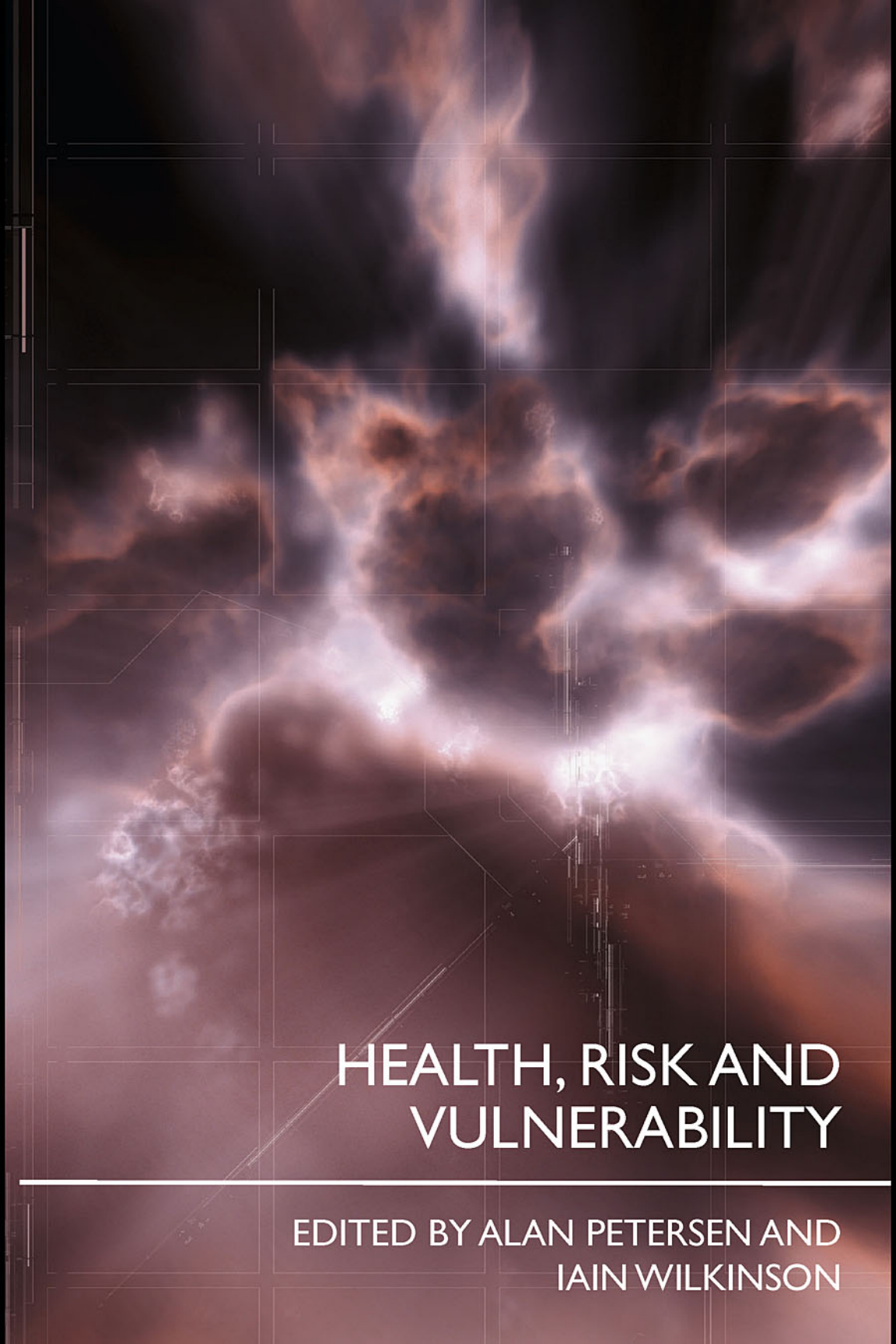
HEALTH, RISK AND VULNERABILITY
EDITED BY ALAN PETERSEN AND IAIN WILKINSON

Health, Risk and Vulnerability

The concept of risk is one of the most suggestive terms for evoking the cultural character of our times and for defining the purpose of social research. Risk attitudes and behaviours are understood to comprise the dominant experience of culture, politics and society.

