HEALTH EDUCATION AND HEALTH BASED PHYSICAL EDUCATION: A CULTURAL CRITIQUE

by

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ABSTRACT

This thesis examines the key assumptions of contemporary health education and specifically Health Based Physical Education (H. B. P. E.). The approach of a cultural critique is adopted throughout the thesis, where H. B. P. E. is analyzed in light of broader cultural movements and trends in health education. It is argued that the individualistic ethic underpinning these programmes is inadequate essentially because it relies on individual responsibility as the only means of improving health. It is suggested that such a notion of health improvement is impoverished since it falsely assumes universal individual free choice and therefore fails to acknowledge in any significant sense the political and economic elements which impinge upon the achievement of health. It is argued that health education, including H. B. P. E., must go beyond the narrow focus on individual responsibility, and consider the cultural, political and socio-economic factors which determine the health of the community. The thesis therefore concludes by making some recommendations for current practice in health education programmes and specifically for Health Based Physical Education.

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CHAPTER 1

Introduction

Background

Since the mid 1970's there has been a dramatic change in Health Education (Reid, 1981), not only in the United Kingdom, but also in Canada, Australia and the United States of America. Steadily gaining momentum during the early 1980's, health education has ceased to be regarded as only a peripheral curricular concern, and become instead an important part of the curriculum in many schools. Dealing with all kinds of issues ranging from smoking (Health Education Council, 1983), drugs (TACAPF, 1981), to personal relations (Baldwin & Wells, 1979), health education has in many ways become more broad. Within the Physical Education context, Health Education has become especially significant. McNamee (1988) suggests that "it has been one of the most prominent single issues in terms of the journal space it occupies and the number of inservice courses devoted to it, not to mention the rise of curricular justifications for physical education" (p. 83).

Health Based Physical Education (H. B. P. E.) was established and augmented on the grounds of promoting fitness for life (Corbin, 1979) in an effort to enhance the health of the nation (Almond, 1983). In Britain, much of the impetus for health related fitness has come from the national curriculum development project "Physical Education and Health" sponsored by the Health Education Council in conjunction with the Physical Education Association at Loughborough University.

A similar development in British Columbia has been the Active Health Programme. Its origins date back to 1971 when the Ministry of Education established the 1971 Health Science Guide. After revisions in 1977 by Bannister

and Savage of the school of kinesiology at Simon Fraser University, it was stated that the aim of the health programme was to enable children to understand the relationship between exercise and long-term health (Goss, 1986). Justification for the programme was based on escalating costs of medical care and the increasing problem of an aging population. They argued that people place an increasing burden on society due to the irreversible diseases they develop, and it was the opinion of those involved in Active Health that a good programme could remedy some of these problems.

Today, the Active Health orientation is currently a main focus in many school physical education programmes. In the United Kingdom, Australia, and the United States, health education courses in the physical education curriculum also continue to gain prominence.

Rationale

It might be expected that innovations of such magnitude in the Physical Education world would be accompanied by large volumes of literature making a critical evaluation of the main issues involved in these programmes. This was clearly not the case. Central issues have not been addressed to any depth.

Colquhoun (1989a) calls for the "critical appraisal of health related fitness" and the need for the profession to "highlight the hidden assumptions behind the rhetoric of the advocates of health related fitness" (p. 122). McNamee (1988) and Kirk (1989) suggest that the whole movement has developed in an uncritical climate and also call for its critical appraisal.

It seems pertinent at this time to address some of these fundamentally critical issues which advocates of H. B. P. E. have traditionally failed to address. This

study will therefore clarify what the nature of these innovations are, highlight some of the underlying assumptions, and make some sound recommendations for the practice of H. B. P. E. And although the focal point of reference throughout is H. B. P. E., the thesis makes a broader analysis of Health Education. H. B. P. E. is therefore a main issue, but the field concern is Health Education. In the wider sphere, then, the theoretical area of focus within this piece of work are issues related to health care on a more general and wider level.

A Cultural Critique

The thesis takes the form of a cultural critique, where developments in H. B. P. E. are viewed against a background of significant social trends that are influential in determining the direction of these movements.

The notion of a cultural critique is certainly not new. There have been a number of significant critiques of health care in the wider context (Dubos, 1959; Ehrenreich, 1978; Freidsoun, 1970; Illich, 1975; Powles, 1973; Zola, 1978). Bruce Haley's book, The health body in Victorian culture (1978), traced the history of fitness and sport in England and brilliantly linked the political, social, economic, and religious changes of 19th century England to the evolution of sport and public attitudes towards games and athletics. Haley was a pioneer in terms of his ability to unearth connections between popular and professional medicine and sport. Green (1989) also notes other scholars and states that:

> Donald Mrozek carefully examined the linkages among the military, sport, health crusades, body building, and the broad movements of American Ideology in the 19th century in Sport and American mentality 1880-1920 (1983). In Crusaders for fitness (1982), James Whorton analyzed the various dietary solutions Americans sought for their ailments, as well as certain aspects of sport and physical fitness crusades of the 19th century. Whorton was particularly attentive to the

> transatlantic connections that are present in this broad-based series of movements and demonstrated the connections between such socioreligious concepts as "Muscular Christianity" and dietary reform and faddism. (p. 5)

There have, however, been few critical analyses of P. E. within the cultural context in recent years. Although some writers have submitted critical scrutiny (Colquhoun, 1989; Hoyal, 1977; Kirk, 1986; McNamee, 1988; Parry, 1987), many innovations, including H. B. P. E. and Teaching Games for Understanding (T. G. F. U.) have developed in an uncritical climate. Evans and Davis (1986) have called for more critical analysis in P. E., and suggest that "detailed studies of P. E., whether carried out by researchers or teachers, are now badly needed to advance our understanding of what P. E. teaching is, of what it does to pupils, and of how departments and teachers work and change across all levels of curriculum decision making" (p. 32).

Goodson (1987) notes how subjects change and gain impetus for their development within a social context. In his book, School subjects and curriculum change, he examines how certain subjects and areas of the curriculum gain ascendency, and analyzes their construction, promotion and rhetoric within the framework of the social context. Although Goodson's work is limited in that he only deals with academic subjects, he does emphasize the analytic importance of placing subjects within a wider social and political structure for analysis. He quotes Musgrove, who, in 1968 made the following comment to sociologists. He said that they should:

> Examine subjects both within the school and the nation at large, and the social systems which are sustained by communication networks, material endowments and ideologies. Even innovations which appear to be essentially intellectual in nature can be usefully examined as an outcome of social interaction. (Goodson, 1987, p. 5)

School subjects do not always change because educators forsee a need for the subject to change in itself (Goodson, 1987). Much of the impetus for H. B. P. E. in Canada and in the U. K. has arisen due to an upsurge of interest in health in society at large (Colquhoun, 1990). Although some changes may have arisen due to questions raised about the fundamental nature of P. E., much of the impetus has derived from external factors. Williams (1988), in her article The historiography of health and fitness in P. E., proposes that "the revival of public interest in health and fitness coincided with the emergence of coronary heart disease as the largest single cause of death in western society" (p. 2). She goes on to suggest that "this preceded the increased importance given to health related fitness as a justification for the inclusion of P. E. in the curriculum" (p. 2). Kirk and Colquhoun (1987) have also proposed several reasons for recent developments. They suggest that:

(i) There is a growing and definite increased societal interest in health related issues. The prevalence of Coronary Heart Disease and the spiralling cost of curative medicine are powerful arguments for preventive medicine.

(ii) Research has shown that an effective preventive tool for combatting Coronary Heart Disease is physical activity and lifestyle modification.

(iii) There is currently a feeling of discord amongst many Physical Education teachers over the traditional focus of the subject -- competitive games and sports.

(iv) Current evidence suggests that conventional sports-orientated Physical Education programmes are ineffective in promoting and maintaining the health and fitness of school children (see Thomas, 1977; and Haydoch, 1979).

(v) The teaching of health within Physical Education has perhaps been argued more forcefully than other areas of curriculum

> development which in physical education tend to emerge in an atmosphere of "laissez-faire." (Yates, 1977).

It is imperative that H. B. P. E., influenced by certain factors external to P. E., must be analyzed and scrutinized with this in mind. Fitzclarence (1986) suggests that it is necessary to put Physical Education in a wider context, claiming that "it is essential at times to step well back from P. E. as a discrete entity; and to view it against some images of broader social changes" (p. 18).

What must be recognized is that H. B. P. E. should be placed in a political and social context. Contrary to what some health educators claim, the teaching of Health Education does not involve the neutral transmission of objectified knowledge. Instead, it is a political and social act, involving the reproduction of certain values, norms and beliefs (Colquhoun, 1990). It is simply inadequate that health educators postulate a sense of value-neutrality (Hyland, 1988) and fail to locate health within the socio-economic and political framework that gives it meaning. Health is clearly a social construct shaped by and incorporating social, political, economic, and cultural dimensions.

This purpose of the present study is thus to expose H. B. P. E. to wider social and cultural critique. It is only through this means that the inconsistencies, contradictions, and areas of confusion within H. B. P. E. become apparent, and significant and justifiable recommendations can be made for practice. By placing H. B. P. E. within a wider cultural understanding, some crucial assumptions that steer practice can be brought to light. Once these become explicit and the contradictions they expose are articulated and understood, they present themselves as important sites where action can take place (Kirk, 1989). That is, if teachers and others involved in the physical education profession come to have a more comprehensive understanding of what they are teaching and why, and of

some of the underpinning of particular activities, it provides the first opportunity to enable us to modify and improve physical education practice. This is particularly the case when critical analysis exposes negative practices and influences in physical education.

H. B. P. E. Developments: An Overview

As stated earlier a major impetus for H. B. P. E. has arisen from public concern with the nation's health, particularly the incidence of Coronary Heart Disease (C. H. D.), and research indicating the basis of such disease in childhood. Williams et al. (1979) argue that "the recognition that adult chronic disease risk factors can be easily identified in childhood has led many to the conclusion that the primary prevention of chronic diseases must begin with children" (p. 506).

In recent years much fitness testing has been undertaken in response to this concern (Armstrong, 1987; Pate, 1983). The first of these tests was the AAHPER (American Alliance for Health, P. E., and Recreation) fitness survey in 1955. More recently an escalation in testing has also occurred in Canada. Ferris et al. (1987) note the increase in motor fitness test batteries in the last decade, involving substantial funding by federal and provincial governments. Tests have focused on youth (Canada Fitness Survey, 1983, 1985), girls and women (Canada Fitness Survey, 1986), older populations (Canada Fitness Survey, 1982), and regional and urban-rural deficiencies in physical activity patterns (Canada Fitness Survey, 1986).

One outcome of these tests has been the development of fitness norms and percentiles for use in Canadian and American schools. In the U. S. A. these tests

have comprised part of the initial impetus for H. B. P. E. courses. For instance, Corbin (1985) established a staircase to fitness incorporating fitness testing, based on a taxonomy of physical fitness objectives (Pate & Corbin, 1981).

More recently Almond and the Health Education Council established and augmented the British Movement. They stressed the need to develop lifetime fitness in an effort to enhance the health of the nation (Almond, 1983; Biddle, 1983; Whitehead & Fox, 1983). In particular, they put emphasis on altering individual lifestyles. Almond (1983) makes such a claim to amend lifestyles, based essentially on empirical evidence from the medical profession. He says:

> The medical profession have (sic) endorsed the value of an active lifestyle and made us more conscious of the role of diet and circulatory and heart disease. These diseases manifest themselves 20 - 30 years after they have started and affect the body, which raises an interesting issue for teachers of physical education - the school years could be an interesting period for fostering a concern for an active lifestyle. (p. 19)

Not only have many P. E. teachers accepted the validity of the somewhat simplistic assumption that dedication to lifetime fitness alone will "fix" all our health problems within our society, but worse, this narrow focus on lifestyles has resulted in the apolitical presentation of H. B. P. E. That is, there has been a failure to acknowledge or even allude to the political, social, and economic factors which impinge upon an individual's health.[1] This is clearly demonstrated by highlighting some of the suggestions made by the advocates of H. B. P. E. who make no reference to or acknowledge the social construction of health. As examples, Armstrong (1983) makes no reference to health within a larger social context, and

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[1] I use this term "apolitical" here to refer to a depolitization of the notion. It should be noted though, that the teaching of health education based on the traditional model is of course highly political by nature of its omissions.

suggests that a H. B. P. E. course should incorporate Muscular Energy, Exercise and Health, Exercise and Training Principles, and Cardio-respiratory Fitness. He further states that H. P. B. E. should include Body Composition, Muscle Strength and Endurance, Flexibility, Looking Good, and Exercise, Leisure and Community.

Whitehead and Fox (1983), two of the initial advocates for the H. B. P. E. movement in Britain recommend Physical Fitness: Exercise, Accidents, First Aid and Safety, and Lifestyle Management . Even recently Almond (1988) fails to place health education in the wider social or cultural context. He recommends the following for a H. B. P. E. course: Exercising safely and correctly, maintaining cardiovascular health, nutrition balance, stamina, lifestyle management, posture and stress.

