Introduction

In this chapter, I will begin with a discussion around changing notions of health and health promotion, and how these fit with health psychology. The chapter has been organized into three sections to highlight the central themes of social relations, and reflexive research and practice, which will be reiterated throughout the book. The first section addresses understandings of the social location of health. From a social perspective, health is understood as much more than a matter for individual experience and responsibility; health behaviour is seen in terms of relations with others, and health is structured by society. Second, the chapter describes understandings of health promotion as socially and politically constructed. This includes an overview of the history of the changing views of health promotion and the different perspectives and values of health promotion practice. Third, in the light of these understandings, the chapter addresses the changing aims of health promoters and how these changes have affected the ways in which we approach working to improve the health of people in communities and understanding the effects of our own practice.

The social location of health

Health is social

Health concerns in Western societies have been dominated by a biomedical model of health and illness for over 200 years, and the medical perspective dominates our views of health today. This model has also been imposed on other cultures such as those in colonized countries (Durie, 1998). From this perspective, health is located only in the body; a physical entity quite
separate from psychological and social processes. The development of behavioural approaches to medicine, and health psychology as a discipline, has included the importance of the mind to illness and well being (Lyons and Chamberlain, 2006). Psychology is a discipline focused on the individual as the basis of thought and behaviour, and this individual approach has mapped very well onto the medical model of the mechanical body. The well known ‘biopsychosocial model’ of health (Engel, 1977) introduced a more holistic approach to explaining health. However, the ways in which mind, body and social life work actually together have not been well conceptualized or developed since, and the model has remained an ideal image, rather than providing guidance for understanding.

From the biomedical perspective, epidemiological work has shown that groups within populations, such as those of gender, ethnicity, socioeconomic status and age, have marked and reliable differences in health. Many of these have been explained in terms of physiological differences, such as deterioration with age or genetic weaknesses in certain groups. However, there is increasing evidence to show that many of the regular differences cannot be explained biologically. For example, why do women live longer than men these days, and yet women generally have more illness than men? Some answers come from large bodies of work in psychology and epidemiology, which demonstrate strong and reliable relationships between constructs such as social support or social networks and health (Seeman, 1996; Berkman et al., 2000). In addition, a great deal of evidence about the importance of social life can be found in research from other disciplines such as sociological and anthropological inquiry which has pointed to the very social nature of categories such as gender and age. Critical enquiries have shown both the impact of social life on well being, and the socialized nature of research and treatment itself which leads to observed differences. For example, women are more likely to experience ill health and also less likely to receive diagnoses and treatment for illnesses such as heart disease (Rodin and Ickovics, 1990; Annandale and Hunt, 2000). Members of oppressed minority groups, who are more likely to suffer ill health and early death, are also subject to discrimination in everyday life and in access to health care services (Smedley et al., 2003; Blakely et al., 2006). A growing body of interpretive work has shown that people hold diverse, culturally and socially bound understandings of the meanings of health, suffering, disease and behaviours that might affect health (Radley, 1993; Hardey, 1998; Levin and Browner, 2005).

**Health behaviour is relational**

Health related behaviour has been seen as underlying many modern ills such as cancer, heart disease, infectious diseases and the outcomes of many chronic diseases. Many health promoters feel that if people could be persuaded to eat healthy foods, engage in exercise, safe sex and other safety
practices, screen their bodies for disease and manage their stress, then they would be healthier. It turns out that there are some problems with this apparently simple plan, and many of them may be explained by the lack of understanding of the very social nature of behaviour. For example, we do not necessarily do things with a disease outcome in mind. There are many socially located explanations for our behaviour that we are not even necessarily aware of as individuals. Some behaviours only make sense in certain social contexts or have different meanings within different relationships. In addition, there are many layers and forces in any society. Requirements to conform with ideals, mores and moral strictures, from family, peers and wider society, are far more important to our social well being than the requirement to prevent disease. Moreover, many of us are controlled by others with greater power and more access to resources. Our ideal health related behaviour and a healthy environment are not necessarily within our own control. In sum, the fundamental importance of social life to everyday being in the world means that any actions that impact on our health are much more than the result of an individual decision to act in a certain way.