Health, Risk and Vulnerability investigates the personal and political dimensions of health risk that structure everyday thought and action. In this innovative book, international contributors reflect upon the meaning and significance of risk across a broad range of social and institutional contexts, exploring current issues such as:

- the 'escalation of the medicalization of life', involving the pathologization of normality and blurring of the divide between clinical and preventive medicine
- the tendency for mental health service users to be regarded as representing a risk to others rather than being 'at risk' and vulnerable themselves
- the development of health care systems to identify risk and prevent harm
- women's reactions to 'high risk' screening results during pregnancy and how they communicate with other women about risk
- men and the use of the internet to reconstruct their social and sexual identities.

Charting new terrain in the sociology of health and risk, and focusing on the connections between them, *Health, Risk and Vulnerability* offers new perspectives on an important field of contemporary debate and provides an invaluable resource for students, teachers, researchers, and policy makers.

Alan Petersen is Professor of Sociology, School of Political and Social Inquiry, Monash University, Australia.

Iain Wilkinson is Senior Lecturer in Sociology at the School of Social Policy, Sociology and Social Research, University of Kent, UK.

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Contents

Contributors

Andy Alaszewski is Professor of Health Studies and Director of the Centre for Health Services Research at the University of Kent. His research examines the ways in which the assessment, perception and management of risk structures the ways in which health and social care service users experience the care and support they receive. He is editor of the international journal *Health, Risk & Society*. His publications include Alaszewski, A. *et al*. (eds) (1998) *Risk, Health and Welfare: Policies, Strategies and Practice* (Open University Press) and Alaszewski, A. *et al*. (2000) *Managing Risk in Community Practice: Nursing, Risk and Decision Making* (Bailliere Tindall).

Kirstie Coxon, Research Associate, Centre for Health Services Studies (CHSS), University of Kent, is a health services researcher with a background in nursing and midwifery, and has worked on a range of projects in older people's health and social care, using a mixture of methodologies including quantitative, qualitative and case study/evaluation research. Kirstie's areas of research interest include partnership working, integrated health and social care, care of older people and primary care research. She is currently academic lead for the Kent arm of the South East Research and Development Support Unit.

Jacqueline Davies is a Research Fellow in the Health Care Research Unit at City University. She is interested in a wide range of public policy research issues. Her publications include (2002) 'The research potential of practice nurses' *Health and Social Care in the Community* 10(5): 370–81 and (2006) 'The problems of offenders with mental disorders' *Social Science and Medicine* 63: 1097–1108.

Paul Godin is a Senior Lecturer in Sociology at City University. His edited book *Risk and Nursing Practice* was published in 2006 in the Palgrave sociology and nursing practice series. He was the principal investigator on a Department of Health funded service user-led project completed in 2006, 'Engaging service users in the evaluation and development of forensic mental health care services'.

Bob Heyman is Associate Dean for Research and Professor of Health Research at St Bartholomew School of Nursing & Midwifery at City University. His research focus is qualitative approaches to health risk management. He has

researched and published in relation to a wide variety of groups, including pregnant women who are offered chromosomal screening, adults with learning disabilities and forensic mental health/learning disabilities service users. His publications include Heyman, B. and Henriksen, M. (2001) *Risk, Age and Pregnancy: A Case Study of Prenatal Genetic Screening and Testing* (Palgrave) and Heyman, B. (ed.) (1998) *Risk, Health and Health Care: A Qualitative Approach* (Edward Arnold).

Pru Hobson-West is a Research Fellow based at the University of Nottingham in the Institute for Science and Society. She is currently researching issues around the use of animals in biomedical science. Her publications include (2007) 'Trusting blindly can be the biggest risk of all' *Sociology of Health & Illness* 29: 2 and (2003) 'Understanding vaccination resistance: moving beyond risk' *Health, Risk & Society* 5: 3.

Dawn S. Jones is Senior Lecturer in Sociology at Liverpool Hope University. Her research focuses on the relation between discourse, perception and reality. Her recent publications have explored the relation between expert narratives and the perception of risk. Building on her research into women's perceptions of risk in pregnancy, she is currently exploring the production of risk-knowledge amongst health care professionals. Recent and forthcoming publications include a chapter in Raisborough, J. and Scott, J. (eds) (forthcoming) *Risk, Identity & the Everyday* and in Bates, D. (2007) *Marxism, Intellectuals and Politics* (Palgrave).