The apolitical presentation of health education has also been endorsed at a national level in the U. K. The British Association of Advisers and Lecturers in P. E. (1988) have suggested that a H. B. P. E. course in the secondary school should include: physical and psychomotor skills, decision making skills, and social skills.

Development of the Coquitlam Active Health Programme in British Columbia has also followed similar lines. In 1980, a committee of educators involved in gathering resource material for the secondary school Active Health Programme addressed the following areas: cardiovascular disease, musculoskeletal weakness, and obesity, and examined how these related to personal health status (Mackay et al., 1980). In 1983, the final programme was developed, with the emphasis being placed on lifestyles. As Goss (1986) states:

> The philosophy of the programme was to develop an understanding of the body and how it works so that one may enjoy good physical

> and mental health, and to develop a more positive lifestyle in terms of exercise and nutrition and discourage abuse of one's body. (p. 8)

Recent revisions in 1989 still make no reference to health within the wider cultural context. The definition of health is narrow, concentrating soley on lifestyles and behaviour modification. It is stated that:

> Active Health is the process of developing an individual's physical, social and emotional well-being through the applied knowledge of concepts related to fitness, nutrition and personal health management. (p. 3)

Further, the goals and outcomes make no reference to the social context of health and it is suggested that the Active Health Programme should provide for:

1. Affective development as it concerns the appreciation for physical activity resulting in improved health, enjoyment, and resultant feelings of self-worth.

2. Cognitive development as it involved knowledge, perception, memory, and imagination.

3. Psychomotor development as it is concerned with proficiency and performance. (p. 3)

It will be argued in this thesis that H. B. P. E., has, by focusing on the apolitical presentation of health education, adopted a very limited and restrictive approach at the expense of an approach which appeals to social morality and justice, and is firmly rooted in an understanding of the social determinants of ill-health.

The Traditional Approach to Health Education

Many contemporary health education programmes have followed the traditional medical model. Hyland (1988) states that "the theoretical perspective of

current practice is largely informed by the traditional medical model -- emphasizing the dissemination of information, piecemeal curative measures, and concentrating on people's unhealthy lifestyles" (p. 23).

This model of medicine as an approach to Health Care was certainly appropriate at the start of the century when numerous deaths were caused by infectious diseases, and medical intervention was required to cure and care for existing illnesses, and prevent others through immunization producing techniques (Lalonde, 1974). Today, however, while viral diseases are still operative, "chronic diseases such as cancer, cardiovascular disease, cerebrovascular disease, stomach and intestinal illness, colitis and migraines account for an ever increasing percentage of medical practice" (Albrecht, 1979, p. 2), and may require different treatment. McKeown (1979) argues that such illnesses cannot be dealt with in the traditional manner, i.e., by treating the body like a machine which can only be protected or fixed by external intervention. He goes on to suggest that most non-communicable diseases of today are most effectively treated by removing the cause rather than intervening in the disease mechanism.

In addition to the fact that the nature of serious disease has now altered, and in view of the frustrations spawned by escalating health care costs, low returns of disease orientated medicine (Cohen & Cohen, 1978), and challenges made to traditional medical practice (Illich, 1976), it has been suggested that a new medical paradigm is required, one which focuses on preventive rather than curative medicine (Engel, 1977, Wildersky, 1977). Unfortunately, the result of such challenges has been an increased stress on prevention, an emphasis that all too often places responsibility wholly on to the individual and fails to take into consideration the social context which largely determines individual action. Health

choices may be influenced by the communities in which we find ourselves, the people we interact with, and socio-economic factors, to mention but a few examples. Even the food we eat, is, in part, determined by the huge power of the food corporations.

Health educators, and federal and provincial governments have adopted a narrow approach, in which even the definitions of "prevention" and "health promotion" have been at best ambiguous and unclear, and at worst, inadequate. Brubaker's (1983) linguistic analysis of health promotion attempts to grapple with a wide range of efforts to define the concept, but suggests that on many occasions the words "health promotion" and "disease prevention" are used interchangeably. The Ontario Ministry's of Health Bill 138, for example, while respecting the protection and promotion of public health, only alludes to the concept of health promotion, and does not define it or include it in the Mandatory Health Programmes and Services which cover traditional public health programmes (Malone, 1987). These programmes and services include community sanitation, communicable disease, preventive dentistry, family health, home care, nutrition and public health, and education regarding the above programmes (Ministry of Health, Ontario, 1984).

Although various attempts have been made to define health promotion, these attempts have been largely inadequate. Invariably the focus has been placed upon the individual's responsibility to maintain proper health, and it has been assumed that personal habit alteration will bring about increased health. The consequence has been the promotion of individual responsibility at the expense of recognizing and acknowledging the social construction of health. As Crawford (1977) says:

> The ideology of individual responsibility promotes the concept of wise living which views the individual as essentially independent of his or her surroundings, unconstrained by social events and processes. When such pressures are recognized, it is still the individual who is called upon to resist them. (p. 677)

This concept of health results in the failure to consider the degree to which individuals are influenced by their social environment. In terms of H. B. P. E., the result has been an inadequate, narrow formulation of a health curriculum and a depolitization of the notion of health. As Crawford (1980) explains, this failure to acknowledge the impact of the social environment upon health:

> fosters a continued depolitization and therefore undermining of the social effort to improve health and well-being. As an ideology which promotes heightened health awareness, along with personal control and change, it may prove beneficial for those who adopt a more health-promoting lifestyle. But it may in the process serve the illusion that we can as individuals control our own existence. (Crawford, 1980, p. 368)

Throughout this study I will show that advocates of H. B. P. E. in British Columbia and the United Kingdom are mistaken in adopting "the false consciousness that what is basically a collective, and therefore a political problem, can be solved by individual therapeutic intervention alone" (Navario, 1978, p. 195). This is not to say, of course, that the individual has no control or responsibility, and although it may well be beneficial to encourage people to eat healthy food and exercise, it must be recognized that the economic and practical realities of doing so may be limited (Postinkoff, 1984). A local effort at conveying more knowledge about healthful diets, for example, is not likely to result in changes of eating patterns unless it is accompanied by a combination of healthful, low cost, readily available foods -- changes which require effort beyond individual or small

group methods and extend to the community public and private organizational structure (Brown & Margo, 1978).

The H. B. P. E. movements in British Columbia and the U. K. are not alone in adopting the individualistic approach to prevention. Many contemporary health promotion attempts have tended to focus on individual change. An important policy statement released by the Canadian federal government called A New Perspective on the Health of Canadians, and chaired by Marc Lalonde (1974), adopted a similar approach. The paper intended to unfold a new perspective on health and thereby stimulate interest and discussion on future health programmes in Canada. Although Lalonde's group never did arrive at a clear definition of health promotion, a new notion termed "the health field concept" was developed which viewed health as depending on such factors as lifestyle, environment and health care organization. Unfortunately, the "health field concept" never materialized as a practice, and subsequent health promoters and educators have tended to view the different health factors as discrete phenomena largely operating in isolation from one another (Milio, 1981). The effect of Lalonde's report was to create the impression that health is primarily dependent on individual lifestyle choices (Labonte & Penfold, 1981). Lalonde (1974) makes his stance quite clear when he states that:

> individual blame must be accepted by many for the deleterious effort on health of their respective lifestyles. Sedentary living, smoking, overeating, driving while impaired by alcohol, drug abuse and failure to wear seat belts are among the many contributions to physical and mental illness for which the individual must accept some responsibility and for which he [sic] should seek correction. (p. 26)

Evans (1982) suggests that the ideas in the Lalonde document are "not based on the philosophy of a collective social pursuit of health and have not

resulted in any significant changes in health policy. In fact, there has been little allocation of resources, and, the quality of new resources devoted to the "traditional" system of health care organization remains far greater than that of other programs" (Evans, 1982, p. 328). Unfortunately, even when the environment and social factors are acknowledged, modification is still interpreted as vis-a-vis the individual. Ubell (1972) in his article Health behaviour change: A political model tells us that "any behaviour change must include efforts to arrange the mechanical or environmental situations so that individuals who are led to change their behaviour can actually do so" (p. 210).

Propounding an even more extreme view, Knowles (1977) goes as far as to say that the individual should be held morally accountable for his/her failure to stay well. He states that:

> the idea of a "right" to health should be replaced by the idea of an individual moral obligation to reserve one's own health ... a public moral duty if you will. (p. 59)

It will be argued in this study that placing responsibility for poor health wholly upon the individual is absurd and amounts in essence to a tacit attempt to "blaming the victim" (Love et al., 1984; Mitchell, 1984). The victim-blaming ideology, discussed in detail in Chapter Two, identifies the individual for his or her illness, and proposes that the individual should take responsibility as the perpetrator of his or her own health. Although the social causes of many disease forms are only beginning to be explored, the victim-blaming ideology adopted by contemporary health education programmes acts against a social orientation to health prevention and towards an unrealistic behavioural model. Crawford (1980) suggests that "it both ignores what is known about human behaviour and minimizes the importance

of evidence about the environmental assault on health. It instructs people to become individually responsible at a time when they are becoming less capable as individuals of controlling their health environment" (p. 365).

Unfortunately, this ideology is the hallmark of health education philosophy, and the central assumption of H. B. P. E. My intention in this study is to show that focusing solely on lifestyles, behaviour modification and to victim-blaming is ineffective (Gather et al., 1979) and may even be counter-productive to the goal of improved health (Morgan, 1986). Brown and Margo (1978), in their article "Health education: Can the reformers be reformed" suggest that health education programmes often rely on techniques that manipulate behaviour rather than facilitate individuals' and groups' abilities to influence and control their physical, social, and economic environments. Berberian et al. (1976), Horsay (1970), Young (1969), and Green (1972) have similarly presented a rather bleak picture of health education's inability to alter behaviour meaningfully (Malone, 1987). Milio (1981) has noted the limitations of strategies focusing solely on behaviour change, and proposed that change can only occur if there are opportunities for new health choices available at relatively low cost and readily available when compared with habitual choice. Richards (1975) suggests that it has been increasingly realized in recent years that information and knowledge may not in themselves lead to recommended actions if these actions conflict with existing motives, attitudes, beliefs, and values not consistent with social groups and norms (Malone, 1987).

This work points to a new approach to H. B. P. E., one based on a collectivist value system, which appeals to social morality and justice and is firmly rooted in an understanding of the social determinants of illness.

A New Approach

Although I will argue in favour of a new educational approach to health, it is probably worth noting that some individually-oriented health promotion attempts have been successful for certain consumptive and financially secure groups of people. For instance, fitness and exercise promotion has been successful enough to encourage extensive development of exercise facilities. Sporting magazines are becoming a major reading staple. Fitness programmes are constantly being advertised, and sports stores are looking less like the inside of a locker room and more like the interior of a high fashion boutique (Labonte & Penfold, 1981). I will show in subsequent chapters, however, that this money-making aspect of current fitness programmes reflects a basic problem inherent in health promotion, and one currently perpetuated by H. B. P. E. programmes. It reveals a middle-class bias that favours the reasonably affluent individual who can afford the luxuries of expensive sporting equipment and facilities. Labonte (1981) also expresses this concern and suggests that current health promotion programmes reflect a middle-class bias in the belief that all persons have equal abilities to either adopt healthier lifestyles or gain access to needed medical services. He further states that "health promotion programmes do not work for most of the people most of the time, and that our goals are far from being attained. To create a dramatic impact on the health of all Canadians requires, in part, addressing the social context in which personal lifestyle choices are made -- something which most current health promotion programmes fail to do" (p. 30). Considerations should be broader and go beyond the focus on simply personal choices of one's lifestyle.

What is required, then, is a new approach and methodology which address both social and health problems in society, and the intervention

strategies that could be orientated towards a solution, that is, a theory that results in successful praxis. Such an approach may reflect Paulo Freire's theory of praxis; a recognition of the dialectic of thought and action, a philosophy and methodology of *conscientization* or education for critical consciousness. Freire's method involves groups of individuals in a process of reflecting upon concerns that are real to them (e.g., problems of poor health, housing, etc.), looking behind these immediate problems to their root causes, examining the implications and consequences of these issues, and finally, developing a plan of action to deal with the problems collectively identified (Minkler & Cox, 1980).

I will argue then H. B. P. E. has the potential to incorporate a framework of teaching that provides connections between health knowledge, and the social and cultural context in which this knowledge will be applied. It is simply inadequate that contemporary health education programmes, including H. B. P. E., fail to even allude to the social and political dimensions of health. In terms of health practice, the promotion strategies will need to go beyond the descriptive information form designed to encourage the adoption of a particular conception of healthy living, and will have to consider in addition the cultural, political, and socio-economic factors which influence the health of the community. Pring (1984) has called for the need for "political values" and "political skills". Cribb (1986) has called for the fostering of "political literacy" as a prerequisite for effective health education.