Crossley (2000a) provides some provocative examples of the ways in which our social life is entwined with the things we do. Qualitative enquiries cited by Crossley show young mothers using smoking as a positive resource within daily struggles against pressures and lack of support, or risky behaviours such as unprotected sex are seen by young men as a symbolic assertion of living a full life. Ironically, it is the very strictures suggested by health promotion that provide the basis for such rebellion.

Qualitative enquiry has shown that social relationships do not just shape or influence health behaviours. Rather, the shared language of participants in particular contexts constructs particular actions as being meaningful in specific ways. For example, using a condom in a classroom has a completely different meaning to its use in sexual intercourse. Thus, an individual may quite honestly report an intention to act in a certain way that is inconsistent with later actions. Willig (1999) has analysed people’s talk about condom use in relationships to show how meanings such as trust and romance (not just protection) are an important part of condom use in practice.

The social and structural basis of health

Research into health disparities among population groups has demonstrated that social and economic forces influence health through more than individual health behaviours and individual coping skills; more broadly based psychosocial and environmental risk factors are at work (Smedley, 2006). The relationship between social inequalities and health was highlighted by the British Black Report (Townsend and Davidson, 1982). This report highlighted a great deal of evidence for inequalities in health between social groups, and disparities in resources and service provision. The report awakened a surge of international research in health disparities of every sort,
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to reveal alarming and growing inequalities in health within and between countries.
A renaissance of health inequalities research (Labonte et al., 2005) has lead in turn to a focus on the socially based influences on health. In 1998, WHO published *The Social Determinants of Health: The Solid Facts*, which has since been updated in a second edition (Wilkinson and Marmot, 2003). This publication presents a collection of research evidence for the social determinants of health in the areas of the social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food and transport. For each aspect the book suggests the role that public policy can play in shaping a social environment that will support better health.

An important shift in research and policy that has accompanied this new focus is understandings of health as a population issue. Epidemiologists and sociologists have noted that populations have characteristic disease rates or health issues that have causes which cannot be explained by studying individual differences. The implication is that societal interventions may be more effective than targeting individual behaviours, even for behaviours that are traditionally understood and treated as located in personal behaviour such as heavy alcohol consumption (Marmot, 1999).

These understandings have led towards a shift away from an exclusive focus on individually based theories of health behaviour and the need to include conceptions of social life in social policy and health promotion. In 2003, Prilleltensky and Prilleltensky made strong suggestions for critical health psychology practice. They pointed to the disappointing results of individually focused interventions to suggest that ‘risk factors’ such as diet, smoking and exercise are symptoms of deeper social causes of ill health. One of the effects of this shift has been to start thinking of people as embedded in social groups or communities.

Towards community approaches to health

Whaley (2003) notes that ‘the public health approach of individual risk factor modification has proved to be expensive but not very successful’ (p. 740). A growing recognition of the shortcomings of individually focused approaches to health promotion, in conjunction with recognition of the importance of social life, has led to the development of new approaches and a focus on people within broader social contexts. One useful descriptive word for this approach is ‘community’, encapsulating the new focus on groups of people. Community-based approaches to health promotion to address the failures of individual behaviour oriented approaches have become increasingly common since the mid-1970s (Guldan, 1996). However, this shift has been a matter of slow and faltering development rather than transformation. There are many practical, political and institutional issues involved in the moves toward community approaches noted by commentators like Guldan. An issue underlying all of these problems is our understandings of
social life and health and meanings of community. It has not been sufficient to transfer individual-based theorizing into community applications and this is still a problem. Commentators still note that the application of individual theories at population levels has proved to be awkward (Hepworth, 2004) and dangerously unethical (Mabala, 2006).