Alan Petersen is Professor of Sociology at the School of Political and Social Inquiry, Monash University, Melbourne, Australia. His research encompasses the sociology of health and illness, sociology of new biomedical technologies, the sociology of risk and gender and sexuality studies. His recent publications include *The Body in Question: A Socio-Cultural Approach* (Routledge, 2007) and *Engendering Emotions* (Palgrave, 2004).

Anthony Pryce originally intended to be an art historian but is now Reader in Sociology (Sexual Health) at the Institute of Health Sciences, City University, London. His research focuses on sexualities and health in hard to reach and hidden populations. He contributes widely to the literature and recent publications include (2006) '"Let's talk about sex": Kinsey, outrage and the construction of postmodern sexualities' *Sexuality & Culture* 10(1): 63–93 and '"...planting landmines in their sex lives": governmentality, iconography of sexual disease and the "duties" of the STD clinic', in King, M. and Watson, K. (eds) (2005) *Representing Health: Discourses of Health and Illness in the Media* (Palgrave).

Lisa Reynolds is a Lecturer in Forensic Mental Health Care at City University. Her PhD is on the experience of forensic mental health care and risk management in a medium secure forensic mental health unit. She has undertaken research into forensic mental health care and risk both in the UK and South

Africa. She has forthcoming publications based on an on-line discussion forum e-learning project with mental health service users and student mental health nurses, and a women incarceration workshop.

Monica Shaw is a Senior Research Fellow at City University and was previously Dean of Social Sciences, Northumbria University. Her publications include Heyman, B. *et al*. (2004) 'Forensic mental health services as a health risk escalator: a case study of ideals and practice' *Health, Risk & Society* 6: 307–25.

John-Arne Skolbekken is an Associate Professor in Community Psychology at the Department of Psychology, the Norwegian University of Science and Technology (NTNU), in Trondheim, Norway. His research is focused on the influence of the risk concept in modern medicine and modern living. As a member of NTNU's Research Group in Bioethics, he is currently involved in research projects focusing on the impact of various forms of medical screening on lay people's health perceptions. His publications include (1995) 'The risk epidemic in medical journals' *Social Science and Medicine* 40(3): 291–305 and (1998) 'Communicating the risk reductions achieved by cholesterol reducing drugs' *BMJ* 316: 1956–8.

Joost Van Loon is Professor of Media Analysis at the Institute of Cultural Analysis, Nottingham Trent University. His current research focuses on media technologies, risk, affect and sense-perceptions, among other things. He is co-editor of the journal *Space and Culture.* His recent publications include *Risk and Technological Culture: Towards a Sociology of Virulence* (Routledge, 2002). He is currently finishing a monograph entitled *Media Technologies: An Introduction to Media Analysis* (Open University Press).

Joanne Warner is a Senior Lecturer in Social Work in the School of Social Policy, Sociology and Social Research, University of Kent. Her research interests include socio-cultural approaches to risk, mental health and social work and the significance of 'race' and ethnicity, gender and place in this context. She has also explored the impact of cultures of inquiry and blame on professional practice. Recent publications include Warner, J. and Gabe, J. 'Risk, mental disorder and social work practice: a gendered landscape' *British Journal of Social Work* Advance Access, 17 October 2006 and Warner, J. (2006) 'Inquiry reports as active texts and their function in relation to professional practice in mental health' *Health, Risk & Society* 8(3): 223–37.

Iain Wilkinson is a Senior Lecturer in Sociology in the School of Social Policy, Sociology and Social Research, University of Kent. His research explores socio-cultural approaches to risk and contemporary forms of 'social suffering'. His work engages with social theory, the sociology of risk, the sociology of health and the history of sociology. His publications include *Anxiety in a Risk Society* (Routledge, 2001) and *Suffering: A Sociological Introduction* (Polity Press, 2005).

