issue that should be of significant concern for feminist academics and activists, given its gendered implications and damaging effects among and alongside other health issues. As they suggest, 'to argue that women who practice self-starvation are either compliant with, or revolting against, patriarchal body images is to posit a causal and unproblematic connection between cultural images and corporeality, representation and the body' (Bray and Colebrook 1998, p. 50). Here, we have dealt with the coding problem in terms of, on the one hand, pro-ana communities appearing to be a viable challenge to postfeminist healthism; on the other, its claims to agency, empowerment and practices of self-surveillance making it possible to read pro-ana websites as an exaggeration of postfeminist sensibility. To overcome the dualisms present in these kinds of binaries, Bray and Colebrook (1998) propose

that an ethical approach to anorexia could come from understanding anorexia (and, by extension, pro-ana) as a Deleuzian assemblage – to which we turn below.

Deleuze and Guattari's (1987) concept of the assemblage proposes that we view objects through their relationships and interconnections with other related objects. However, rather than these connections between objects being ever static and finite, the assemblage has a plasticity, it changes shape, reacting to the way other nodes in that assemblage are also constantly changing. Deleuze describes their assemblage as follows:

In assemblages you find states of things, bodies, various combinations of bodies, hodgepodes; but you also find utterances, modes of expression, and whole regimes of signs. The relations between the two are pretty complex.

Deleuze, 2006, p. 177

Assemblages, with their emphasis on 'emergence, heterogeneity, instability and flux' (Duff, 2014, p. 33) stand in opposition to enduring, stable social structures. In Bennett's (2010) account of the assemblage, for example, she uses both the real physical event and metaphor of a power cut in the USA and Canada in 2003 that affected around 50 million people. Imagining the power grid as an assemblage, the energy of electricity that ran through the grid was connected to power stations, transmission lines and the different buildings and people who consumed it. Electricity flows on seemingly well-worn lines. However, on the day of the blackout the electricity changed direction: 'Electricity sometimes goes where we send it, and sometimes it chooses its path on the spot, in response to the other bodies it encounters' (Bennett, 2010, p. 28).

Like a power grid, the assemblage can be understood as a never-ending network or series of relations that are bigger than the whole, which are connected at every point but always changing (or, in Deleuze and Guattari's terminology, *becoming*). This also leads Deleuze and Guattari (1987) to propose that agency works differently. Within the assemblage, agency is dispersed through the different networks. This means that the question of whether the woman engaging in pro-ana communities is participating in a form of agentic resistance against the norms of the beauty industry becomes problematic because this question locates agency within the individual. Deleuze and Guattari's assemblage means that concepts like agency, free will, desire, and other ontologically humanist constructs are not 'interior' – located in the body – but instead move through the assemblage, "... just like weapons" (Deleuze and Guattari, 1987, p. 400) ... branching, reversing flows, coalescing and rupturing' (Fox and Alldred, 2013, p. 5). Agency (or 'affect') is not located in one of the nodes of the assemblage; instead, the becoming of the assemblage is constantly affecting and affected, by the flows that move through it.

According to a Deleuzian empiricism, the concept of the assemblage means exploring the nodes within the assemblage that extend to other points in the assemblage (Colebrook 2002; Coleman and Moreno Figueroa, 2010). As we have described above, the assemblage is always in a state of constant movement, being 'assembled' and

'reassembled' endlessly, reacting to changes within itself and constantly relating to other structures that are connected with. Objects of study therefore cannot be examined in isolation, but must be explored in their relations, contexts and processes of becoming – relations, events and affects rather than stable subjects, identities, experiences and worlds. This means reframing the question from what it is, to how something works and for whom. Such an assemblage could be useful to describe our taxonomy of pro-ana sites above. Pro-ana communities act as an assemblage with different nodes (e.g. the ana evolution, hardcore site, post-pro-ana) and their attendant images, aesthetics and platforms. These nodes themselves are always in motion, dynamically made and remade, as different elements of pro-ana respond to changes within communities and in reaction to public discussion, censorship other self-help and self-harm sites, the medical model, and so on.