A first step in recognizing the importance of social life has been to consider the cultural context and human relationships as additional factors affecting individuals and their behaviours. However, to understand groups of people as ‘organisms’ we needed to shift toward understandings of the person as inextricable from their social context: the individual as a part of, product of and producer of that context. Public health workers and health psychologists (whose disciplines are traditionally individually focused) have needed to make some important shifts in their understandings of health and behaviour, and in doing so have called upon explanations and methods from several other disciplines.

Multidisciplinary approaches to public health issues and health promotion have introduced a raft of socially focused theorizing and application from other areas such as community psychology, community development, sociology, social epidemiology, health geography, anthropology, social work, political science and public policy. Many health research groups are deliberately multidisciplinary and interdisciplinary. An example is the Institute of Population Health in Ottawa, Canada, described by Labonte et al. (2005). This centre aims to effect social change based on three central tenets:

1 Health is seen as embedded in social relations of power and historically inscribed contexts.
2 Research should be shaped by the interests of those communities who carry the greatest burden of disease.
3 Research methods should engage community constituencies as active agents in the process of research.

Thus, a focus on the social nature of health has been translated into a focus on communities, including communities of need and communities of power. However, the use of the word ‘community’ to denote social life has led to some anomalies and issues itself that must be noted here.

‘Community’ is a word that is used quite freely and often unreflexively in the literature. Goodwin (2003, p. 29) noted that: ‘wherever social relations are described, analysed, remembered, or even mythologised, various conceptions of “community” are almost invariably deployed’. Owing to the everyday meaning of the word, and varying conceptions deployed in the literature, community has proved impossible to define consistently. In 1955, Hillery identified 94 different definitions of community in the academic literature on which there is no clear agreement, a situation which has not been resolved by academics to date. For practical purposes, McLeroy et al. (2003) identify four types of community-based interventions: community as the setting; community as the target for change; community as the resource
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and community as agent. At the same time these authors note that there are many other typologies of community approaches that have been proposed in the literature. Campbell and Murray (2004) describe the focus in the community health arena as being on either communities of identity (such as the ‘gay community’ or the ‘Jewish community’) or communities of place (such as neighbourhoods and rural towns). Geographically based communities are most often the target of health promotion work for very pragmatic reasons: areas such as neighbourhoods or towns provide for identification of deprivation and a focal point for gathering people together for community action.

‘Community’ as a word has positive, friendly connotations and it is often used to strike a positive note in a way that has also been exploited by politicians. In the 1980s and 1990s there were several critiques of the contradictory uses of the notion of community. For example, Bryson and Mowbray (1981) from Australia, called ‘community’ a ‘spray-on solution’ to describe the way in which the label had been seized upon and applied in a simplistic way to complex social problems. In 1994, Farrant pointed to gaps between such rhetoric and the reality in UK practice, including issues such as the structural and institutional barriers to actual implementation of community-based development for health. These criticisms have not abated. More recently, Pearce (2003) pointed to the dangers of unexamined assumptions about community as locality in health promotion practice. In a paper entitled, ‘Which community?’ he raised some practical problems: not all social identities (such as ethnicity or sexual orientation) are geographically based; social networks are more often built through other connections such as work or family; and deprived people do not necessarily live in deprived areas. Pearce’s underlying critique is that targeting resources and power to local areas can lead to the suppression of minority groups in these areas, whereas more centrally devolved provision can provide for all groups.

Towards developing a coherent theoretical approach for community health work Campbell and Jovchelevitch (2000) defined community in terms of three key dimensions: shared identity; a shared set of social representations; and shared conditions and constraints in access to power. In regard to shared representations, Stephens (2007) has used people’s everyday talk about community to show that people have access to multiple social representations of community and these are used to serve different purposes at different times. Thus, health promoters’ uses of representations of community are also likely to be deployed contingently. Rather than attempt to hammer out final definitions, it is best to be aware of our use of the word and the purposes that it is serving at any time. In this book, the word ‘community’ will be used in accord with different theoretical and practical contexts. Thus its use, although not overtly contradictory, may shift across the chapters and we must keep interrogating the social purposes of its application in these different contexts.
Health and health promotion as social practice

Health promotion is socially constructed

Just as health is a part of social life, health promotion as an activity engaged in by people, is socially constructed and a matter for political struggles. One way of understanding this is to look briefly at the history of health promotion and to note the ways in which shifting discourses have been used by health practitioners and politicians to construct health promotion activities.