Abbreviations

AA	Alcoholics Anonymous
AAA	Action Against Autism
AiA	Allergy induced Autism
ASW	approved social worker
BMJ	*British Medical Journal*
CDA	critical discourse analysis
CHD	coronary heart disease
CMC	computer-mediated communication
GM	genetically modified
GUM	Genito-Urinary Medicine
HRA	Health Risk Appraisal
JABS	Justice Awareness and Basic Support
JFAVDC	Justice for All Vaccine Damaged Children
MMR	measles, mumps and rubella
MSU	medium secure unit
PICU	Psychiatric Intensive Care Unit
PMS	premenstrual syndrome
RCT	randomized controlled trial
SAHM	stay-at-home mum
SARF	Social Amplification of Risk Framework
STI	sexually transmitted infection
TPS	Teenage Pregnancy Strategy
VAN	Vaccine Awareness Network

Chapter 1

Health, risk and vulnerability

An introduction

Alan Petersen and Iain Wilkinson

The concept of risk is now well established as part of the language of social science. It is widely accepted that the experience of everyday life is significantly influenced by the ways in which individuals think and act about and institutions respond to 'risk'. Encounters with risk are perceived to take place within every aspect of our public and private lives. Indeed, it has become almost a matter of sociological common sense to identify risk as both an organising principle of society and a major coordinate of personal identity. Risk now features as one of the most suggestive terms for evoking the cultural character of our times and for defining the purpose of social research.

Yet there is no agreement among the social science community as to why risk has come to occupy such a central position within the terms of academic and public debate. Broadly speaking, there are at least four contrasting ways in which analysts venture to explain this interest. Firstly, following Ulrich Beck, an emphasis has been placed upon the extent to which the public salience of risk signals that people are increasingly aware that technological hazards and industrial pollutants are drawing us to the brink of ecological catastrophe (Beck 1992). Accordingly, our shared interest in risk is framed as an expression of the fact that we know ourselves to be living in an environment made dangerous through the hazards courted by modern science and technology. A second explanation is developed with reference to Mary Douglas' cultural theory, where it is argued that the popularisation of risk is more closely related to a pronounced experience of individualisation in modern societies that erodes traditional ties of moral solidarity and community (Douglas 1985, 1992). On this account, it is not so much the case that we know for sure that the reality of danger is increasing; but rather, via an erosion of trust in public institutions we are made to be more anxiously disposed to express our concerns in terms of 'risk'. Thirdly, an accent has been placed upon the 'stigmatisation' that results from the way in which modern science tends to be portrayed in mass media (Flynn *et al.* 2001). This is perceived to be further exacerbated by a common psychological tendency to exaggerate the threat of dangers we associate with institutions and technologies that are beyond our immediate sphere of influence and control (Slovic 2000). Fourthly, basing their work on a critical analysis of the language of current government legislation

and social policy, some claim that, if we are more prone to address our motives, attitudes and experiences in terms of risk, then this is the result of a governmental strategy that is designed to promote 'individual responsibility' as the organising ethos of welfare and work (O'Malley 2004; Rose 1999).

A considerable conflict of interpretations surrounds the social significance and political meaning of risk in our times. In this chapter we take the view that any reference to risk needs to be carefully qualified so as to make clear the analytical frame in which it is set. From the outset of our discussion, we emphasise that, in the context of social science and health studies, the language of risk comes ready laden with theoretical premises, ethical commitments and political interests. We are critical of any attempt to present 'risk' as simply another word for a 'problem' or form of 'precautionary deliberation' or 'probabilistic thinking', for we recognise this concept to be embedded in cultural worldviews that present us with *ideologically* stylised accounts of our society, individuality and the moral ties that bind us.

Our particular interest lies in the associations and conjunctions between health, risk and vulnerability. We follow a number of writers in arguing that, whilst it is widely acknowledged that the meaning of 'health' has been revolutionised over the last fifty years so that the 'healthy person' is now readily identified as engaged in the pursuit of ideal conditions of physical and mental well-being, then this was always bound to make 'health' a matter of negotiation with 'risk'. We understand the cultural practices, social techniques and institutional arrangements that are now committed to the pursuit of health to be heavily implicated in the current popularisation of the language of risk. Indeed, we go so far as to suggest that, more often than not, where the politics of risk becomes a public concern, then at the same time this is bound to the politics of health; and where we aim to expose the ideological interests at work within the language of risk, we are also concerned to bring critical attention to the ideological construction of our notions of health, health practice and health promotion.