By revealing the various assumptions implicit in H. B. P. E. programmes, I will show in subsequent chapters, that if health education is to

have any degree of efficacy it must be placed in a political and social framework.

The thesis has the potential, then, of providing theoretical direction and practical knowledge about health promotion and its related strategies of intervention. An alternative approach to the present emphasis on victim-blaming will be proposed. It will be suggested that an approach needs to be adopted in which the importance of individual action in altering debilitating personal health habits is acknowledged, but also collective political action to improve social and environmental determinants and obstacles to achieving health (Postinkoff, 1984).

Structure of the Study

In the present chapter I have given a brief overview of H. B. P. E. developments in British Columbia and the United Kingdom, and introduced the main concern in the thesis, namely, the notion of individualism in health education. I have indicated that this conception underpinning these programmes is inadequate in that it denies the social construction of health. The ideology disguises the need for a critical examination of social structures and fails to consider the existence of social inequalities in health (Colquhoun, 1990). In Chapter Two, the notion of individualism will be analysed in much more depth. In Chapter Three, I will extend this analysis and focus on the ideology of healthism, and discuss some of the implicit assumptions of H. B. P. E. In particular, focus is placed upon the notions of "health as self-control" and "health as release". Chapter Four involves a broader analysis of health prevention in the wider social and cultural context

and specific reference is made to occupational health. Finally in Chapter Five, I suggest some of the possible consequences of the adoption of the individualistic creed in health care, and provide some recommendations for current developments in health education, and I will make specific reference to H. B. P. E.

CHAPTER 2

Assumptions of Health Education

Introduction

Throughout this chapter, my intention is to highlight some of the implicit assumptions of Health Education. The concept of individualism is briefly alluded to, and its manifestation explored through reference to various examples in Health Education.

Since the approach of a cultural critique is adopted throughout the chapter, the development of Health Education programmes will be viewed in light of changes at the wider cultural and societal levels. Reference will be made on occasion to the political, social and economic dimensions which impinge upon and influence changes in health care. Although examples are cited mainly from this country and the United Kingdom, reference is also made to the United States of America and Australia. All four locales provide useful examples of how the socio-cultural contradictions of Western Capitalism appear most discernible, and of how individualism manifests itself in sometimes insidious ways. In addition, as Kirk and Colquhoun (1990) note, "the fact that there are issues common to each of these countries is important because they provide an antidote to parochialism and illustrate the extent to which international capitalism is able to generate mass culture across national boundaries" (p. 12).

Individualism: A Theoretical Critique

Following a brief introduction to the concept of individualism in society, I will reveal in detail how an individualistic creed manifests itself in the health care

system. In addition, I will cite reasons as to why Health Education has gained such ascendency in recent years.

Individualism: An Overview

The word "individualism" derives from the French "individualisme," the latter term coined by Alex de Tocqueville in his De la Democratie en Amerique, in which he explains the word's meaning as follows:

> Individualism is a mature and calm feeling, which disposes each member of the community to sever himself from the mass of his fellow creatures; so that after he has thus formed a circle of his own, he willingly leaves society at large to itself. (Cited in Devaue, 1948, p. 3)

It was after the translation of Tocqueville's book by Henry Reeve that the term passed into the English language (Devaue, 1948).

Although many political and social movements adopted in the name of individualism have been similar in the sense that they incorporate the notion of the autonomous individual to a greater or lesser extent, the term since the date of its inception has come to have different meanings in various countries. In the United States, as only one example, the word became synonymous with capitalism and liberal democracy. As Lukes (1973) notes: "It became a symbolic catch word of immense ideological significance expressing all that has at various times been implied in the philosophy of natural rights and the belief in free enterprise and the American dream" (p. 26). Individualism was perceived as the actual and imminent realization of the final stage of human progress in a spontaneously cohesive society of equal rights, limited government, natural justice and equal opportunity (Lukes, 1973).

A central assumption of individualism is that individuals are autonomous human beings, and can make decisions rationally and independently of social forces. Lukes (1973) describes this notion as follows:

> An individual's thought and action is his own, and not determined by agencies or causes outside his control. In particular, an individual is autonomous (at the social level) to the degree to which he subjects the pressures and norms with which he is confronted to conscious and critical evaluation, and forms intentions, and reaches practical decisions as the result of independent and rational reflection. (p. 52)

Many advocates of individualism espoused the need for autonomy of the person. The individual is thus portrayed as an isolated entity, with given interests, wants, purposes and needs. The society or state is perceived as a set of actual or possible social arrangements which respond more or less adequately to those individual requirements (Lukes, 1973). A crucial aspect of this conception is that the relevant features of individuals determining their ends are assumed as given and independent of social context. Lukes (1973) notes that: "This givenness of fixed and invariant human psychological features leads to an abstract conception of the individual who is seen as merely the bearer of those features which determine his behaviour, and specify his interests, needs and rights" (p. 73).

From the perspective of individualism, society is regarded as a summation of independent individuals in which the association of the parts produces no more than a superficial or mechanical community. Devaue (1948) notes that:

> This conception is called "individualism" because it is one in which society and the state are thought of exclusively in terms of the individual. In every type of individualism the individual is the main thing, not the community. Individualism has its own conception of right, apart from any assumption that there exists a society *sui generis* contraposed to the individual. (p. 59)

Society, then, is viewed as a mechanical aggregation or summation of persons, not something with its own collective identity.

A major weakness of this position is the failure to recognize the extent to which the individual is dependent upon and indeed constituted by the operation of social forces (Devaue, 1948; Lewis, 1961; Lukes, 1973). The perception of individuals as "independent centres of consciousness" (Wolff, 1968) results in an impoverished appreciation of the social nature of persons. Indeed, Devaue (1948) quotes the distinguished French Catholic sociologist, the Marquis de la Tour-da Pin La Charce, who in an article entitled "Individualism," Dictionnaire Apologetique de la Foi Catholique (1911), makes clear the lack of recognition to "the social". He states that: "Individualism is a condition of abnormal mentality, although gaining more and more influence, which is characterized by the systematic ignoring of social bands and duties, and by the rise in the cult of "the self" -- of "the ego" (*le culte de "moi"*)" (Cited in Devaue, 1948, p. 5). He goes on to suggest that : "The condition is abnormal and unnatural because the nature of man is essentially social; he can live only in a social condition. The human race is human society, humanity. It is not only in time but also in eternity" (Cited by Devaue, 1948, p. 5).

The concept of individualism is therefore constituted by some serious limitations. This is not to suggest, however, that it has had no value historically. Indeed, the creed of individualism entitled people to push for increased independence, rights, and claims. Prior to its emergence many individuals were suppressed under traditional hierarchies and privileges, with unequal social orders and ranks (Lewis, 1961; Lukes, 1973). As a result, the quest for human rights became more evident. But though there have been useful gains, individualism adopted today in an idolistic manner, has actually resulted (ironically enough) in a

new system of privilege and hierarchy, not one constituting increased human rights, but one perpetuating a system of inequality and dominance.

Overall then, individualism is an inadequate and naive conception if equality and liberty are to be taken seriously. It is essential to go beyond the notion of the person as an abstract individual, and consider in addition the social context, which enables people to exercise their autonomy, possess dignity and develop their potentialities (Lukes, 1973).

Individualism in Health Promotion

Many current health promotion programmes are based upon the individualistic ethic referred to above. In this section, my intention is to reveal the main assumptions of this approach to health. First, however, I will cite reasons for the ascendency of health promotion in recent years.[1]

The rise of health promotion. Health promotion has increased markedly in the late 1970's and early 1980's, and health preventive programmes have become more extensive within schools and community organizations. Many of these programmes have emulated commercial marketing techniques, and have made use of high profile mass media (Anderson, 1985; Tones, 1986). Accompanying many of these approaches has been an increase in self-help groups[2] and political

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[1]The later provides the historical context for the subsequent critique of both Health Education and Health Based Physical Education. A number of specific occurrences during the 1970's and early 1980's, including the rise of health care costs, the challenge to traditional medicine, and focus of responsibility for the social production of disease, gave impetus to those postulating an individualistic orientation in health prevention.

[2]See Butler et al. (1980) for a listing of some self-help groups.

activism[3] (Tones, 1986), not to mention the proliferation of government funded programmes. Taylor (1982) suggests that health promotion is "the new catchword in American Health Care policy" (p. 32), and Tones (1986) notes that the degree of enthusiasm, both in schools and the wider health promotion context, is suggestive of a remarkable new panacea against ill-health. Unfortunately, many of these programmes have been surrounded by considerable conceptual confusion as I will detail throughout this chapter.

Health care costs. Increased costs of health care, and the notion that increased expenditure on medicine has a minor influence upon health, has in many ways given impetus to health promotion (Crawford, 1980; Taylor, 1982). Wilarsky (1987) states:

> The best estimates are that the medical system (doctors, drugs, hospitals) affect about 10% of the usual indices for measuring health. The remaining 90% are determined by factors over which doctors have little or no control, from individual lifestyle (smoking, exercise), to social conditions (income, eating, habits, physiological inheritance), to the physical environment (air and water quality). (Taylor, 1982, p. 32)

Consequently, many people involved in public policy have concluded that if money spent on medicine has had little effect, it should instead be directed at alternative preventive measures, including health promotion.

The challenge to traditional medicine. Health promotion has also gained impetus from recent critics exposing the power of medicine and its domination in American life. Academics including McKowen (1979), Powles (1973), and most significantly Illich (1975) have brought to light what they argue to be the irrelevancy

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[3] Tones (1986) cites two Australian examples of such an approach: "Movement opposed to unhealthy practices ("Mop up"), and "Billboardists utilizing graffiti: Against unhealthy practices" ("Bugger up").

of medicine in maintaining health (Crawford, 1980). It has been suggested, furthermore, that medical practitioners have taken responsibility for health from the individual and vested it in abstract notions of disease and mental illness (Armstrong, 1983). Additionally, the medical profession has been criticized for having expanded its influence over problems of everyday life. Armstrong (1983) notes that "especially through psychiatry, medicine is now invading areas of human behaviour to claim that it alone has jurisdiction over them" (p. 83). As well as the increased medicalization of our everyday lives, Illich (1977) has suggested that medicine also plays a major part in creating ill-health. That is, by offering a diverse and extensive range of supportive services for many kinds of symptoms, medicine has made patients become dependent upon doctors to cope with their everyday lives. According to this argument, people become reliant upon medicine, and lessen their own individual ability to cope (Armstrong, 1983).

Many health educators have used the work of Illich (1975) and others (McKowen, 1979; Powles, 1973) to give support to the notion that an alternative means of health maintenance is required. Indeed, Crawford (1986) notes that the victim-blaming ideology in health promotion emerges alongside the argument citing the limits to medicine. He suggests that by "basing itself on the irrefutable and increasingly obvious fact that medicine has been oversold, the new ideology argues that individuals, if they take appropriate actions, in other words, adopt lifestyles which avoid unhealthy behaviour, may be able to prevent other diseases" (p. 665).

The reaction against an increased reliance upon medicine has therefore given impetus to those who postulate health education as an alternative, and

additionally resulted in a proliferation of self-help groups based on the ethic that individuals control and maintain their own health care.

Social production of disease. Another phenomenon giving impetus to the notion of health promotion and individualism in health has been the politicization of the social production of disease. Crawford (1980) comments upon the increased political awareness of social and environmental factors impinging upon ill-health and states that "widely reported scientific and popular critiques of environmental health and safety hazards have resulted in a growing awareness, concern and polarization over these issues" (p. 667).

In recent years, cancer warnings have inundated the public. Food warnings, ozone watches, and air pollution disasters have encouraged "vulnerable" people to stay inside and protect themselves (Crawford, 1980). This approach is certainly convenient for governments and large corporations. It distracts the public from the political, social and economic realities behind the social production of disease, and alternatively places blame on the individual for the problem. At times of fiscal crises in many western countries, it is clear that this shift of responsibility is most attractive. The problem of pollution, for example, is no longer on the doorstep of large corporations or the government, but upon each person in society[4]. It is certainly interesting to note the increase of individualistic health promotion campaigns during such financially insecure periods. As Taylor (1982) has put it:

> Recently the emphasis on individual behaviour has garnered more political support than efforts to tackle the social determinants of disease. Under the Reagan Administration, pressure by food manufacturers has all but killed congressional efforts to require the

[4]This is not to suggest that the role of the government is necessarily completely eradicated in terms of pollution controls, but it is to suggest that the responsibility to solve these problems may well be altered quite significantly.