What is ‘health promotion’?

Health promotion involving professionals and organizations is generally sponsored by governments or non-governmental organizations (NGOs) with public good goals. Government funded health promotion in Western countries is usually organized as part of the ‘public health’ sector of government concern. However, ‘public health’, as a branch of medicine, is also a discipline in its own right, and these related but different versions of the phrase both signal the dominance of medicine in the field and lead to confusion in the jostling for control of public funding among disciplines and institutions. Webster and French (2003) outline a history of some of the conflicts between public health and health promotion goals while also noting their common interests:

The goals of public health are usually stated to be ‘preventing disease and promoting health’ and the mechanisms for realizing these objectives are to be organized interventions directed at particular groups or the community as a whole. Clearly, therefore, public health has always been associated in some way with health promotion.

(2003, p. 10)

Shifting constructions of health promotion

There have been major changes in the construction of ‘health promotion’. It must be noted that these understandings and ways of talking about promoting health are available and co-exist in practice today. As some come to prominence or new understandings arise, there are ongoing disputes regarding the history and goals of public health activities. Here I will describe some major changes in dominant constructions of health promotion in Western societies to illustrate the shifting nature of understandings of health and health promotion.

Sanitation, health services and health care

In nineteenth century Europe, the early public health movement focused largely on sanitary conditions and especially on housing, water, disposal of waste and working conditions (Webster and French, 2003). These remain
important aspects of public health concern in many countries to this day. However, in the twentieth century the emphasis in countries like the UK shifted to a focus on clinics and services, including health education, to deal with the needs of vulnerable groups. Following World War II, this emphasis in many Western countries shifted to the provision of health care services such as GPs, nurses, dentists and hospitals. In other words, to a biomedically dominated approach that valued medical treatment as the focus of public health. In more welfare oriented countries such as the UK and Canada this was the time for the development of extensive state provision of health care which dominated the public health scene.

To those of us who grew up in this era, the provision of medical services does seem to be the fundamental basis of health. The provision of hospitals and access to medical services including general practitioner care and surgical operations are the basis of political competition for votes in countries with state provided services, and the basis of activism and protest in those without. Nevertheless, there have been many critiques of the dominance of biomedical discourses in our understandings of health. Among the famous and influential works are Illich’s (1977) *Limits to Medicine: Medical Nemesis, the Expropriation of Health*, whose title is a good indication of content. Another very influential work was McKeown’s (1979) *The Role of Medicine* which argued (convincingly for many) that medical care had little to do with the improvements in life expectancy in the UK at the end of the last century.

**Lifestyle and health behaviours**

A major shift in the way public health was understood took place in the 1970s. Robertson (1998) describes these changes in terms of a change from the dominance of a medical discourse of health to discourses privileging ‘health promotion’. There are two important stages in these changes and the discourses that underpin them can be found in two influential documents. First, the Lalonde report (New Perspectives on the Health of Canadians) was published in 1974. The Lalonde report introduced the ‘health field’ concept as an explanatory model including various factors such as lifestyle and environment as determinants of health. Medical health care was positioned as only one of many determinants. The lifestyle aspect of this model dominated health promotion discourse, and individual level behaviour change became a major focus for improving health in the 1970s and 1980s (Robertson, 1998).