Through the work of Deleuze and Guattari (1987) we therefore need to rethink the basic dilemma posed above: could we (*should* we) think positively of the pro-ana movement, as evidence of pathologised women's self-knowing agency and the self-knowing body? Or should we understand it as just as troubling as the medical model's attempts at objectification, or even worse as something that actively promotes the death of women? As we have demonstrated above, pro-ana is too diverse and heterogeneous to provide an unambiguous response. However, bringing Deleuze and Guattari (1987) to bear on such a question also means that we move away from asking what something is (or is not), and instead are able to ask 'what can it do'?

It is this Deleuzian sentiment that allows Bray and Colebrook (1998) to state that 'there are no anorexics, only activities of dietetics, measuring, regulation and calculation' (p. 62). Adopting this approach, Dyke (2013) has suggested that the pro-ana movement can neither be seen as a form of '[celebrating] anorexia as a lifestyle choice or [determining] it as a mental illness' (p. 160). Asserting the value of thinking with Deleuze in navigating biomedical and social models of anorexia and evaluations of the phenomena of pro-ana, she works with Deleuze's ideas about the nature of events by challenging notions of fixed and stable categories. This allows her to sidestep judgements about the relative validity of biomedical, psychosocial or feminist understandings about the aetiology and nature of anorexia to map the complexity of 'becomings' and to explore the implications of co-existing and conflicting perspectives for those living with eating difficulties.

In closing, we also want to say something about the digital platforms that allow for pro-ana's existence and the mediated subjectivity that exists through these platforms. The revolutions that our current digital contexts have created are productive in the construction of new and emerging health issues, moral panics and critical responses and communities (Lupton, 2013a). These platforms have been an insightful space for the analysis and interpretation of postfeminism (for example, see Dobson, 2015; Ringrose et al., 2013; Keller, 2012). In the analysis of pro-ana as a post-feminist sensibility, we think the emergence of this digital subjectivity does something. Postfeminist sensibility is full of contradictions, including constant 'authentic' self-transformation to similar ends; love yourself, but only if you are working on the

self; 'having it all' in increasingly socially stratified societies; be (hetero)sexually flexible and 'up for it', with the aim of normative sexual relationships, marriage and the 'perfect' ending. However, these contradictions create cracks and fissures in ideas of femininity, providing a fertile space for new articulations of health and femininity. If we want to take hold of the radical potential, we will need to take up the challenge presented by pro-ana, without celebrating the potentially fatal effects of ignoring the pain and suffering that it produces.

Notes

- 1 We have skipped over an equally large literature from anti-psychiatry here, influenced largely by the work of R. D. Laing (1960), who was in turn influenced by Foucault's work on the clinic and the asylum (1965, 1973).
- 2 See our discussion in Chapter 2 for the commercial implications of increasing the number of people who can be clinically diagnosed.
- 3 For another example of this approach, see Jackson, Vares and Gill's (2012) analysis of the complexities of how differently positioned young women engaged with postfeminist media.
- 4 www.theguardian.com/media/2007/may/24/dailymail.pressandpublishing
- 5 This term is in reference to House of Thin's use of the term 'evolution' to describe the shift from lifestyle to advice and support, and to define itself against 'hardcore' pro-ana sites.
- 6 www.salon.com/2001/07/23/pro_ana/
- 7 <http://content.time.com/time/health/article/0,8599,169660,00.html>
- 8 <http://s.telegraph.co.uk/graphics/projects/inside-the-world-of-anorexia-blogging/>
- 9 <http://christopherleesauve.tumblr.com/post/89718298846>
- 10 This comment was taken from a news story in the *Daily Mail* that discussed the recovery of one woman who had become 'addicted' to pro-ana websites. We have chosen not to put a link to it because such reactions to the pro-ana community are repeated regularly in almost any news coverage of pro-ana and/or anorexia: highlighting one response individualises this form of reaction.
- 11 Although there is a sub-genre of #blackfitspo, its existence points to the normativity of white women's bodies.