> industry to include sodium content on food labels, the Clear Air and Water Acts have been attacked, and both occupational safety and Health air/Administration (OSHA) and the Environmental Protection Agency (EPA) have been seriously weakened by cuts. Meanwhile, the office for disease prevention and health promotion, which is one of the few health-related agencies to escape the Reagan cuts this year, concentrates exclusively on lifestyle issues. (p. 33)

As an example, "Cancer Prevention," a promotion agency encouraging the notion of how we as individuals can prevent cancer, received increased funding under the Reagan administration, while social approaches to cancer prevention were abruptly curtailed. Taylor (1982) goes on to say that:

> the hazardous waste programme was cut for fiscal 1982 from $141.4 million to $107.2 million, the 1983 air research budget will be 42% lower in actual purchasing power than 1981; the centres for disease controls are being systematically stripped of their scientists and researchers to mention but a few cuts. (p. 39)

It would seem, then, that despite the increased politicization of the social production of disease, individualistic approaches to prevention have been favoured.[5]

Having briefly given some reasons for the acceleration of individual health promotion in recent years, I will now discuss some of the assumptions of individualism in contemporary health education.

Assumptions of Individualism in Health Education

The notion of individualism is clearly evident in many recent health promotion campaigns. In the United Kingdom, for example, the Department of

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[5]I've only used one era, the early 1980's, and one country, the U. S. A., when making the above point. The Reagan era of the early 1980's provides a good example in terms of social policy since the individualistic creed underpins a number of health policies. This particular emphasis at the government and policy levels has given support to those who postulate health education based on the ethic of individualism. It should be noted, however, that other countries, including examples from "Thatcher's Britain" could also have been chosen. It is beyond the scope of this thesis, though, to give such a comprehensive review of this particular area.

Health and Social Security (D.H.S.S.) (1976) document "Prevention and Health: Everybody's Business," states that "much of the responsibility for ensuring his (sic) own good health lies with the individual" (p. 96, cited by Naidoo, 1986, p. 17). Although this document was important as an attempt to recognize prevention as a national goal, the ultimate message promotes only individualistic solutions. The main focus of prevention within the D.H.S.S. document is upon alteration of personal lifestyles and habits. Somewhat cynically, Draper et al. (1977) explains this new focus as a not so tacit admonishment to the public to "be responsible and pull yourselves together naughty children" (p. 124). We should therefore fasten our seat belts, take regular exercise, not overeat, change our lifestyles, not smoke and so on (Draper, et al., 1977). However, the fact that the adoption of many "unhealthy habits" and the choice of particular lifestyles may involve other social and cultural dimensions is ignored. Instead, responsibility for health is placed wholly upon the individual, and the role of the government in maintaining health is reduced or glossed over (Naidoo, 1986).

The D.H.S.S (1976) document, for example, neglects possible public measures encouraging the adoption of healthier lifestyles. Referring to potential public measures to be adopted Draper et al. (1977) suggest that:

> although the government's document mentions the high costs of road accidents, it does not raise the question of transport policies that might be utilized as one means of fostering healthier patterns of living. Equally, it might have noted that present policies (e.g., the emphasis on road rather than rail transport) undeniably cause health and accident problems. It does not seem unreasonable to suggest that it should have discussed the relative accident rates associated with different forms of travel and the high capital investment in road transport. (p. 125)

Government involvement is often reduced to ensuring that the public has access to information about the importance of personal habits on health, and as

Naidoo (1986) notes, guaranteeing that "at the very least, no obstacles are placed in the way of those who decide to act on that knowledge" (p. 62). Some advocates of the individualistic approach go even further and propose no government involvement whatsoever in health care. As an example, Knowles (1977) states that a person should "change his personal bad habits or stop complaining. He can either remain the problem or become the solution to it. Beneficent government cannot and indeed should not do it for him or to him" (p. 78).

What is clearly ignored in all of the above examples championing individual health responsibility are the social, cultural, and political aspects influencing many forms of unhealthy behaviour. Clearly explicating the assumptions of this approach in greater detail further highlights the inadequacies of such a concept of health.

Free choice. It is often postulated by advocates of individual responsibility that a significant portion of "modern diseases" could be substantially reduced if only people would alter their lifestyles and eradicate personal bad habits. Knowles (1977) suggests that "control of the present major health problems in the USA depends directly on modification of the individual's behaviour and habits of living" (p. 61). Along the same lines, Beauchamp claims that "In recent decades it has become a truism that significant portions (perhaps as much as half) of the disease and early death in industrialized societies stems from *personal risk taking* " (p. 69).

This victim-blaming approach sees the individual as responsible for his or her own iliness. Taking the logic of this position to the extreme, we must conclude that individuals can *choose either health or ill-health* as an option. As Rodmell and Watts (1986) state, "Emphasis placed to such a large extent on lifestyles implies that we can choose our lifestyles to a certain extent, we can alter our ways of life on advice from health professionals" (p. 6).

The above is not to suggest that individuals cannot make any choices with regards to their lifestyles or personal habits; however it is important to recognize and acknowledge the limitations of "free choice" in achieving health. As Rodmell and Watt (1986) comment, "making 'healthier choices easier' often requires significant transformations in the social conditions under which such choices are made" (p. 7).

Consider, for example, the complexities behind the food people eat. In terms of health, to assume that people are wholly responsible for the food they eat is inadequate, since behind the choice lies a complex food industry, including "the ubiquity of junk food advertising, the unknown risk of additives, and the widespread social phenomenon of fast food outlets" (Labonte & Penfold, 1981, p. 5). But many contemporary health education programmes, including H. B. P. E. make no reference to possible restrictions faced due to the social context. No mention is made of the potency of food advertising or the increased opportunities of food choice for those in higher socio-economic groups. As Labonte and Penfold (1981) note, the impact of poverty, poor education and the immense power of a profit oriented food processing industry is not noted.[6]

In addition, claims made with regards to the *choice* of sedentary lifestyles are equally flawed. Health promotion programmes frequently refer to sedentary

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[6]Fortunately, there have been some exceptions to this narrow-minded attitude. For example, The Centre for Health Studies at Yale University ,established in 1977, has attempted to develop a multi-disciplinary, more comprehensive approach to health promotion. As a case in point, the connection between food consumption and social institutions has been clearly drawn. The Centre states that: "If dietary factors are implicated as proximate risks for colon cancer or for heart disease, they must be understood in combination with other social factors, for example, perhaps a lifestyle requiring quick, high energy foods, the vulnerability of consumers to food advertizing, the use of chemical additives in certain types of foods in the marketplace, and the structure of the food industry" (cited by Townsend, Phillmore and Beattie, 1982, p. 3).

lifestyles and "lack of exercise" as a major reason for ill-health among Canadians.[7] Little regard is given, however, to the sedentary lifestyle imposed by industrial capitalism, or to the social constraints of accessibility to exercise facilities. As Labonte and Penfold (1981) state:

> the low level of physical activity among Canadians is not simply a problem of individuals who do not use their leisure time for physical activity, it is also a feature of all kinds of highly industrialized countries, which have, within one brief century, all but eliminated physical exertion as part of a person's normal 'working experience'. (p. 5)

They go on to say that:

> Health promotion campaigns therefore respond by comments like "it takes no time out of the working week" requires no special facilities or equipment and so on". The point, however, is that if health promotion has to make a genuine impact on a large number of people, facilities should be provided (possibly by the government), and time should be allowed *within* the working week for exercise programmes. In a highly capitalist society, where profit is the main motive, it is clear to see the resistance to such a proposal. (p. 6)

Unfortunately, little acknowledgement is given in health promotion to such operative social and economic constraints. Rather, the individualistic ethic assumes the supremacy of "free choice." This is clearly evident in the Canadian government document Achieving health for all - A framework for health promotion. It stated that: "'Quality of Life' in this context implies the opportunity to make choices and to gain satisfaction from living. Health is thus envisaged as a resource which gives people *the ability to manage and even change their surroundings*" (p. 3). It is further stated that: "This view of health recognizes *freedom of choice* and emphasizes the role of individuals and communities in defining what health means to them" (p. 3).

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[7] See for example ParticipACTion (1977).

It may certainly be useful for communities or individuals to have an increased understanding of what it means to be healthy. Such knowledge could be used to facilitate possible social and political action to achieve that end. However, the notion of free choice is inadequate without a comprehensive analysis of what constitutes such a concept or its limitations. Further, it ignores to a large extent, the substantial body of empirical evidence[8] about our social structure and patterns or ill-health under capitalism (Naidoo, 1986). Naidoo states that: "The black report on inequalities in health found that social class differences in health status are becoming more, not less, marked. The working group concluded that "it is difficult to begin to explain the patterns of inequalities except by involving material deprivation as a key concept (Townsend & Davidson, 1982). The Black Report's thirty-seven recommendations concentrated on measures designed to improve the material conditions of life of poorer groups as the most effective means of improving their health" (p. 20).

It seems mistaken to assume that illness is just bad luck or the result of poor choice (Naidoo, 1986). Illness is not randomly distributed throughout the population, but to a large extent is socially and culturally patterned. Naidoo (1986) quotes Mitchell (1984) who, in her book What is to be done about health care, states that "working class people experience more ill-health than middle-class people, not through choice but because they are exposed to a health damaging environment over which they have little control" (p. 98, cited by Naidoo, 1986, p. 20).

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[8]There is a substantial body of knowledge specifically related to social inequalities in health. The U. K. literature provides some useful sources of reference, since the 1980's saw a marked increase in the nature of this kind of work, most significantly "The Black Report" (D.H.S.S., 1980). (Other examples include Bradshaw et al. (1982); Sheffield Health Authority, 1986; West of Scotland Politics of Health Group, 1984).

To assume that health is amenable to wholly individual control and "free choice" is therefore absurd. A major flaw with this conception is the presentation of the individual as an abstraction from society, or as Niska (1982) puts it:

> the individual is portrayed as acting in a moral and social vacuum. This picture diffuses the importance of social class and social institutions in shaping the individual's life. It also obscures the role that the mythological elements of health beliefs have in determining people's actual health behaviour. (p. 42)[9]

Even when the social dimension of free choice is acknowledged, recommendations for change generally involve only individualistic solutions. For example, the Canadian document, Achieving health for all: A framework for health promotion, gives recognition to the social determinants of illness, and yet proposes health promotion as the main solution to the problem of gross inequalities in health. Initially, the document states that "Reducing inequalities, widening the prevention effort, and enhancing people's ability to cope are the principal challenges confronting us as Canada enters the 21st Century. It is toward these challenges that we must dedicate our resources" (p. 5). Having acknowledged this, however, the document fails to recommend substantial structural and social changes that might potentially begin to meet these immense challenges.[10] It implies that health

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[9]"Mythological elements of health beliefs" refer to certain myths or delusions people may hold with regards to "healthy" behaviour. These beliefs and values are formulated by the social and cultural context within which people live. Cornwall's (1984) fascinating book "Hard Earned Lives" provides some interesting examples of beliefs and values people adhere to with regards to health and illness. Documenting people's perceptions and health beliefs of a group of twenty-four individuals in a poor area of the East End of London, she exposes some examples of "myths" some people hold with regards to health and illness. Her work is important to health educators, since it is essential to acknowledge the beliefs and values people hold with reference to health and illness, and formulate subsequent "action" with an appreciation of those views. Otherwise, the result is the imposition of a white middle-class value system, which in many cases has no meaning and indeed is often futile in terms of genuine change.

[10]In terms of structural changes, as one example, this may require challenging the unequal distribution of health services as related to social class (for further detail of structural inequalities in health care see Maxwell, 1981; Allsop, 1984; Townsend, 1982). With regards to social changes, health policies for improvement may require action to alleviate poverty and unemployment within our

promotion alone will provide a main means to achieve such a goal. The document concludes by suggesting that "The experience of the past ten years has confirmed our view that health promotion provides an avenue for dealing with emerging challenges, an approach which supports Canadians in improving the quality of their health. In summary, *it offers a means of achieving health for all Canadians*" (p. 6).

Along similar lines, the World Health Organization (W.H.O.), fails to go far enough with regards to the social context of health. Indeed as Townsend (1982) states:

> Its definition of health, by virtue of concentrating upon and emphasizing positive aspects of health while ignoring negative influences, conveys a curiously passive idea of well-being and to some extent free-choice, rather than a concept grounded in political and social roles and relationships. The definition implicitly favours an individual rather than a social orientation towards health, which may be said to perpetuate the wrong order of priorities in understanding and gaining control over the phenomenon. A more thorough going social and dynamic conceptualization has to be sought. (p. 9)

A main failing of both health education programmes and health promotion campaigns is the failure to recognize the extent to which in many cases freedom of choice is manifestly curtailed by adverse social circumstances. What is required instead, "is acknowledgement of the limitations of choice, and recognition of the long catalogue of evidence of the deleterious effects of social inequalities in health. It is only then that a more substantive preventive approach, attempting to assault the social and environmental factors which limit choice can be made" (Townsend, 1982, p. 9).

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society, as well as an attempt made to improve housing conditions (see for example the Black Report, 1980).

Health care delivery and cost control: "Consumer responsibility".

Advocates of individualism suggest that each person should take responsibility for his or her own health. Many propose further that individuals be made financially accountable for their ill-health. Knowles (1977), for example, suggests that individuals' ill-health contributes significant social cost to society, including, for example, loss of productivity and increased medical and insurance costs, and consequently it is argued that these individuals should be held financially accountable to others in society for their ill-health. Knowles (1970) states that "one man's freedom in health is another man's shackle in taxes and insurance premiums" (p. 59).