There has been a great deal of critique of the effects of this shift. In 1993, Becker who, as a medical sociologist contributed to the health promotion movement and developed a model of health beliefs, also noted what he termed the ‘dark sides’ of health promotion activities at the end of his career. First, he criticized constant exhortations to the public to change their behaviours, based on cavalier and premature use of tentative research
evidence. Thus we see the familiar reversals and contradictions in public health messages that continue today: ‘Don’t eat eggs, they have bad cholesterol’, ‘Do eat eggs, they are full of Omega-3’; ‘Protect yourself from the sun, it causes cancer’, ‘Get more sun to avoid vitamin D shortage’. Becker believed that the promises of longer life based on such ill founded messages are unethical. Second, he believed that the relentless nature of such health promotion messages has caused an ‘epidemic of apprehension’ so that people are needlessly and excessively anxious about the health effects of their behaviours such as their diet. Third, he criticized the tendency of lifestyle health promotion to locate the responsibility for all health issues with the individual. Becker believed that this last issue was the most serious, and many other commentators have pointed to the damaging effects of this shift to individual responsibility. From a cultural and sociological perspective, Petersen and Lupton (1996) suggest that the focus of the new public health on psychological, social and physical aspects of health is, at its core, a moral issue that deserves scrutiny. This scrutiny has been provided by several other commentators who have written about the rise of ‘healthism’ and the individualization of health concerns. The term ‘healthism’ was coined by Crawford in 1980 to describe the effect in society of individually focused prevention messages. The emphasis on an individual’s obligation to be concerned with health and to live a controlled life, valuing self-restraint and avoidance of risk, has lead to a moral climate in which people feel they have failed if they do contract disease; people may be blamed for their own illnesses; and some may be denied health care for diseases linked to ‘bad’ behaviours.

Social determinants and empowerment

The dominance of the health fields model in health promotion was extended by a second major influential document. The Ottawa Charter for Health Promotion (1986) which built on concepts of health from the WHO’s Global Strategy for Health for All by the Year 2000 (1981). These publications redefined health as broad-based well being rather than just the absence of disease. Based on growing evidence for the social determinants of health, they included factors such as poverty, social exclusion, unemployment and poor housing as providing the basis of health outcomes. These reports also suggested new focuses and methodologies for health promotion. A new focus on public policy and cooperation between government sectors such as housing, transport and health was called for. New methodologies such as community development, empowerment of people to take charge of their own health, advocacy and social marketing were promoted. The resulting radical shift to policies and approaches based on social explanations of health, including the importance of social interaction and participation as important aspects of well being, became known as ‘health promotion’ or ‘the new public health’.
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Of course, the dominance of particular constructions of the purposes and methods of health practice do not stand still. There are ongoing shifts, jostling for economic and ideological prominence, and related discussions in the literature about the choices and policies of successive governments, public health officials and institutions. For example, in her critique of shifting discourses, Robertson (1998) criticized the increasingly popular notion of ‘population health’ in public health discourse. In contrast to health promotion, she describes this approach as devoid of theory concerns for morality and social justice, and denying the political aspects of health practice. Porter (2007) has followed these lines to critique the 2005 WHO Bangkok Charter for Health Promotion in a Globalised World. She compares the discourses used in this report with the Ottawa Charter of 1986 and notes a shift from a ‘new social movements’ discourse of environmental and social justice to a ‘new capitalist’ discourse focused on law and economics. Porter compares this new discourse with that of economic determinants promoted by the population health approach. Labonte also lamented the rise of the “population health” discourse in 1997. However, later (Labonte et al., 2005) he describes the development of a critical approach to population health research which can include theoretical engagement and social and moral values.

The practice of health promotion

As the discourses of public health impact directly on people’s understandings of their health and lifestyles, so these shifting discourses construct the practice of health promoters. In 2005, Fairhurst noted that health promotion and community health workers were now expected to respond to calls for a social model of health embracing environmental matters, active participation by members of the public, and recognition of the importance of the structure of communities and society. Thus, health promotion professionals must respond as social policy and organizational demands change. These responses have lead to some notable shifts in health promotion practice: from a focus on pathology to a focus on well being; from aims of behaviour change to aims of empowerment and participation; and from the choice of instrumentally based approaches to ethically based choices.