The politics of health risk gives rise to debate over the definition, bounds and meaning of human vulnerability, and in recent years this matter has been brought to the fore across a number of fields of interest. Most notably it features in development and disaster studies as a means to draw critical debate towards the plight of the most materially and institutionally disadvantaged groups in developing societies (Blaickie *et al.* 1994). In these domains, it is often the case that reference to people's 'vulnerability' takes place as writers work to criticise technocratic approaches to risk and disaster management that overlook the involvement of state policy and capital interests in the on-set of disaster. Accordingly, by highlighting the ways in which populations are made 'vulnerable' to experience harms, either challenges are brought to the ways in which the causes of disasters are officially identified (i.e. as discrete events that 'strike' from 'outside' the normal workings of the status quo) or, rather, increased levels of vulnerability are identified as the unintended consequence of managerial policy. At the same time, the concept of vulnerability features as part of a new managerial discourse that

aims to target sectors of population for policy intervention (Alwang *et al.* 2001; Delor and Hubert 2000). Accordingly, while on the one hand reference to human vulnerability is used as a means to caution against the ways in which technical regimes of risk management are blind to the human consequences of regulatory practice, on the other hand it is being adopted as part of a technical language that is designed to specify problems for increased measures of expert intervention and technological control. One way or another, it appears that expert approaches to risk assessment and practices of risk management are having the unanticipated effect of making the appeal to human vulnerability a major component of debates over the legitimacy of government and governmental technologies of risk.

We contend that it is increasingly the case that the discourse on human vulnerability features heavily in critical debates over the bounds of 'health risk' in so-called 'advanced' industrial societies. In this regard, the sociology of health risk appears to be mirroring developments in disaster and development studies. However, one noticeable difference concerns the extent to which the debates on vulnerability in countries such as Britain and the United States are not simply focused on questions of survival and basic needs, but rather encompass concerns such as the felt quality of patient–practitioner interactions and emotional well-being of individuals. In the context of Western medicine, the turn to debates on vulnerability reflects an ever-broadening conception of health as well as the tendency to subsume health under the category of risk.

Constructing 'health' in terms of 'risk'

In modern times, the conceptualisation of health has been transformed to a point where commentators are prone to take this as an indication of a paradigm shift in the common experience of embodiment, self and society. From 1947 onwards, definitions of health advanced and elaborated by the World Health Organization are held up as a collective representation of a new approach to thinking about human well-being that, rather than locate this as simply a matter of bodily function, emphasises the extent to which our capacity to feel healthy takes place as a mode of interaction between body, culture and society. Whilst a Cartesian approach towards understanding the body persists within many sectors of medical research and practice, increasingly this is supplemented and challenged by a more 'holistic' account of health that places emphasis upon the extent to which our felt quality of life is determined by social environment and cultural outlook (Larson 1999).

In part, this development can be attributed to improvements in material conditions, coupled with advances in medical science, which have radically transformed patterns of morbidity and mortality among Western populations. Here the majority of people no longer die from tuberculosis, diarrhoea and pneumonia, but rather from heart disease, cancer and stroke. Towards the end of the nineteenth century and during the first half of the twentieth century, dramatic improvements in bodily health and quality of life were achieved through sanitation, nutrition, vaccination

campaigns and antibiotic treatments. Throughout this time, the principal causes of disease could be identified among a discrete range of environmental and biological factors, for which it was possible to specify effective solutions and treatments. This was the era of 'magic-bullet' medicine, which according to Allan Brandt encouraged the popular understanding of health as the absence of a clearly identifiable disease (Brandt 1997). However, in a context where the most life-threatening disease is not so much 'caught', but 'acquired', a new epidemiology has emerged that emphasises a host of environmental, social and behavioural factors that hitherto were not recognised by medical science as a health concern.

The association of 'health' with 'risk' is encouraged by the epidemiological understanding that many of the most life-threatening diseases are caused through a combination of multiple lifestyle factors. David Armstrong contends that the language of risk enters into the everyday lexicon of medical practice at the point where the imperatives of health care move beyond the treatment of bodily symptoms to work at understanding and controlling social environments implicated within the aetiology of modern 'diseases of affluence' (Armstrong 1995: 400). Health care as 'risk management' is an integral feature of 'surveillance medicine'; it amounts to a further intensification and extension of processes of rationalisation around the conduct of the individual and social body. It emerges when medical researchers turn to biostatistics and randomised controlled trials as the means to identify segments of population most 'at risk' of developing symptoms of disease. Indeed, John-Arne Skolbekken maintains that it was particularly in the aftermath of the application of computing technologies to the gathering and analysis of probability statistics relating to health and illness that the language risk reached 'epidemic' proportions in medical journals (Skolbekken 1995: 298).