A particular example of a health promotion document that emphasizes financial costs as part of its justificatory rhetoric is the British Columbia Alcohol and Drug program, "Try - The Responsibility is Yours," funded by the Minister of Labour and Consumer Services, which states that "dealing with alcohol and drug abuse costs all of us" (p. 5). They go on to suggest the following points:

- Trying to cope with alcohol and drug abuse is expensive from beginning to end: policing abuse, accidents caused by abuse, court costs, prosecuting cases, and of course, prison treatment centres.
- The medical and social services costs involved in dealing with drug abuse are staggering. In 1987, it cost the British Columbia health service system over half a billion dollars to deal with problems related directly to alcohol abuse.
- The figure probably runs higher, because many of the ongoing health problems caused by excessive or prolonged use or alcohol

are commonly diagnosed illnesses such as heart disease, high blood pressure, pneumonia and mental illnesses.

- The costs in injuries and low productivity in the work place is immeasurable. People who abuse drugs or alcohol miss work three or five times more than non-users. This means higher premiums on benefit plans, costs to employees for overtime, and substitute workers, lowered production capacity, and general inefficiency. (p. 5)

As is clear from the above, this document strongly emphasizes, among other things, the significant social cost of alcohol and drug abuse. Other advocates of the individualistic approach go as far as to suggest economic sanctions on health behaviour. Illustrative of this severe approach is a quotation Crawford (1980) cites from the New York Times. Here, in an editorial entitled "The Your Fault Insurance," the writer proposes "a reward and punishment system based on individual choices."

Such a retributive approach makes an implicit value-judgement about the health-care delivery system and the form of health education. In other words, individuals should not only adopt "healthy lifestyles," but they should also be responsible "consumers" with regards to medical care. This "consumer approach," directly derived from the market economy, again places ultimate responsibility upon the individual. The complex array of social, economic, and structural constraints, as well as individual factors in attaining health, are ignored. Again, individualistic solutions are proposed, including self-help groups and behaviour modification techniques (Draper, et al., 1987). As Green notes in his article,

"Health promotion policy and the placement of responsibility for personal health care,"

> Health providers must recognize that most consumers are ready and willing to learn self-care skills, but this alone will not achieve increase in health and economic benefits unless providers simultaneously make adjustments in the delivery system and in their own attitudes and responsiveness to new consumer roles. (p. 53)[11]

Green postulates limited resources and economic restrictions as the main rationale for individual responsibility. He further suggests that "in a system of limited resources, ultimate responsibility for health care should be shared by individuals, families and self-help groups" (p. 57). Individuals in society, then, are to be motivated to adopt alternative means of individual prevention. Some advocates of this approach go as far as to suggest "Rules for Self-health." Smith (1976), for example, states that "it is what we do by the hour, day by day, that determines the state of our health; whether we get sick, what we get sick with and perhaps when we will die" (p. 199). Two of his rules for self-health are as follows:

- Learn to relax. A playtime is important for children of all ages.
- Take regular vacations and be sure to schedule time away from the kids.
- If drugs (alcohol, tranquilizers, sedatives, stimulants) are a part of your usual day, cut it out. (p. 199)

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[11] "Consumer roles" implies the need for individuals to be responsible consumers and "shop around" for medical care. Health care is perceived as a "good" to be bought. However, this concept is limited, since it fails to acknowledge the huge array of structural inequalities embedded within the institutional system of medicine, including access to medical care of different ethnic and socio-economic groups. As an example, the December 1990 edition of "Harpers Index" states: "Average amount of time a black American waits for a kidney transplant in months: 13.9 Average amount of time a white American waits in months: 7.6." Hence, failure to recognize these factors merely perpetuates social inequality of access to medical care. Also the deeper rooted problems, like that of racial bias, within U.S. society, are not tackled.

Although suggestions such as the above seem desirable and appropriate on health grounds, the implied message is that all individuals merely have to resort to self-will in order to effect positive change in their well-being. The absurdity of such statements becomes obvious, however, when we consider the social context within which many people live. "Taking regular vacations," for example, is not a feasible option for many people on low incomes, and "scheduling time away from the kids" is difficult, if not impossible, for many parents, including single mothers and fathers. Eliminating an habitual reliance upon drugs often requires solutions more complex than merely "cutting out" stimulants.

In addition to the inadequate conception of these individualistic solutions implying responsible "consumer" choice of healthy lifestyles and health care, the above orientation lends support to advocates of cost control in the medical system (Crawford, 1980). Concerned with utilization reduction and cost control measures, many health promoters utilize a victim-blaming ideology that subtly shifts the responsibility of health costs to the consumer (Crawford, 1981). It is also interesting to note that many contemporary health promotion campaigns[12] have adopted "marketing approaches" to reinforce this preference for a consumer orientation towards health. With regards to recent attempts by the U.K. Conservative government to restructure the National Health Service (N. H. S.), for example, Rodmell and Watts (1986) state that "'cost effectiveness' and 'maximization of a revenue profile' are current catch phrases, indicating the increasing trend towards the marketing of health as a commodity, and the NHS as a business" (p. 12).

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[12]See for example Look After Yourself (1978), Play it Safe (1981), and The Great British Fun Run (1985). All three were organized by the Health Education Council (H.E.C.) in conjunction with other agencies.

The Great British Fun Run in May and June 1985 provides a direct and concrete example of the attempt to market health as a consumer product (Naidoo, 1986). As "Britain's biggest ever health promotion campaign" (H. E. C., 1985), the Fun Run encouraged individuals to take up one or more forms of physical recreation as a regular activity. Again Naidoo (1986) notes, like other health campaigns, it fails to acknowledge the prohibitive social context in which many less financially secure individuals live.

> The cost involved in using private exercise facilities and the lack of adequate public provision was not addressed by this campaign. To do so would have involved a fundamental rethinking of the premises of the campaign. The decision to exercise or not is informed by many factors, of which health beliefs are but one. Convenience, cost and accessibility are other relevant factors, but to tackle these would require the use of different strategies such as lobbying. (p. 27)

Although the ideology of this particular campaign was clearly one of individualism, unlike other H. E. C. campaigns, the GBFR relied heavily upon marketing health as a consumer good (Naidoo, 1986). The race's sponsorship by Allied Bakeries heavily influenced the content of the campaign, and as Naidoo (1986) further notes:

> This kind of advertising of health promotion, relying heavily on mass media advertising, addresses the individual as a consumer whose buying decisions are capable of manipulation by a wider variety of techniques. Advertising works by equating "X" product with some desirable quality such as "manliness" or "sociability". The commodity being advertised acquires, by association the concrete expression of this desirable quality. Thus to achieve status, or happiness, all one needs to do is to purchase "X" product. (p. 28)

As is the case with advertising of any specific consumer product, health campaigns in some cases resort to sloganism in order to suggest an often erroneous connection between physical fitness and greater personal success or happiness. Indeed, slogans are increasingly being used in health promotion, and

many of these slogans make direct or indirect allusion to sexual satisfaction or guile. As an example of an inappropriate slogan, Naidoo (1986), makes reference to the Australian Breast Self-Examination Campaign (1983) which used the catchphrase "*I do it once a month in the shower!*" Although it proved very effective in terms of behavioural change with regards to regular breast examination, the slogan, with its obvious sexual connotations, can be interpreted as being exploitive of women. Change of behaviour has therefore been brought about at the expense of portraying women as sexual objects.

It is clear, then, that individualistic strategies in health care often encourage a "consumer mentality" with regards to lifestyle choice. In addition, many health promotion campaigns rely upon a marketing approach that encourages "consumers" to "shop around" for the best "deal" in health!

Conclusion

In conclusion to this chapter an attempt was made to give a broad historical and contemporary context to individualistic health education. I highlighted several factors -- rising health care costs, the challenge to traditional medicine, and the social production of disease -- as examples of instances which may well have provided support to those advocating an individualistic focus in health prevention. In the latter part of the chapter I revealed some of the assumptions of the individualistic approach in contemporary health education. It was suggested that this approach to health maintenance, as the only means of prevention, is limited in its conception since it assumes individual "free-choice" which does not always exist in terms of health behaviour, and it promotes a consumer orientation in health care.

In the following chapter I will elaborate upon the notion of individualism in health prevention as it relates specifically to Health Based Physical Education (H. B. P. E.). It is interesting to note that many of the assumptions underpinning general health education are also resembled in the physical education context of H. B. P. E. (Indeed, health education in the wider field may well be a significant driving force in terms of influencing and orienting the physical education curriculum.) Having given a general overview to a commonly held assumption then, the ethic of individualism, in the following chapter I will show how this notion manifests itself in the physical education context, and will explore this through specific reference to examples in Health Based Physical Education.

CHAPTER 3

Assumptions of Health Based Physical Education

Introduction

Having exposed some of the key individualistic assumptions that underlie general health promotion, my purpose now is to show how the ethic of individualism manifests itself in the form of "healthism,"[1] and, in particular, how the covert acceptance of individualism leads to certain taken-for-granted assumptions within the H. B. P. E. movement. It is essential that the implicit and explicit messages of H. B. P. E. be examined, particularly when we consider the interconnectedness between the body and culture, and possible tacit messages conveyed to young people through the physical education curriculum (Coquhoun, 1990). This chapter makes specific reference to the social construction of the body and to consumerism, and examines the impact of broader cultural movements and trends upon the conception of the body. Historical examples illustrating the interconnections between body image and culture will also be examined. How the body is judged by social standards, the way individuals attach physical importance to the self, and the significance individuals attach to the body all vary with historical circumstances (Freund, 1986). And since H. B. P. E. programmes are involved in projecting an "idealized" image it seems important to provide a basis of contemporary and historical examples to further our understanding of the overall conception and shaping of such images.

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[1]This term was coined by Crawford (1977) to refer to the individualistic orientation in health.

The Body as a Cultural Object

A main failing of H. B. P. E. has been a lack of recognition of the notion of the body as a cultural object. Although the body has been subject to critical analysis within a cultural or social context (Featherstone, 1982), on a general level, the overriding perception of the body as a machine, with its concomitant emphasis on biomedical definition, has resulted in a failure to acknowledge the body as a social and cultural entity (Hargreaves, 1986, 1987; Kirk & Colquhoun, 1990). Indeed, as Armstrong (1987) notes with reference to medical sociology, the few sociological studies on the body which have been carried out, often question the supposed "universal" and "true" character of the biological basis of the body (Wright & Treacher, 1982), or study the social aspects of disease of the body. Yet rarely, if ever, do these studies question the actual vision of the body itself. Both general and medical sociologists have accepted the human body as the starting point of their analysis. This is inadequate, since there is a failure to truly acknowledge the notion of the body as a social and cultural object, and as an object not to be studied as a point of commencement, but instead as an end product of social forces (Foucault, 1977) and cultural influences (Armstrong, 1987).

Throughout this section then, specific attention is given to the relationship between the human body and culture. In terms of the concept of health, this is particularly pertinent since the symbolic category of "health" is often structured through bodily experience, and in particular through body shape (Colquhoun, 1990; Crawford, 1986). The body acts as "a powerful medium through which we interpret and give meaning and expression to our individual and social experience" (Crawford, 1986, p. 60). In addition, the manner in which we view the body within

any given historical context reveals many tacit assumptions of our existence. As Crawford notes,

> Bodily states are key markers in which are invested the social definitions of the self -- not only regarding role, but normality and abnormality, inclusion and exclusion, domination and subordination. The body also supplies a universally experienced model of living and dynamic unit, an organic whole, a prototype which we can draw in our attempts to explain and give meaning to larger social units and experiences. (p. 61)

The body acts not only as a medium through which we make meaning of our social world, but it is also a direct reflection of that world, of "the social body" (Crawford, 1986). In the following pages I will therefore elaborate on the notion of the body as a social and cultural object and show how H. B. P. E. lends support to a particular conception of the physical body.

Healthism and H. B. P. E.

Crawford (1981) coined the term "healthism" to refer to the individualistic ethic prevalent in the health conscious movement. As an ideology, it serves to depoliticize the social determinants of illness, and further reduce complex etiological factors to simple behavioural or lifestyle factors. As mentioned in Chapter 1, it appears "natural" and "given" that individuals be wholly responsible for their own health. Further, Crawford (1986) identifies two themes emerging from this ideology: "health as self-control" and "health as release," both of which provide a useful basis from which to analyze H. B. P. E. programmes (Colquhoun, 1990). Consequently, in the following pages I will first show how both notions are implicit in H. B. P. E. Next, I will propose that these twin notions derive from certain assumptions inherent within the ethic of individualism.