From pathology to well being

In 1948 the WHO reconceptualized health as a positive state with their famous definition which has not been amended since (WHO, 2008): ‘Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.’ (This was the preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June–22 July 1946; signed
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on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.) Although this classic definition has proved difficult to conceptu-

ize (Levin and Browner, 2005) and very difficult to operationalize (Saracci, 1997), its symbolic weight signalled the beginning of a renewed understanding that illness and disease are only a small aspect of health. This definition has been an important basis for the aims of health promotion which have increasingly included the social and positive aspects of well being.

Antonovsky (1996) saw that the revolutionary ideas of the new health promotion were in danger of stagnating for lack of coherent theory. He was concerned to develop theory that would enable health promotion to move towards promoting health. In proposing a model for health promotion that would move populations toward better health, Antonovsky developed the notion of ‘salutogenesis’, a neologism which he had coined in 1979. A ‘salutogenic’ theory of health rejected the pathogenic orientation of ‘all Western medical thinking’ which focuses attention on disease and ignores broader interests in well being. Although ignored for many years, Antonovsky’s ideas have attracted renewed interest since the 1990s; this interest has centred on the importance of the salutogenic focus in many areas of health promotion practice. For example, Sidell (2003) describes how Antonovsky’s framework may be applied to understanding the differences between older people’s accounts of their health and morbidity data. This perspective includes health seen as a continuum, rather than as the absence of disease, and provides a new view of health promotion for elders. The aim of helping older people move toward the healthy end of the continuum includes perceptions of the role of ageing unfriendly physical environments and ageist social environments. McCreanor and Watson (2004) similarly use this broader framework to consider the role of physical and social environments in promoting the well being of young people.

The changes in health promotion aims, from those of prevention of sickness to those of promotion of wellness are reflected in the Ottawa Charter for Health Promotion (1986). These have been increasingly drawn upon in the new health promotion movements.

**From behaviour change to social change**

Recognition of the social location of health has also lead to a shift in the aims of health promotion from individual behaviour change to changes in social conditions that affect health, especially the health of disadvantaged people. In turn, this has brought theories of empowerment and the participation of community members in health promotion activity to the foreground. Thus, there has been a growing focus on ‘community’ since the new public health developments in the 1970s which draws on conceptualizations from areas such as community development and community psychology, although health psychology has been slow to include these changes.
In the last 20 years there have been some moves toward including a public health orientation and community approaches within health psychology practice. Hepworth (2004) outlined a conceptual and practical framework for a ‘public health psychology’. The defining features of practice include ‘a focus on public rather than individual health, inequalities in health, multi-method design and multidisciplinary and interdisciplinary practice’ (2004, p. 52). In the same issue, Murphy and Bennett (2004) suggested that psychologists adopt a more holistic approach to health. One avenue of this public health oriented approach would be to draw upon the ‘long-standing tradition in public health of community involvement’ (2004, p. 22). They point to the usefulness of concepts used in these approaches such as empowerment and participation. Nelson et al. (2004) and Murray et al. (2004) consider these shifts as the development of a ‘community health psychology’. Community health psychology is characterized by these authors as taking a broader view of health and well being to include the social environment, power inequalities and an ecological perspective in which people are seen as being embedded in small groups which are part of larger systems. Community health psychology interventions strive to change the social conditions that affect health. Rather than be driven by ‘experts’ who know what changes should be made, a community health psychology emphasizes community driven approaches involving partnerships between professional and community groups.

Campbell (2003), a social psychologist working in health promotion, has summarized the arguments for the importance of community participation in improving health. These include the importance of involving community groups in decisions about health care and in the design of promotion campaigns. In addition, there is the recognition of the environmental and social community conditions on health so that concepts such as community cohesion and empowerment become a focus of activity. Campbell also notes that much remains to be understood about how participation relates to health and although practical application is growing, theoretical understanding is weak. Other critiques of the use of communitarian approaches are noted above.