EPILOGUE

In Gill's (2007c) original use of the term, her elements of a 'postfeminist sensibility' included a shift from sexual objectification to sexual subjectification; a makeover paradigm creating an imperative to transform the mind and the body; a resurgence of biological essentialism; and an emphasis on the body, so that the body becomes a marker of success. Ten years on, these elements have moved from the magazine page and TV show to everyday sense making. As Gill (2017b) argues, postfeminist sensibility now acts as a hegemonic ideology, shaping affective, cultural and psychic life in ways that structure our most intimate, personal ways of making sense of our (gendered) selves. But unlike a fixed hegemonic ideology, as a *sensibility* postfeminism is conceptualised as a flexible, fluid and unstable ideology. To define postfeminist sensibility as a *sensibility* thus moves us away from thinking about a fixed ideology in the Althusserian sense and towards using the concept of postfeminist sensibility to capture a feeling, cultural moment or affective set of ideas about femininity (Gill, 2017b; Riley et al., 2017).

In this book, we have taken Gill's (2007c, 2017b) concept of postfeminist sensibility (combined with McRobbie's 2004, 2009, argument that postfeminism both draws on and refutes feminism) and have considered how this set of affective ideas impact on women's health. This represents a radical new direction in research both on postfeminism and on women's health. There is a body of work on postfeminist sensibility in relation to new femininities and sexual subjectivities, and how the makeover paradigm creates an expectation to work on both the body and the mind; and there is an emerging body of work producing intersectional analyses of media representations of women or examining the circulation of postfeminist sensibility in digital cultures (for a review see Riley et al., 2017). Similarly, researchers are using the concept of postfeminist sensibility to conceptualise new forms of feminist activism or interpret the rationality behind new femininities in countries such as India, Nigeria, China and Russia. Very few, however, have considered

postfeminism as relevant to health. For example, at the time of writing, a Web of Science search brought up only two publications with ‘postfeminism and health’ in their title. The focus of these studies – how dieting is rebranded as healthy eating (Cairns and Johnston, 2015) or how women’s health is represented in US public discourse in ways that individualise health and privilege white, middle-class women (Dubriwny, 2012) – are important. But neither addresses the range of ways that postfeminism, as a hegemonic ideological sensibility, is structuring women’s health. Cairns and Johnston focus on a specific aspect (restricted eating), while Dubriwny is concerned with the problematic way that women’s medical issues are represented and the implications for feminist activism, rather than the focus of this book, which is on postfeminist sensibility, health and subjectivity. The impact of postfeminist sensibility on women’s health subjectivities is therefore a hitherto neglected dimension of postfeminist research. Equally, the failure to consider the context of postfeminist sensibility for women’s health is a significant gap in health research.

We have addressed these important lacunae with a novel poststructuralist-informed methodology that sits at the intersections of critical psychology and media studies. Through this methodology we were able to develop the concept of ‘postfeminist healthism’ to describe ways of thinking about women’s physical and mental health that are formed at the intersections of postfeminist sensibility; a neo-liberal imperative to be self-enterprising and risk managing; an historically shifting landscape of gender relations that put women in the spotlight of a new form of citizenship; and a construct of health as an individual responsibility that is managed through consumer activity.

Assembling postfeminism and health

Our methodology is informed by a transdisciplinary approach. We have drawn on our locations within psychology and media studies, but in a way that breaks down the boundaries between a range of disciplines. Thus, our account also draws liberally from sociology, political science, medicine, cultural geography, gender and women’s studies, cultural studies, education, history and a range of other critical approaches in the social sciences and humanities including international development, consumer theory and economics. Our reason for doing so is that such transdisciplinarity gives us opportunities to develop analysis that is multiperspective, providing an account of postfeminist healthism able to engage with the complexity of an issue like health. Thus, drawing on and reviewing research, as well as analysing aspects of popular culture, media and history through our novel methodology has allowed us to extend theorising and shed new light on to specific constructions and understandings. Below we outline the conceptual framework that underpins this transdisciplinarity.