Self-Control and Healthism

"Health as self-control" incorporates the belief that individuals, in order to achieve a healthy state, must assert self-discipline and will power, and adhere to a long list of prescriptive "do's" and "don'ts". Implicit in this notion is the view that "health" is not a given or something we should possess automatically, but something we should work to achieve (Crawford, 1986). A healthy body state is therefore seen as essentially dependent upon the behaviour, habits and lifestyle one chooses to adopt. Those who fail to achieve this state of optimum health are thus led to feel guilt and disappointment for not adhering to particular health standards or norms (Colquhoun, 1990). Health as self-control emerges in H. B. P. E. through the endorsement of a particular conception of healthy lifestyles and the technocratic presentation of the human body as a machine. Both assumptions serve to depoliticize the concept of health and reinforce the notion of self-responsibility in health maintenance. In the following pages I will show through reference to the British Columbia Active Health Program, how both assumptions serve as an impetus for many H. B. P. E. proposals. I will reveal further how they constitute Crawford's first mandate of "health as self-control."

Self-Responsibility, Self-Control, and Lifestyles

Similar to health education in the wider context, the British Columbia Active Health program places emphasis upon behaviour and the alteration of lifestyles. It is clear to see from student graph #13 called "My Lifestyle Profile" (p. 200), that the notion of self-control and individualism provide the main focus. Students are informed that they should be "responsible," have a "sense of purpose," and "be in control of life's changes" (p. 200). Indeed, the teaching guide states that one of the

learning outcomes of the activity is "to assist the student in accepting personal responsibility for their (sic) health and fitness" (p. 47).[2] The worksheet corresponding to this graph also reiterates the notion of self-control and individualism in health maintenance. Students are asked to consider and comment upon the following statements:

- My diet contains adequate amounts of vitamins, minerals and fiber
- I nurture myself -- (take) pleasure in taking care of myself, e.g., long walks, buying presents for myself, "doing nothing," sleeping late without feeling guilty, meditation, doing things for the fun of it, having creative outlets
- I believe I am fully responsible for my wellness or illness.

(p. 199, Active Health Program)

These considerations are similar to the "Rules of Self-Health" referred to by Smith in the previous chapter, and it is clear to see the absurdity of some of these statements when we consider the social context within which many students live. It would seem that the diet and nutritional status of many students would be influenced substantially by their home, social and cultural environment. Also, the extent to which all students have the opportunity for "creative outlets," "meditation," and opporunities to "buy presents" for themselves, would seem attainable only by the select few.[3] Again the final statement places emphasis on complete self-responsibility, and shows an insensitivity to the external social factors impinging

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[2]As another example, see worksheet, p. 213, "Life Management Skills and Wellness".

[3]With regards to the latter point, it seems absurd that "buying presents" comes to be associated with the notion of living a healthy lifestyle. This seems, if anything, to give tacit endorsement to consumerism and materialism, an endorsement which may have no place in schools.

upon ill-health. Even when the Active Health Program refers to "social health," it does so only in the psychological sense. No reference is made to the political, social or economic dimensions of health. Worksheet #1, entitled "The Relationship of Exercise to Total Health" (p. 143), provides a good example. Presumably, "social health" here is equated with "self-concept and appearance" and "social interaction." Other references made to "social health" reduce the notion to issues of health and lifestyle management, which again shows an inadequate understanding of the complexity underpinning the social dimension of health. The concept of health incorporates ethical, social and political dimensions, and to reduce these multifaceted dimensions to issues of management or life skills is to impoverish the concept. The Active Health Program, by placing its main focus on health and lifestyle management and behaviour modification techniques,[4] not only colludes with the ethic of victim-blaming, but also endorses superficial and inadequate measures by which to cope with complex health problems. As an example, students are told that they are required to "cope" and "adapt" to life's stresses, as opposed to making an attempt to examine the root of the problem contributing to stress. After completing worksheet #21 (p. 122), "Keeping Track of Your Stress," students are advised that:

> A high stress rating on the quiz could mean that an individual simply isn't handling the stress in his/her life and needs to learn how *to manage* the stress. (p. 97, original emphasis)

The extent to which students really do have the potential to be in control of their personal, financial/legal, health, family and work problems does, however, seem open to question. Yet, throughout the Active Health Program document,

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[4]See for example pages 37, 83, 125, 161 and 203 in the Active Health Program.

"self-control" by the student is assumed and behaviour modification techniques to solve various health problems are proposed. The notion of self-responsibility is clearly evident throughout. Students must cope with stress, and failure to do so demonstrates an individual weakness.[5]

In a vein similar to the Active Health Program, other related literature may acknowledge the social dimension of stress, yet still suggest strategies for change that resort to "coping mechanisms." The root or cause of the problem remains unexamined. The article, "Life in the Fast Lane -- The Health Issue of the 90's," in the Globe and Mail's health magazine (June 1990) provides a good example. The article initially describes the increased stress in the social dimensions of lifestyle faced by those in the 1990's. The article states:

> Children today face a far more aggressive world. In the 50's and 60's North American children grew up in a relatively safe environment. They faced a seemingly secure financial future, and the Great American Dream was within their grasp. Women, too, face ever-increasing stress. The struggle for equality, particularly in the workplace, has driven many women to the brink of nervous breakdowns and beyond. While the opportunity for professional advancement has improved over the years, many women continue to feel driven to perform beyond their male counterparts. And that vision is coupled with the reality that despite professional achievement at work, women remain the prime care givers in the home and assume all the responsibilities that that entails. (p. 24)

Although it would be possible to take issue with some of the claims made above, the significant point to be made here, is that the writer, having outlined possible social factors, still concludes the article by proposing individualistic solutions. He states that:

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[5]This in itself can be problematic, since the guilt that is produced for being held responsible for something out with the individual's control can be emotionally harmful and actually create ill-health (Watt, 1988). Combs (1989) also notes that "health education which ignores the very real restrictions on choice which for many people, lie outside their control, perpetuates an illusion and a distortion of reality" (p. 70).

> Stress comes in many forms and while the perception is that stress is an external pressure, it is more often than not an internalized process. The burdens we place on ourselves are often based upon what we perceive to be reality, rather than what actually exists. (p. 28)

The result is a form of victim-blaming and a concurrent failure to analyze the social and structural dimensions of the inequalities he refers to. As another example, some researchers (Lazarus, 1966; Moss, 1973) have suggested that a failure to cope with alienating work conditions is a failing of the person to adjust to "routine" or "authority" (Freund, 1981). Consequently, "coping strategies" are proposed to help the individual come to terms with these conditions. That the conditions are often an artifact of the social structure within the organization is often ignored, and as Freund (1981) notes:

> Institutional environments vary in their destructiveness. Because of deeply rooted economic and social contradictions, such environments often render individual coping skills ineffective or at best provide a precarious buffer between individuals and the structurally produced events that overwhelm them. The failure to cope is often seen as an inadequately socialized individual, rather than an outcome of a situation in which coping is made more or less possible. (p. 60)

In terms of examining the problems embedded in the social structure and the effect of those problems on an individual's health, it is obvious that the solutions proposed in both British Columbia's Active Health Program and the examples from other health-related literature cited above are limited in their conception since the social sources of ill-health remain unchallenged (Watt, 1986).

Self-Responsibility and the Body as a Machine

The notion of "self-control" in healthism is reiterated in H. B. P. E. through the presentation of the body as a machine that can be fine tuned and perfected. Emphasis is placed upon a technocratic ideology, with a focus on physiology and

measurement. Consequently, the body comes to be viewed as an instrumental entity to be manipulated in order to achieve the desired ends. As an example of this kind of portrayal of the body in health education, Colquhoun (1990) cites from the Australian "Body Owner's Manual," which establishes a metaphorical link between the human body and a smoothly functioning automobile engine:

> **Neville's main problem was that he failed to take control and organize a regular maintenance check for both himself and his car.**
>
> **To Take Control**
> (1) You need knowledge about how things work.
> (2) You need knowledge about the needs of the parts.
> (3) You need skills to maintain those parts.
> (4) You need a regular maintenance plan.
>
> **Being Healthy** ... means all systems "Go" ... and requires regular checking of each system.
>
> (B.O.M. (1984), cited by Colquhoun, 1990, p. 232)

It is clear to see that the machine metaphor lends itself nicely to a simplistic view of the body (Colquhoun, 1990). This technocratic approach diverts questions away from considerations of the value of particular activities, contributes to a depolitization of H. B. P. E., and ignores the notion of the body as a cultural and social object. In contrast, the body is presented in a simplistic manner. All the individual is required to do in order to achieve health is to maintain his or her body, in the same fashion he or she would maintain a car. Similar to the Australian B. O. M., the Active Health Program's emphasis on physiological "do's" and "don'ts" requires vigilance on the part of the person. The notion of self-control and self-responsibility is clearly evident, and as Colquhoun (1990) notes:

> Individuals need to look after themselves and need a certain amount of self-control to be able to organize regular service and

> maintenance. Indeed, regular servicing and maintenance are desirable and essential. If an individual does not subscribe to his/her maintenance schedule, "the fault" is theirs -- a reinforcement of the "your fault dogma" and victim-blaming approach. (p. 232)

Because self-control manifests itself in physical terms, the body is perceived as a biological entity able to be manipulated by certain processes. The assumption is one of practical logic -- the belief that treating the physical body will bring about increased health in society at large (Colquhoun, 1990; Crawford, 1986). This kind of conception underlying body maintenance messages makes an appeal to the rationality of self-preservation, and offers incentives of longevity and lowered risk of disease (Featherstone, 1981).

Likewise, there is an appeal to a "futuristic perspective" based on the notion that coronary heart disease is now a pediatric concern (Colqhoun, 1990). Hence, the message is that if we maintain bodily health during both childhood and adulthood, "health" in society at large will be achieved (Colquhoun, 1990; Crawford, 1986; Featherstone, 1983). Colquhoun (1990) cites an example of this futuristic perspective from his qualitative study of health attitudes among children in Queensland elementary schools.

> Colquhoun: Why do you think you do daily fitness?
> Student: To keep fit ... *not to be fat*... You need to exercise to use all the food up ... have a good time ... *to keep your heart healthy* when you're young.
> Colquhoun: Why is that important?
> Student: So you don't have a *heart attack* when you are older ... or *blood clots.*
>
> (p. 235, original emphasis)

The body then, is viewed as an object to be controlled by scientific processes. In an effort to protect this medical and futuristic perspective, the body as an object of rational control is treated as unproblematic. The fact that this instrumental or practical logic can only be understood in the context of culture is

ignored (Kirk & Tinnings, 1990)[6] The result is a one-dimensional presentation of the body wherein the body is portrayed as a socially and culturally neutral entity and physical health or ill-health is regarded as an individualistic concern. It therefore seems hardly surprising that most health education documents implicitly carry a normative image of an acceptable healthy individual.[7] The following excerpt from the U. K. document, "Fitness for Life," lends itself nicely to such a prescribed image.

> The Bad News. Keeping Fit Won't:-
> Make a small person tall!
> Making long noses shorter!
> Change the shape of your face!
> Change the shape of your bones!
>
> and then
>
> The Good News. Keeping Fit Will Help To:-
> Make a fat person slim!
> Make a weak person stronger!
> Make me supple if I'm stiff!
> Make me look better and feel better!
>
> Finally, it ends with the plea:
>
> Don't become a dull, pampered armchair athlete... get up ... get out ... get fit. ... Discover enjoyment, the excitement, the challenge ... USE IT OR LOSE IT.
>
> (Fitness is Fun, cited by Evans & Clark, 1989, p. 133)

The above example and the B. C. Active Health Program both imply the physical (and perhaps even the moral) superiority of the "Active Mesomorph." Both these examples of health based literature function to devalue other body types

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[6]This is not to suggest that scientific knowledge about C. H. D., for example, is not of value. Clearly it is, and children should be made aware of it. However, it must be understood by health educators that the application of this knowledge occurs within a cultural and social framework.

[7]See page 63 in the British Columbia Active Health Program.

within our culture, including the ectomorphs and endomorphs. Indeed, as Evans and Clark (1989) state:

> There is, in effect, a double distortion in (health-oriented) discourse. It not only represents or signifies one particular image of the body, it also devalues other "bodies" which are "recontextualized" as having less value. (p. 169)

The descriptions in the Active Health Program are not merely idealized descriptions of body shape, but also convey strong moral messages. Kirk and Tinning (1989) state that:

> To be fat, for example, elicits moral reproof. These descriptions, particularly those of the media, have such a powerful impact on people, precisely because they go beyond rational descriptions to become moral imperatives. Indeed, since the body has such a powerful impact on people's lives, it seems of little surprise that these messages become internalized within the individual and located in the moral category of guilt and reproof. (p. 6)

It would seem that many images portrayed in British Columbia's Active Health Program may reinforce feelings of alienation many teenagers already experience with regards to their bodies. If we bear in mind that many adults in North American culture, especially women, already have a negative body image, this focus on physical perfection is problematic. In her book, "The Obsession -- Tyranny and the Cult of Slenderness," Kim Chernin (1981) notes that the majority of women dislike their bodies because they see them as overweight and spend a major part of their lives trying to make them a shape they weren't genetically meant to be. She further notes that "food is a constant factor in the lives of many women, whether it be counting calories or trying to ignore constant feelings of hunger while living on 600 calories a day" (p. 91). The Active Health Program, in placing emphasis on body composition and nutritional counts[8], may therefore be

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[8]See page 190 in the British Columbia Active Health Program.

inappropriate for many teenagers already self-conscious about their bodily shape and appearance. Additionally, there is also a failure to recognize the fact that the size of the body is often a matter of highly subjective individual preferences and natural endownments (Chernin, 1981).