Rather than focusing solely on the community level of action, a community health psychology also recognizes the importance of wider social systems to the well being of smaller or disadvantaged groups in society. It may include concerns with the broader social context of inequalities and focus efforts toward influencing social policy and working towards social justice. Prilleltensky and Prilleltensky (2003), suggest that engaging in health promotion activities at any level of practice, individual, group or community, must include a critical perspective that challenges the hegemonies and power relations that are apparent within a societal and economic view of health. In particular, they consider the importance of power differences and the effects of inequalities and oppression that are obscured in individualist approaches. Murray and Poland (2006) propose that moving
toward a critical health psychology approach to practice includes social action that contributes to the movement for social justice. They suggest that such actions include research that reveals the deleterious impact of unjust social arrangements, advocacy efforts to highlight unhealthy living and working conditions, and engaging in community and collective action to transform unhealthy living conditions. These actions involve connecting with community and liberation psychologists and others who have been engaged in movements for social justice.

From instrumental to ethical

In taking their more radical positions, both Prilleltensky and Prilleltensky (2003) and Murray and Poland (2006) note the importance of an awareness of one’s own social position and how this frames our view of the world. This awareness includes becoming sensitive to the values involved in our own theories about health, and the research questions and practical applications that they underpin. It has also supported a shift from an instrumental or strategic approach (which ignores underlying assumptions and values) to a values-based approach to choices about health promotion.

Prilleltensky and Prilleltensky (2003) critique the functionalist or strategic approaches of traditional health psychology and the assumption of scientific neutrality in health promotion practice. Crossley (2001) also critiques the functionalist or strategic approach of traditional health psychology in which the aim is prediction and control of health related behaviour, based on assumptions that researchers and practitioners are objective scientists with privileged access to a body of validated knowledge. The aim to identify and manipulate the predictors of individuals’ unhealthy behaviour excludes consideration of values, morality and the reflexive consideration of the practitioners’ own values and the values of those they serve in these activities. Stam (2000) also notes that health and health care is a social activity in itself. Focusing on ‘individual actors usually obfuscates the complex moral/power relations involved’ (p. 274). Thus, there are both moral (What worth do such goals have?) and political (Whose ends do they serve?) questions which are not engaged with in instrumental, individually oriented approaches. Both Prilleltensky and Prilleltensky (2003) and Crossley (2001) draw on critical theorists to argue that instrumental approaches that exclude a recognition of social values support the individualistic ideologies which actively work against the achievement of values of social justice, participation, caring and health.

Seedhouse (1997) argues that ethics is all-pervading in health promotion. Health promotion is a moral endeavour and yet health promoters act as though they are in an ethical vacuum. Seedhouse claims that the perception that health promotion is driven by evidence, and strategies chosen to deal with preventable problems, is simply erroneous. Health promotion is always driven by values, and the evidence and strategies are then selected according
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to the particular values and political philosophies. Once we acknowledge this, and examine our own values, then we can move forward to acknowledge and discuss the 'political tap roots' of health promotion. To contribute to this shift from an instrumental approach to acknowledging the values behind all choices, Guttman (2000) discusses the ethical dilemmas in health promotion. In her book she has provided cogent analysis and structured suggestions for the ways in which practitioners may shift from strategic analytic approaches to a values-based approach to public health interventions.

Murray et al. (2004) discuss the specific aims and values of a community health psychology. A first aim is seen as the need to broaden our understandings of health and illness to include the social, cultural and political dimensions of health. This has implications for our understandings of the basis of knowledge and the theoretical basis of our research. A second aim is to contribute to a reduction in human suffering and improvement in quality of life. This aim leads to a reconsideration of the role of the practitioner (from detached observer to personal commitment) and the basis of practice. Underlying these changes in approach is a set of acknowledged values. Community health psychologists would value health promotion, the empowerment of oppressed people, action for social justice, diversity, caring, compassion and community.