As is evident throughout this book, Foucault’s work and conceptual tools have been insightful and inspiring. For some, he might be overused, and sometimes misused, as argued by Hook (2010) in his critique of the application of Foucault in discourse analysis and by different feminist scholars who urge caution in combining

Foucault with a feminist emancipatory politics (e.g. Ramazanoglu, 1993). But, for us, Foucault continues to offer important concepts for understanding how power works in contemporary society. We hope we have shown throughout this book the usefulness of governmentality, disciplinarity, bio-power and bio-politics, surveillance, confession and technologies of the self/subjectivity. Where women's health has been so tied to the body, and where 'good health' has come to represent so much in relation to becoming a 'good person', we kept organically returning back to Foucault. Our continual return to Foucault revealed to us how important his ideas are in helping to illuminate and unravel the power relations implicit in contemporary understandings of women's health that directly impact on women's capacities to act.

Our application of Foucault in this book perhaps best represents how he himself defined his work, where he states that 'I would like my books to be a kind of toolbox which others can rummage through to find a tool which they can use however they wish in their own area ... I don't write for an audience, I write for users, not readers' (Foucault, 1974, pp. 523–4). Indeed, in playing with Foucault's concepts, we hope that the ideas discussed in this book do not merely represent good examples of, for example, governmentality, but show how these ideas can be used to disentangle taken-for-granted assumptions about health.

In Chapter 3, for example, using governmentality to think through the use of technologies to shape and change the body (whether through weight-loss surgery or female genital cosmetic surgery), allowed us to move away from ideas that surgery is extreme, marginal, or morally wrong. Instead, we could see how the women who undergo such procedures may be better understood in terms of a desire to 'be normal', fit in and belong, as a 'good' member of society. These desires, experienced at some level by many of us, are still problematic in the case of weight-loss surgery or female genital cosmetic surgery because of the way they are shaped by larger institutional, cultural, societal pressures and expectations around, for example, being able to 'control' ones eating or not be influenced by representations of vulvas in porn. But, understood through governmentality, we can appreciate more how these ideas come to take hold and shape a person's own subjective relationship to their body.

Across the book we have used Foucauldian analytics to interrogate a number of topics related to self-help, weight, technologies, sex, pregnancy, intimate responsibilities and pro-ana. In each of these chapters, we have also turned to the work of Deleuze and Guattari. Deleuze and Guattari's work often helped us in the conclusion of our chapters, offering us directions for identifying next steps. Their work also helps conceptually frame the overall organisation of this book. In particular, we draw on Deleuze and Guattari's (1987) concept of the assemblage that suggests a network-like structure of numerous connections, of ideas, events, objects, words, histories to consider the interconnectedness of the topics we have explored. The discourses used in pro-ana websites, for example, would be impossible to imagine without the transformative language of self-help and its attendant historical discourses of pathological femininity. Constructs of weight-loss surgery in

Chapter 2 are saturated with current understandings of what counts as a healthy weight that we explore in Chapter 2; while ideas around how female genitalia should look (Chapter 3) are bound up with our anxieties on the enjoyment and pleasures that we explore in Chapter 4.

Deleuze's philosophy conceptualises health as a complex, multiple, dynamic assemblage rather than a stable state which can be achieved and maintained through simple, rational lifestyle decisions and choices (Duff, 2014). Our postfeminist healthism assemblage is structured by molar and molecular processes; molar being those power relations that have become relatively fixed and molecular being those in the making. Molecular processes can destabilise molar structures through what are called processes of territorialisation and de-territorialisation. For example, second-wave feminism challenged aspects of traditional femininity, which were then re-territorialised through postfeminist sensibility that reinstated traditional femininities through the language of biological essentialism (see for example, Chapter 5).

Postfeminist sensibility can be understood through the lens of territorialisations and de-territorialisations that produce unexpected consequences of intersecting ideas around, for example, gender, feminism, neoliberalism and consumption. Likewise, each chapter in this book can be read through the lens of the molar and the molecular, where we have shown how constructs of femininity and health have been both apparently relatively stable over time, and also ever-shifting and changing. Although these changes are not always radical, Deleuze provides us with the tools to map the dynamic processes involved in the disruptions, ruptures and transformations of dominant health discourses. Understanding women's health as an assemblage of material and non-material objects and forces, and the affective flows between those components, allows us to conceptualise the multiplicity of postfeminist healthism as a set of diverse discourses and practices while also being able to name it as a phenomenon.