In conclusion the presentation of the body as a machine, and the emphasis placed upon the mesomorphic shape as the ideal, result in a failure of the health or educational professions to examine critically the social construction of these body images. Issues of gender, ethnicity, and social class differences are not touched upon. Conversely, the body is viewed through the eyes of scientism, perceived to be culturally and socially neutral, and promoted as an object to be slenderized and toned in order to increase its social value and acceptability (Bain, 1990).

Release and Healthism

Crawford (1986) refers to "health as release" as the second component of the ideology of healthism. In contrast to a discourse of "controls," "will-power," and "discipline," there exists their opposite, and Crawford (1986) notes that "the releasing motif suggests pleasure-seeking rather than ascetic self-denials, the satisfaction of desire instead of the repression of desire. Release is the antithesis of discipline, a de-engagement or extrication from imposed and internalized controls. Instead of a language of willpower and regulation, there exists a language of well-being, contentment and enjoyment" (p. 81).

In contrast to the notion of self-control, there exists a discourse of immediate gratification, or as Colquhoun (1990) puts it, there is

> A prerequisite for such a view is to be a non-worrier free from stress. There is a feeling of "live for today" -- a sense of immediate gratification or indulgence unlike the delayed gratification of the exponents of health as control which has a futuristic perspective. In fact, for advocates of release, present self-denials may lead to a "fetishism of self-control" where almost any behaviour is perceived as harmful. Alternatively, release may be seen as an acknowledgement of a lack of self-control -- a reaction against "thou shalt not" mentality, a release of "long suppressed desires" (p. 241).

The notion of "health as release" is a major component of the justifiability rhetoric of the H. B. P. E. movement (Colquhoun, 1990). Not only are students presented with the concept of delayed gratification, i.e., that will power and self-control in the present will guarantee some futuristic reward, but the rhetoric paradoxically espouses notions of immediate gratification. Indeed, as Colquhoun (1990) notes, instead of concentrating upon the controlling nature of physical activity (i.e., in terms of CHD), advocates of H. B. P. E. espouse the notion that physical activity enhances the "quality of life," makes us "feel good," "look good," "have fun" and so on. All suggest immediate rewards rather than grueling self-denials (Colquhoun, 1990; Featherstone, 1982). It is the curious juxtapositioning of the notions of "health as release" and "health as self-control" that displays "a logic of freedom and constraint which in advanced capitalist countries is an inherent contradiction between production and consumption" (Crawford, 1986, p. 81). On one hand advocates of H. B. P. E. espouse the need for us to abstain and control our behaviours yet, on the other hand, propose that we should "have fun," "enjoy life" and attain the "good life." And the latter, of course, becomes synonymous with the freedom to consume in Western Capitalism (Berger, 1972; Crawford, 1981; Ewan, 1976). The former constitutes fundamental values of production in the western world (Haley, 1978; Weber, 1930; Whorton, 1982). That is, in order for companies to reap the rewards of production, they must exercise a substantial

degree of control over their workers, and workers must exercise self-control in order to meet high levels of production. However, a high level of consumption must also occur within capitalism, and paradoxically, the mode of consumption involves that of immediate gratification, as opposed to rigid controls. (Although the consumer is in many ways controlled, the rhetoric espouses notions of joy and pleasure-seeking.)

Before exploring further the connections between the social construction of the body and industrial power relations, it is probably worth noting that much of the rhetorical veil of the present H. B. P. E. movement is certainly not new. The notion of "health as release" and pleasure-seeking was an integral, almost hedonistic premise of early 20th century sport. Mozorek (1989) notes that:

> In the first few decades of the 20th century the pursuit of enjoyment and the conscious quest for personal satisfaction were becoming legitimate goals in their own right. It was as if fun and personal gratification themselves were somehow socially "useful," perhaps as an individual effort to construct "the good society," and to fulfill the pursuit of public happiness by attaining it one person at a time. By the 1930's it was to become a virtual duty to "have fun" and "enjoy yourself". Having fun meant using your body as a vehicle of gratification and pleasure. (p. 20)

The conscious celebration of the body and the intentional pursuit of pleasure that characterized the 1920's and 1930's spurred a host of new slogans and phrases that came to be applied to fitness and health. The term "shaping up," for example, originally referring in the 1880's to the preparation of cattle hides and later to the fattening of stock before slaughter, was incorporated into the health and fitness rhetoric (Mozorek, 1990). Even today, the H. B. P. E. movement espouses a similar rhetoric of pleasure seeking with an underlying enthusiasm for the body. The modern movement emphasizes a casual and comfortable embrace of the physical body and celebrates what it can do without any accompanying

explanation or justification (Green, 1990; Mozorek, 1990). Current slogans include, for example, "Just do it," "Don't be fat ... be fit," "Make the most of yourself," "Look after yourself," "Shape up for life," and so on.

Power, Control and the Body

"Health as self-control" and "health as release" both provide means by which to exert power over the body, albeit in opposing ways. Why such mandates should exist in the first place, may relate to the wider cultural and social forces being exerted upon the physical body (Colquhoun, 1990: Kirk & Tinnings, 1990). Within society, the physical body has been used as a means to impose power, and power has been used to constrain the physical body. For instance, as Foucault (1980) notes, "in a society like that of the 17th Century, the king's body wasn't a metaphor, but a political reality. Its physical presence was necessary for the functioning of the monarchy" (p. 55). Therefore, the physical body of the king, and rituals of the monarchy were used to impose power over others in society. The physical body, however, is also a reflection of that social body. The following quote from Bourdieu (1990) is illustrative of the reflection of "the social body" through "the physical entity". He states that:

> Every social order systematically takes advantage of the disposition of the body and language to function as depositions of deferred thoughts that can be triggered off at a distance in space and time by the simple effect of replacing the body in an overall posture which recalls the associated thoughts and feelings, in one of the inductive states of the body, which, as actors know, give rise to states of mind. Thus the attention paid to staging in great collective ceremonies derives not only from the concern to give a solemn representation of the group (manifest in the splendour of a baroque festival), but also, as many uses of singing and dancing show, from the less visible intention of ordering thoughts and suggesting feelings through the vigorous marshalling of practices and ordering disposition of bodies,

> in particular the bodily expression of emotion, laughter and tears. (p. 69)

Foucault (1980) is essentially in agreement when he states that "the phenomenon of the social body, is the effect not of a consensus, but of the materiality of power operating on the very bodies of individuals" (p. 55).

Social Control and the Body

Regulation of the body has been influenced significantly by production and consumption in society (Foucault, 1980). With regards to increased levels of production of early capitalism, Freund (1982) notes that the result was an increased emphasis placed upon the importance of self-control, a disciplined use of time, and an assertive way of life. People therefore came to believe in greater self-reliance, increased self-imposed criticism, and analyzed their internal states (both physical and psychological) to account for failure (Freund, 1982; Fromm, 1965). These changes, however, also resulted in an internalization of bodily expression, including, for example, the emotional expression of anger. Hence, immense power was exerted over the body by the mode of production. This power derived from the imposition of highly refined controls over bodily movements (Foucault, 1980; Freund, 1982).

A number of scholars have noted, however, that the form of control over the body has altered significantly in recent years. Prior to the middle of the 20th century the form of control was disciplinary and overt. In contrast, modern social control does not comprise overt forms of coercion and repression, but involves subtle means of control, through not so obvious means (Freund, 1982). Foucault, in an interview with Gordon (1980), comments on the change in the nature of

control exerted over the body. In reply to the question, "What is demanded of and what power is exerted in a capitalist society?" he replies that:

> From the 18th century to early 20th century, I think it was believed that the investment of the body by power had to be heavy, ponderous, meticulous and constant. Hence, those formidable, disciplinary regimes in the schools, hospitals, barracks, factories, cities, lodgings, families. And then starting in the 1960's, it came to be realized that such a cumbersome form of power was no longer indispensable as had been thought and that society could content [sic] themselves with a much looser form of power over the body. (p. 58)

It is this latter form of control, referred to by Foucault, which manifests itself in healthism and H. B. P. E. This "civilized" form of control implies that the individual is at the centre of his/her world, and bears responsibility for "making it" and moving through that world (Crawford, 1986; Freund, 1982). However, despite this all pervasive illusion of freedom, constraints are nevertheless imposed on the body and its expressions. Contrary to the disciplinary control of the 19th century, constraint occurs in an increasingly covert manner. Freund (1982) notes that "it is the embeddedness of controls inside the body, social controls such as personal internalized control, the reliance on information manipulation (for instance, propaganda, public relations, etc.) and other forms of indirect coercion that constitute its invisibility" (p. 21). This form of control is insidious since it succeeds through mystification. That is, although there may be the perception of freedom (like the notion of "health as release"), in practice many activities act as an instrument of domination over certain socio-economic and ethnic groups (Crawford, 1986; Freund, 1982). As a result, many elements within our society, including socal inequalities are not tackled, since there is the superficial illusion that all people, regardless of gender, class or ethnicity have equal opportunity to succeed.

The Consumer Culture and the Social Construction of the Body

My intention in this section is to show that advertising and consumerism has exerted substantial power over the social construction of the body. Increasingly, the notion of lifestyle management has been "sold" and marketed to a wide social audience, and the marketed emphasis is placed upon appearance and bodily presentation (Featherstone, 1982). H. B. P. E., in placing priority on "bodily maintenance" and the self-preservationist conception of the body, has also endorsed this consumer lifestyle. Within the wider health context, advertising has been repeatedly used to reinforce a consumptive ideology. The visual media, for example, has utilized increasingly diffuse lifestyle imagery associated with material goods and possessions (Featherstone, 1982).

Although the advertising of health and lifestyles has increased markedly in the 1980's, and now often incorporates a materialistic focus, the influence of advertizing in terms of the social construction of the body has been operative for over 100 years (Green, 1986). Before elaborating on the contemporary situation, therefore, it is probably worth examining certain historical instances of health advertising. Such commercialized images of health and the idealized human form show the extent to which the definition of what counts as an "acceptable" body (in both shape and expression) varies within different social and historical contexts. In addition, the ideology of healthism becomes discernible through an examination of the depiction of the body within the changing iconography of advertisements.

In the United States of America, the notion of "health as release" was evident in the early 19th Century,with notions of pleasure seeking and hedonism clearly linked to the human body. The physical body was perceived as an object or

vehicle through which to attain "the good life'" and, along with this directive to pursue "the good life'," a series of slogans espousing notions of joy and celebration of the body appeared in advertizing format (Lears, 1989). Even such sundry products as Shredded Wheat (1909), Lifebuoy (1917) and Gillette Razors (1926) promised buyers feelings of exhilaration and a sense that it was great to be alive (Lears, 1989). In stark contrast to this hedonistic message, however, late 19th century advertizing projected a sterilized and controlled image of the body, with emphasis being placed upon the notion of "cleanliness" and the biological basis of the body. The result of this scientism was an obsession with the controlling of biological body processes, and this obsession was reflected in the advertizing of products that would "cleanse" the body. As an example, due to the expansion of cities and the closer proximity of urban residents, natural body odor was no longer accepted as the cultural norm. Consequently, deodorant for women was advertised extensively and in general use by the 1930's (Lears, 1989). The shift in the perception of the body and the obsession with its purification was also reflected in the advertizing iconography of laxatives. As Lears (1989) notes, "the mid 19th century witnessed images of medieval obsession with body purification, as well as the need to make the body a fit dwelling place for the Lord's divine grace, yet by the late 1920's and 1930's the rhetoric had become shriller with the emergence of a new preoccupation with "auto-intoxication" and obsession with biological processes" (p. 61). What is most significant about these historical examples is the manner in which advertizing repeatedly conveys what is socially and culturally acceptable in terms of bodily condition. With regards to the contemporary situation in health, little has changed -- the consumer culture projects images of what we should become (Berger, 1958). It proposes, in other words, that we are at the

moment of viewing "something else" and that by buying a particular product we can become "something more" (Foster, 1988).

Advertising has been particularly influential, for example, in terms of conveying images concerning female body shape, and, of recent, has begun to target male groups as well. The individual consumer is bombarded with images of "the ideal body shape," with the result that "the physical self" is kept in constant flux as the person tries to physically replicate these images (Freund, 1982). One need only scan recent fitness magazines to observe the prolific and persuasive power of these advertizements. For instance, the April 1991 issue of *Men's Fitness*, contains an advertizement that begins with the admonishment "You'll wish you'd done it sooner" (p. 78). It then continues to describe a complete array of plastic surgery that promises to "give you the look you want." Several physical reconstructions are referred to including tummy tucks, breast shaping, hair transplants, eyelid surgery, nose reshaping, calf implantation, facial rejuvenation, and liposuction. As another example, the March (1990) issue of the Globe and Mail gives front page coverage to the desirability of enlargened female lips. "Fashion conscious women looking for a permanent pout" reports on the huge increase in demand for collagen lip injections by cosmetic surgeons and dermatologists across Canada. That so many people feel they must alter their physical shape to satisfy the dictates of fashion is certainly a sad reflection on the emphasis we currently place on ideal physical form. Advertizing, in contributing to and encouraging this dissatisfaction and insecurity with regards to physical shape and appearance, reinforces in an insidious manner the underlying search for the perfectly "made up" body.