As the chapters of this book unfold sometimes my own values will be clear with regard to the ways in which we understand health, the different theoretical approaches to health, and the values that we can bring to health promotion activities. However, I have also attempted to provide a reasonably even handed overview of different approaches, theories and methodologies, and so I will clarify my own position here, beginning with a little background. I began my career in health psychology, researching the effects of social support on the experience of post-traumatic stress disorder from a traditional positivist perspective. At the same time I was introduced to critical social psychology, and began a parallel line of study employing discourse analysis. This developed into research on the social basis of women’s health issues, followed by research into social connections and how these relate to health. Some time in the middle of this, I began teaching health promotion to graduate students as part of a health psychology course. At the start, I drew on traditional approaches in psychology, such as social cognitive models, and traditional texts, to talk with my students about health and health promotion. Encouraged by discussions with students and practitioners, my own background in critical psychology, and increasing exposure to the work of psychologists such as Michael Murray and Catherine Campbell who were developing community approaches, I included fewer and fewer of the cognitive oriented approaches until they have dropped from my course altogether. They do not fit with my own understandings of the social basis of health and with my values of social justice. Nevertheless, I believe they deserve inclusion in this text owing to their widespread use in psychological research and practice today. As exemplified by my own rather
mixed background, the approach towards the focus on social and community approaches that is being suggested by different commentators and practitioners at present has developed from an often ill-fitting and confusing range of sources. Rather than deciding what the one right approach is in a prescriptive sort of way, I hope that the overview in this text will work towards enabling us to evaluate all the tools and methods available to us in terms of their implicit values and the values with which we wish to align ourselves. I believe that a community-based approach to health promotion is emerging but will naturally continue to evolve and change as we develop our abilities to critique our own activities on the basis of shared values. Of course, those values themselves are vigorously debated in the literature today. One thing that I would hope that any reader of this text will gain is encouragement to develop a reflexive approach to practice, and the confidence to critically contribute to these debates.

Summary

This chapter has highlighted three important shifts from traditional views of health and health promotion. First, a shift from an understanding of health that has been dominated by the biomedical view of health as a matter for individual bodies and a psychological perspective that sees health as a matter for individual minds. Looking out from under this single-minded view, we are beginning to understand the very social nature of health; that health is a matter for people embedded in social life; that health related behaviour is more about that social life than about health; and that the structure of society contributes to the well being of its members. From this perspective we can understand that health promotion itself is socially constructed. Second, there has been a move from viewing health as a problem — a pathology-based approach — towards a positive view of health. Public health workers who are focused on wellness work are working toward health promotion for all, rather than on disease prevention as an end in itself. The focus on well being fits well with social understandings of health because a great deal of our well being is about social relationships. The third important shift has been moves by health promoters from scientific paradigms, that emphasize prediction and control, towards a concern with meaning and values. This move leads the health promoter away from a role as an expert impartial observer, towards respect for the importance of participation by those whose health needs to improve.

The development and application of these aspects of health promotion, along with the need for a reflexive health promotion practice, will be discussed and illustrated across the following chapters. I will consider them in terms of framing health issues, theoretical and ethical understandings of those issues, theoretical tools available for health promotion research and practice from community perspectives, and examples of community
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oriented health promotion practice. To begin at the beginning of a process of health promotion intervention, the next chapter will discuss the health issues that we think require some action, and the ways they are chosen.

Further reading


3 This paper serves as an introduction to a special issue devoted to a wide variety of anthropological explorations of the social production of health: Levin, B.W. and Browner, C.H. (2005) The social production of health: critical contributions form evolutionary, biological, and cultural anthropology, Social Science & Medicine, 61, 745–50.


5 This is a collection of contributions that provide excellent examples of the ways in which illness and health are part of social life and their experience informed by the social world: Radley, A. (1993) Worlds of Illness: Biographical and Cultural Perspectives on Health and Disease. London: Routledge.