In addition to Foucault, Deleuze and Guattari, we are also indebted to the work of Patti Lather. Lather's (2009) notion of 'getting lost' provides us with an epistemological framework concerning what to do with feminist science after post-modernism and the deconstruction of all truths and against a backdrop of a rise in positivism. Although this epistemological landscape is too large to cover here,¹ we find the metaphor of 'getting lost' productive in thinking about how we have compiled each chapter and how we have allowed our thoughts, discussions with each other and writing to wander (hopefully not too far!). Getting 'lost' meant that, with each chapter, we combined a predetermined theoretically informed structure with a non-linear process of analysis. In this way, each chapter follows a broad structure based on poststructuralist-informed analytics of identifying historical antecedents that acted as conditions of possibility for contemporary discourses, followed by an analysis of contemporary discourses and their associated experts, subject positions and consequences for action. But, getting 'lost' also meant that as we developed our ideas, we were open to exploring new ways of seeing the topic, identifying particular points to illuminate specific elements within the assemblage.

For some chapters, we felt it was more important to highlight historical constructs, for example in Chapter 1, where ideas about male self-mastery combine with ideas of feminine madness. In others, we provided more discussion of modern technologies. Chapters 5 and 7, for example, include analysis of the digital spaces that health now occupies. Others still, approach postfeminist healthism through measurements of the medical and insurance communities (Chapter 2) or in analysis of government and commercialised health promotion (Chapter 6). We hope that by using different ways of opening up these topics, the ‘stance of “getting lost”’ might both produce different knowledge and produce knowledge differently (Lather, 2009, p.13).

Getting lost is useful in such times where world politics, women’s bodies, health crises and other larger societal questions seem increasingly non-linear (see, for example, Adam Curtis’ discussion of ‘non-linear warfare’ in his 2016 documentary *HyperNormalisation*).² We hope that throughout the book, our getting lost sheds light on pertinent issues, while always being aware that there are other ways of writing an account of the topics we have covered and other topics that could have been covered, such as, drinking, exercise, or in the form of particular postfeminist responses to physical illnesses (for an example of the latter, see Dubriwny, 2013, on prophylactic mastectomies and cancer risk).

Pulling threads and ending on a high note

In ‘getting lost’ at the intersections of postfeminist sensibility, neoliberalism and healthism, we have shown how discourses of choice, autonomy and freedom produce intense forms of self-monitoring and self-discipline. In the contexts that we have described, the promise of health becomes indiscernible from other forms of consumption, themselves only available to the good citizen consumer. Reading healthism through a postfeminist sensibility, we have shown how even making ‘good health’ choices keep people insecure, pulling the subject between contradictory and at times impossible, expectations. Postfeminist healthism is thus a ‘cruel optimism’, offering the promise of health and happiness through practices that might make feeling healthy and happy less likely to happen. Postfeminist healthism is also informed by geopolitics and history and structured through the inequalities of gender, class, sexuality, age, able-bodiedness and racism.

One of our main observations from writing this book is the contradictions of postfeminist healthism. For example, thinking of oneself as agentic by handing agency over to the bariatric surgeon; being naturally and essentially caring but needing expert advice to care; or achieving mental stability by thinking of oneself as inherently in need of fixing. In considering the contradictions of postfeminist healthism, we conclude by highlighting five interrelated and pressing issues in the relationship between postfeminism and health. These orient around the following set of contradictions: 1) an overriding desire to understand oneself as ‘normal’, when normal is an ideal subjectivity to be worked towards; 2) a desiring for a better life, that includes a ‘postfeminist perfection’ that is both expected or anticipated – and impossible; 3) the need for control, either as a neoliberal subject in control

of the self or as the subject relying on the expertise of others, who often promise control and who in turn come to control our thoughts and actions; 4) the importance of technology in making transformation seemingly more attainable, binding some to the self-surveillance, self-monitoring and self-disciplining of postfeminist regimes, while excluding others by geographical location and economic status; and 5) a commercialisation of health, so that our understandings of, and practices towards, health (and our orientation to the four themes outlined above) are structured by vested interests in increasing our consumption, not necessarily our health. We discuss these below.