This development was further consolidated by the rise of 'health promotion' as a distinct field of clinical practice (Lupton 1995; Petersen and Lupton 1996). However, it is important to note that here the vested interests in matters of risk move beyond technical problems of calculation; for the language of risk is also strategically employed in attempts to promote positive health behaviours. Alongside the actuarial understanding of risk that features within practices of 'Health Risk Appraisal' (HRA) as promoted by the Society for Prospective Medicine, and the World Health Organization's 'Risk Approach' framework, there is also a move to advance forms of moral judgement on the health-related aspects of people's lifestyles. Following Mary Douglas, many writers note that, in popular usage, the word 'risk' is used as a synonym for danger; and further, that a danger identified as 'risk' is redolent with moral meaning. 'Risk' is used both to highlight a potential harm and to identify the sources of danger. The labelling of attitudes and behaviours as 'risk' implies a negative judgement upon how these are formed and take place. Accordingly, a number of writers work to make clear the ways the language of risk is now being used to apportion moral responsibility and blame (Douglas 1992; Joffe 1999). Where attitudes and behaviours are labelled as risk and where institutions and individuals complain that they are 'at risk', then this is intended as a form of moral censure. Here an emphasis is placed upon risk as

wholly 'undesirable' and as always involving a call for some manner of intervention to take place so as to correct, reform and morally rectify those outlooks and actions implicated within the possibility of harm.

Some examples of the dual character of risk can be found in studies conducted by Bob Heyman and Mette Henriksen into the communication of information relating to possible hazards associated with prenatal genetic testing for older women (Henriksen and Heyman 1998; Heyman and Henriksen 1998). Here they detail the various ways in which risks are presented to women so as to both communicate the probabilities related to the genetic screening for Down's syndrome and the bounds of moral responsibility in discussions between health practitioners and women over the circumstances where the latter might choose to terminate a pregnancy. Whilst documenting the potential for medical experts to communicate probabilities so as to guide women towards the decisions that suit their professional and institutional interests, Henriksen and Heyman also note that, in many instances, pregnant women appeared to be influenced more by the moral meaning of risk, than by matters of statistical quantification. For the women concerned, it was not so much due to the insights gained through probabilistic reasoning, but more through a process of negotiation with the social stigma of being identified as courting possible risks, that they decided whether or not to subject themselves to serum screening or an amniocentesis.

Indeed, in many studies of the social representation of health risks, a greater emphasis is placed on the extent to which people are more likely to respond to risk with a display of anxiety, rather than take this as a cue to exercise more control over their lives. For example, Nina Hallowell and colleagues argue that, whilst the expert categorisation of health-related behaviours in terms of risk takes place with the aim of extending domains of technical control over the body so as to extend life and minimise harm, in many instances this serves to have a negative impact upon people's emotional well-being (Hallowell 1999; Hallowell *et al.* 2004). In their studies of women attending genetic counselling and testing for hereditary breast cancer, they found that respondents suffered considerable amounts of distress when presented with information on their chances of developing the disease. Whilst patients set out with the original intention of better managing their future health, the increased knowledge of risk acquired through their encounters with medical practitioners became a source of considerable anxiety so that, rather than developing an enhanced sense of control over their lives, they became increasing fatalistic about their life chances.

Accordingly, in the conjunction of health with risk we are presented with the paradox that, whilst this might be readily associated with technological developments and social practices that are designed to increase powers of control over the human body and hazards of life, at the level of everyday experience it may serve more to heighten people's sense of vulnerability before the contingencies of life. Where, on the one hand, the professional discourse of risk can be framed as a set of ritualised practices for managing collective anxieties relating to ever more elaborated domains of modern medicine and health care, on the other hand they

can be viewed as having the unintended consequence of further intensifying shared feelings of insecurity before future uncertainties (Crawford 2004; Wilkinson 2001). By working to control for the future, the unwitting result is that the future is made to appear more menacing.

Arguably, this paradox is further complicated by the ways in which the language of risk is mobilised as a major component of campaigns for health promotion. Where efforts are made to worry people into giving up smoking, lowering their consumption of alcohol, eating a more balanced diet or practising safe sex, then the popular association of risk with danger is readily courted and emphasised. While expert understandings of risk are framed in terms of probabilistic reason, calculation and control, risk is often dramatised as danger for the purpose of promoting good health behaviours. The actuarial account of risk in terms of a technical assessment of probabilities is always liable to be coloured by a more emotive meaning of risk as vulnerability and danger. Further, we find health professionals using the language in both ways according to the guiding interests of their work (Heyman 1998). On these grounds, the language of risk is increasingly made the focus of ideological debate and political controversy.