A dominant theme across a number of the topics we explored is the way health is tied to a *normalising desire for 'good' health*. We read this theme as deeply emotionalising so that the messages we receive about health – that it is about risk, that we are responsible, that it is a measure of us as a person – are powerfully affective, and often feel like they originate in the self. For example, few of us challenge the normalising discourses of body mass index (BMI), which we discussed in Chapter 2, because it has become so taken for granted to think of normality in these terms. Yet the use of techniques like BMI are also exclusionary, through their inadequacy in predicting individual health outcomes; structural inequalities (e.g. racism, sexism, poverty etc.); or because health becomes something for other people or something that involves so much work on the body that it is seen as unattainable (see, for example, Robson, 2016). Notions of what is 'normal' about health are also often tied to cultural ideals or historical constructs that orient towards producing citizens who are economically productive. This links postfeminist healthism to capital, which in late-modern societies works on the principle that consumption is never complete since desire is structured around accessing the new (Bauman, 2000; Evans and Riley, 2014). The notion of 'good health' is thus aspirational, not attainable.

One of the ways that the normalising desire for good health is 'postfeminist' is through the use of feminist rhetoric. Postfeminist sensibility borrows from second-wave feminist terminology, as well as therapeutic language, to propose forms of empowerment, self-love, self-care and care of others. We saw this at work in Chapter 1, where health and happiness become both an expected state of subjectivity and something that has to be constantly striven for. With women as its main addressees, self-help works on the principle of constant self-transformation, so that just as women are told their best possible self is confident, self-assured and self-controlled, old discourses of feminine pathology are normalised, meaning that everyone, even those who have self-belief, have something that can be improved.

Alongside this normalisation of the concept of 'good health', we would also suggest a *'postfeminist perfection'* has become an important element of women's relationship to health. Postfeminist perfection becomes an expectation or anticipated expectation that produces anxiety. As Bauman (2000) suggests, 'health-care, contrary to its nature, becomes uncannily similar to the pursuit of fitness: continual, never likely to bring full satisfaction, uncertain as to the propriety of its current direction and generating on its way a lot of anxiety' (p. 79). We saw this, for example, in our discussion in Chapter 4. By bringing 'good' sex into health discourses, the

image of 'good health' becomes linked to embodying a sexy, sassy, sexually adventurous but appropriately middle-class femininity. A postfeminist perfection assumes women can now enjoy heterosex equally, without questioning or challenging why heterosex is still risky for women. The anxiety embodied by such a figure is two-fold. At a personal level, women must carefully manage perfection. As we saw in our discussion of women's magazines, this includes sexual liberation that is risk preventative and still exists within a sexual double standard that itself is inherently racialised and classed. At a societal level, a wider cultural anxiety persists, for example in relation to race and class, where the white middle-class ideal might become 'contaminated', spurring a moral panic around sexualisation and a concern about respectability dressed up as psychological damage (see Egan, 2013).

Precarity is also part of the anxiety of postfeminist perfection. For example, in Chapter 7, we analysed fitblr blogs. The memes and images contained in these blogs demonstrate anxiety, for example when the seeming perfection of the slim, toned, sexy woman is placed alongside text that claims not to want another woman's body, but 'my' body, so long as it is 'leaner', 'stronger', 'healthier' and all round more perfect (see Riley and Evans, 2018 for a fuller discussion). Pro-ana communities themselves typify such precarity. Postfeminist perfection is relentlessly transformative, involving intense work on the body, yet pro-ana communities demonstrate the cruel optimism of such perfection, where the 'realization is discovered to be impossible, sheer fantasy, or too possible, and toxic' (Berlant, 2011, p. 24, emphasis in original). In the case of pro-ana, constant self-transformation becomes impossible, toxic and potentially deadly.

Postfeminist healthism is thus located as both a normalising sensibility enabled through a desire for good health and provides a fleeting and shifting notion of postfeminist perfection, which is both anxious and precarious. Taken together, these characteristics require the careful management and *control* of the self, which is enabled in part through consumption and the advice of experts. Experts are central to many of the chapters of this book and include self-help gurus, surgeons, sex experts, medical experts, apps and tracking devices. Often, expert advice complements forms of consumption. In Chapter 6, we explored how the institutions of commerce and health promotion exploit anxieties around motherhood. This exploitation incorporates colonial histories, for example targeting women in the global South, and exacerbates inequalities by making economic capacity determine a woman's ability to be thought of as a 'good mother'. In the context of postfeminist healthism, the *dispositifs* of commerce and health promotion become a mechanism of control. Taking shape through the deeply affective register of caring for your child, commercial interests increase consumption by making purchases a mark of motherly love.

New technologies are also drawn into the service of expertise, transformation and control. For example, in Chapter 3 we saw how female genital cosmetic surgery works on insecurities around what counts as 'normal', reducing women's capacities to know and value diversity in genital appearance. In Chapter 4, we showed how mHealth (mobile health) technologies are defining the parameters of 'normal' sex,

binding sex to notions of health and successful subjectivity. These notions of what is normal come to inform how people understand themselves, allowing them to succeed at a narrow concept of 'normal' or understand themselves as failure. In both cases, an ideal outcome is that women spend significant amounts of money to achieve 'health', even while what counts as 'healthy' (e.g. mental stability through 'confidence', dieting for weight loss, or 'neat' genitalia) are deeply cultural and open to revision.

In health discourses, our desires to be a good person or live the 'good life' are the mechanisms by which governmentality works. This desire translates into women working on themselves 'so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection or immortality' (Foucault, 1988, p. 18). But what constitutes 'good' work on the self is deeply contradictory. For example, healthy women should work on their bodies and minds, while also accepting themselves as they are (and thus understanding that they are not in need of work). Again, such contradictions create subject positions structured by precarity and anxiety.

Within postfeminist healthism, being good enough is not good enough. A moral transformative imperative makes it hard not to use transformative technologies even as they are used to support a narrowing of acceptable bodies. In Chapter 5, the good subject holds the promise of an idealised life and happiness for both pregnant and post-pregnant women. Through a postfeminist essentialism and re-traditionalisation, pregnancy is meant to come with feelings of fulfilment, completeness and self-realisation. We have demonstrated this in our analysis of *The Bump* app, in which pregnancy can be self-monitored. The app supports practices associated with femininity and consumption (e.g. making up the house for the newborn), again highlighting the commercialisation of health and the governance of the feminine body and subjectivity in which women, it seems, are set up to fall short.

But we are optimistic (and not in a 'cruel optimism' way). One reason for our optimism is that, throughout this book, we identified creative and critical ways that feminist academics and activists are responding to health issues in the context of postfeminism. In Tiefer's *New View* campaign, for example, lobbyists and activists challenge large pharmaceutical companies over the medicalisation of women's bodies. Arts and activism have also crossed over in important ways, for example in how Jess Dobkin's 'The Lactation Station Breast Milk Bar' challenges us to think differently about the culture of shame, blame and disgust in relation to breastfeeding (see Chapter 6). We have also shown that, in women's own accounts, other ways of making sense of health are available, for example in Perz and Ussher's (2008) research with women making sense of menopause or Cacchioni's (2007) research with women with female sexual dysfunction (see discussion in Chapter 4). Such accounts demonstrate that multiple counter narratives are possible.

A second reason for our optimism comes from sharing the analysis provided here. Poststructuralism is a complex and difficult body of work, but it is also transformative. Poststructuralism allows people to think differently about their worlds, in a world where we are 'taught to overlook so much' (Ahmed, 2017, p. 31). From this perspective, postfeminist healthism provides us with a map to look at the territory.

So, we would like to end with suggesting an ‘affirmative poststructuralism’. An affirmative poststructuralism uses the tools from poststructuralism to undermine accounts that draw on women’s apparently inherent pathology, their implied failures or their faulty bodies. In doing so, we hope to have carved out a space for in-depth thinking that subtly shifts your thinking about the world and from which we can create more collectively resilient, resistant and critical ways of making sense of our health.

Notes

- 1 We recommend both Lather’s *Getting Smart* (1991) and *Getting Lost* (2009) for a detailed overview of a poststructuralist feminist approach to knowledge production.
- 2 A 2014 short version can be found here: www.youtube.com/watch?v=tyop0d30UqQ

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