The ideology and politics of risk

Risk is central to the workings of politics and power in many contemporary societies and provides a major focus for ideological debate in various fields apart from health care and public health, including crime, delinquency, unemployment and the homeless. The so-called 'new' public health is indicative of this emphasis, with its concern about risks in physical and social environments and personal behaviours and about the means to their prevention (Petersen and Lupton 1996). As the contributors to this book emphasise, risk always presupposes some preventive intervention. The epidemiology of 'risk' has led to preventive strategies on a range of fronts, from the global level (e.g. World Health Organization immunisation programmes) to the individual level (e.g. the self-policing of sexual conduct). Health promotion has developed a battery of strategies for identifying and countering 'unhealthy' or 'risky' lifestyles (Hansen and Easthope 2007: 16–25; Petersen and Lupton 1996: 15).

In medicine, genetic and other diagnostic tests allow diagnosis of individuals 'at risk' and the creation of new categories of the 'pre-symptomatic ill'. Diagnostic technologies mean that 'Anything and everything is "sick" or can actually or potentially make one "sick" – quite independently of how a person actually feels' (Beck 1992: 205) (see chapter by Skolbekken). The self-management of risk has become an imperative of citizenship, with individuals expected to become 'knowledgeable' about the sources, nature and consequences of risk and, where possible, take appropriate preventive action. This entails the close monitoring and regulation of one's thoughts and actions and recognising oneself as 'vulnerable'. 'Risk' generates fear in relation to particular practices (e.g. the use of salt in cooking, sedentary lifestyles) and populations (e.g. the diseased and

mentally ill – see chapters by Warner and Davies *et al*.). Many practices and interactions that were once seen as bringing pleasure have become the source of worry. The language of risk implies that a clear delineation can be made between the sources or the perpetrators of danger and sites of vulnerability or the victims. All manner of interventions into bodies and lives and all kinds of exclusions and controls have been legitimised on the basis that a certain behaviour, group or population presents a 'risk to society'.

Robert Castel (1991) has observed the significance of a shift 'from dangerousness to risk' for social regulation in contemporary societies. As he argues, the calculation of risks permits interventions to be legitimated not on the basis of actual existing dangers but rather on the basis of expert assessment that an undesirable event may occur and that this can be prevented through intervention (Castel 1991: 288). There is less dependence on therapeutic or corrective interventions than in the past and more emphasis on the probabilistic calculation of risk and the creation of risk profiles. Risk profiling and risk factor analyses enable the simulated surveillance of entire populations oriented to the fulfilment of the ideal of 'control before the event' (Bogard 1996). This includes measures to prevent disease, for example the outbreak of pandemic flu (e.g. Avian flu virus), dependence on welfare (e.g. screening of immigrants and refugees) and self-harm or harm to others (e.g. screening of certain presumed mentally unstable or violent groups).

The media, including the print news media, the broadcast media, Internet, magazines, and so on, occupy a key position at the interface between expert and lay publics and are likely to exert a significant influence on responses to issues such as the above (Anderson *et al.* 2005). While it is widely recognised that the media shape or very likely do shape opinions and influence policies there is less consensus about the mechanisms of media production and the nature and extent of media influence on particular policies and viewpoints. Naïve perspectives on the workings of the media persist, despite a growing social science literature in this field. Perspectives are dominated by the Social Amplification of Risk Framework (SARF) which suggests that the media are prone to dramatisation, distortion, misrepresentation and error (Pidgeon *et al.* 2003), and work to magnify existing anxieties about certain phenomena. In our view, this is a simplistic 'media effects' perspective on risk mediation that greatly underestimates the variety and complexity of the possible forms of interaction that take place between media, society, culture and politics (Wilkinson 1999).

With a perceived decline of trust in public confidence in authorities and in regulatory systems, including those established to govern technological and other risks, this lacuna in understanding about the role of news media is surprising. Recent public debate and reactions to genetically modified crops, cloning and embryonic stem cell research indicate that news media may play a decisive influence in establishing the framework for debate and policy, particularly during the early phase of the public visibility of issues, and thereby help engender the conditions for trust or mistrust. In the field of environmental risk, this has been shown to be the case with issues such as oil spills, industrial pollution, and climate change