Commercialism of this nature can also be problematic for a number of other reasons. Desirable "consumer products or images," for instance, have historically

been promoted as the means by which to ameliorate boredom and social entrapment (Ewan, 1978). As an example, during the 1930's consumerism often encouraged various escape routes from the harsh reality of Depression era poverty and unemployment (Foster, 1988). If economic security was an impossibility for most, the body building regime promoted in numerous magazine advertizements and editorials offered an effective means by which to acquire at least the envy of one's friends.

Still a further danger arises when the ideologically politicized realm of consumption is used as a means by which social change might be symbolically acted out in the public culture. As Ewan (1978) notes, "through the creation of a spectacle of change, frustrations and boredom within the context of industrial society might be mobilized to maintain and sustain that order" (p. 87). Therefore, although promoting a consumptive lifestyle attempts to conceal the emptiness in many people's lives and provide some notions of contentment and security, advertizing does not encourage any genuine changes at the deeper social level. The superficiality of consumerism gives the public the impression that valid social change is occurring in a positive sense when, in fact, nothing alters in the public realms. Ewan (1978) quotes Helen Woodward, an anti-capitalist of the 1920's, who referred to mass consumption as a means whereby people could act out social change, but only within a rigid, socially controlled environment. He notes that:

> To those who cannot change their whole lives or occupations ... "even a new line in a dress is often a relief. The women who is tired of her husband or her home or a job feels some lifting of the weight of life from seeing a straight line into a bouffant, or a gray pass into beige. The basic issues of industrial capitalism were functionalized, "most people," Woodward declined "do not have the courage or understanding to make deeper changes." (p. 86)

Indeed, as the world becomes governed by institutions and social situations we can no longer control,[9] or even influence, the body remains important as an area we can actually control (or at last think we can) (Lears, 1989). The body therefore provides a commonsense realization of the world, in the sense that "health" appears immediate and attainable with the consumption of goods or alteration of outer appearances (Featherstone, 1983). This belief in body control and attainable health, however, is somewhat problematic, since social and economic inequalities do not ensure that the consumer lifestyle is equally attainable for the majority. In general, then, consumption is limited to the mythic consumption of images (Ewan, 1978). Additionally, the myth often projected by consumer slogans in health that "anyone can make it," merely reiterates the notion of self-responsibility in health maintenance, for individuals are persuaded that with mere effort and body maintenance, health will automatically be achieved (Colquhoun, 1990; Featherstone, 1983). Again, such myth-building encourages us to avoid questioning or even realizing the fundamental inequalities in health. As well, it leaves unchallenged the extensive and morally questionable media manipulation that derives from industry's concern to amass further capital at the expense of naive and uninformed "health consumers".

Holistic Health and Healthism

Individualism in health maintenance is reflected, not only in the consumer culture in general and H. B. P. E. in particular, but likewise in the wider cultural context of the health conscious movement. Holistic medicine provides a good

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[9]In terms of health, examples would include increased pollution and medical costs, and difficulties in accessibility to health care in medical institutions.

example of such an individualistic approach. This increasingly popular form of "health maintenance" assumes unity of mind, body and spirit (Berliner & Salmon, 1979), and thus promotes the overall health of the "whole" person. As Lowenberg (1989) notes, holistic practitioners "assess and treat the entire person, rather than specific set of symptoms or a disease. This derives partly from humanistic concerns and partly from a model of the interrelationship of the physical, mental, and spiritual dimensions of man. A further assumption views humans as dynamically interacting with their environment. Mythical views of the individual and a romanticization of nature underlie these meanings" (p. 18). Its protagonists also imply that the movement is socially and politically based. However, despite this supposed wider orientation to health, in practice holism proposes individualistic solutions to complex health problems. Paradoxically, then, holism incorporates a subtle form of victim-blaming which actually serves to reinforce class domination and social inequalities (Freund, 1982).

In a similar vein to H. B. P. E., holistic medicine places emphasis on alteration of lifestyles. Change, it is argued, can come about simply through a matter of individual will, positive thinking, or the "correct attitude" (Berliner & Salmon, 1979). The fact that many "health damaging lifestyles" are (at least in part) quite beyond personal control is ignored. Within the holistic ethic, little is done to encourage the systematic alteration of external conditions that may have caused ill-health. Rather there is a reliance upon individualistic solutions. As an example, a handout (available in a Toronto bookstore in March 1990) views the individual as the arbiter of his or her health:

TAKE CHARGE

Choose the life you live

> Reduce Stress and Tension
> Increase your concentration and performance in work and sports.
> Find your own inner teacher.
> Discover your unlimited potentials, with meditation and creative visualization.

Although the above illustrative quotation does recognize external factors impinging upon one's health (like tension and stress), change is primarily viewed as the responsibility of the individual. With regards to the individualistic ethic embedded within holistic health promotion, Freund (1982) notes that:

> Holistic medicine recognizes the reality of external pressures such as time, but possibilities of concerted action to affect political and social change are ignored. Instead, the patient feels encouraged to accept such pressures, to view attitudinal reaction as the key, and to adjust through the medium of such individual change, such as the relaxation response. (p. 32)

Therefore, although holistic medicine assumes the existence and power of emotional and spiritual dimensions beyond the physical body, its solutions still center on the internal dynamics of the person. Its advocates refer to notions of "the whole person" and "totality," but it is only the totality of the person, and not that of society, which is being alluded to. Unlike H. B. P. E. and conventional health education however, this emphasis on the individual as an independently functioning unit, is not so obvious, since the rhetoric used incorporates extensive reference to the "social". For instance, holism refers to terms like "the West," "modern society," "we pollute," and so on (Berliner & Salmon, 1979). This supposed recognition of the social world is, however, somewhat deceptive, since there is no political analysis of the power structures at the core of these terms, and no attempt to clearly explicate the deeper social causes contributing to ill-health or the production of disease. The latter, for instance, would involve a critical examination of adverse conditions in the workplace and the urban environment, but is given no mention in holistic literature.

In addition to offering inadequate, only partial solutions to complex health problems, the holistic health movement lends support to the consumer orientation within general health maintenance. As such, it offers commodified packages of vitamins, and encourages the use of spas and the consumption of organic foods. These nutritional products or recreational facilities are available only to the financially secure (Berliner & Salmon, 1979; Freund, 1982).

Although holistic medicine has the potential to alter politically our awareness of social inequalities and to give impetus to the challenge to the traditional medical structure,[10] it has, in practice, proposed solutions in health maintenance which constitute and reinforce victim-blaming. Like H. B. P. E. in particular, and consumerism in general, holism offers an inadequate conception of the social and economic determinants of illness, choosing instead to invest the individual with prime responsibility for healthy living.

Conclusion

In this chapter, I have attempted to highlight some of the failings evident in contemporary health education. By using examples from the B. C. Active Health Program and other sources found within the wider social and cultural context, my intention was to reveal the inadequacy of enforcing individual responsibility as the only means of improving health. Such a notion of health improvement and maintenance is impoverished since it assumes universal individual free choice (which does not always exist in reality) and it ignores the social determinants of illness. Common health promotion programs therefore fail to acknowledge in any

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[10]Freund (1982) notes that some holistic practitioners in the sixties became radically politicized, and that this political consciousness did leave its mark.

significant sense the social, political, cultural and economic elements that impinge upon the achievement of health (Combes, 1989).

What is required as an alternative is an approach that recognizes the limitations of choice, and illustrates a more comprehensive, critical understanding of self-responsibility in health related behaviours (Combes, 1989; Rodmell, 1986). Such an alternative would involve a H. B. P. E. program that moved beyond the narrow focus on individualism and concentrated as well upon the social and environmental determinants of illness.

CHAPTER 4

Health Education in the Wider Social Context: Occupational Health

Introduction

Having delineated the ethic of individualism that underlies general health promotion, and revealed how the covert acceptance of individualism leads to certain taken-for-granted assumptions within the H. B. P. E. movement, my intention in this chapter is to show how an individualistic attitude towards health is also manifest in the wider social and cultural context. This chapter examines the individualistic preventive approach implemented within working environments. It will be suggested that health education based on the individualistic ethic is inadequate as a means to deal effectively with occupational hazards and work-related illness.

The question might be asked, "Why am I looking beyond H. B. P. E., and analysing the notion of occupational health?" There are a number of reasons. Occupational health provides a parallel analysis for this study and gives us further exposure to the broader field of health. This, in turn, provides an opportunity for us to further our understanding and be given additional exposure to notions common to both H. B. P. E. and health programmes in the wider context. The ethic of individualism, for example, is a major focusing concept of many occupational health programmes. The workplace is also concerned in many circumstances with "bodily control" and, since "self-control" is a major focusing concept of "healthism," this may provide further insight into possible constraints imposed on the physical body and health prevention. In addition to the concerns mentioned above, examining occupational health provides a means to "test out" the reliability of what has been said so far in this thesis. That is, to show how the ideology of "healthism,"

so prevalent within schooling environments also has a direct and very pervasive counterpart within health promotion schemes in the working world. Finally, the school, like the workplace is an institution, and by providing a vision for the institutional structure of work and some possible recommendations for health prevention in the workplace, it may be possible to intimate or at least gain some idea as to how we may progress within the institution of schooling, and in particular in H. B. P. E.

Working Environments and the Preventive Approach

Before examining various preventive approaches, the goals of which are to minimize occupational hazards, my intention is to reveal some of the factors within working environments contributing to ill-health. I will also briefly describe the extent of occupational hazard within the workplace.

Work and Ill-health

As has been well-documented, working environments and exposure to harmful substances can contribute substantially to ill-health. Both physical and psychological stress can result in poor concentration leading to work-related accidents and injuries. More significantly, general worker powerlessness can increase an employee's susceptibility to illness (Freund, 1982). Coburn et al. (1978) note that under monopoly capitalism the worker experiences an increased lack of control within the working environment. Bureaucratic and scientific management, rationalization of work tasks and organization, and deskilled tasks can all contribute to eroding self-esteem, leading to increased vulnerability to ill-health (Freund, 1982). Many working environments, in particular those

characterized by highly routinized and mundane assembly line tasks, induce significant psychological stress. The physical body is often constrained in "time and motion" (Freund, 1982) and as Chase (1989) notes, this constraint over bodily motion often imposed through repetitious work induces a high level of stress that can manifest itself physically in the form of dizziness, nausea and headaches. He states that:

> The outbreaks occur most commonly on assembly lines, where each worker performs the same repetitious task over and over, assembling electrical switches, packing fish or punching computer cards, to name but a few examples. Outbreaks have also been known to occur in schools, which like assembly lines, are places of highly organized and structured activities in which tension is likely to mount. (New York Times, May 29th 1979, cited by Freund, 1982)

In many occupational environments tight worker control and discipline are imposed through physically constraining the body to machine-like actions. Freund (1982) quotes from Haratszi's phenomenological study on work which documents the physical and psychological stress induced by working environments. Haratszi (1978) suggests that factory workers become "out of touch" with their bodies, and that machine-paced motions of repetitive work alters one's relationship to bodily sensations. He states that:

> Even at work, when I found the rhythm and became one with the machine, thoughts and feelings did not disappear: they change. What disappears is the direct relationship which unites them with *me*, the identity between me and them. This is difficult to communicate. The best way I can put it is like this: I cease to exist. When the huge slide doors of the workshop are opened and the transporters rattle in loaded with material, I know without having a thought as such, I simply *know* -- that I am in a freezing draught, but I do not feel that I am cold. My back aches, there is a cramp in my fingers, the piece rate is ridiculous: I do not think or feel any of this. (Haratszi, 1979, p. 112, cited by Freund, 1982).

The worker may not only be subject to stress induced by the physical environment, but also made to feel inadequate due to increased managerial control that results in depersonalized and alienating human relationships. In addition, the level of managerial control within the workplace has become intensified in recent years through increasing computerization. The use of computers has enabled worker supervision to be extended and individualized, with supervisors accurately monitoring and controlling levels of worker productivity (Freund, 1982). While some level of regulatory control within industry is necessary in order, for example, to minimize occupational hazards, a too rigid control directed towards increasing productivity levels and profitability compromises worker satisfaction and health. Freund (1982) makes reference to the bureaucratic measures of control which many workers must face, and states that:

> Workers are constantly being reminded of their "childlike" status. Being addressed in terms reserved for children, having to ask one's assembly line supervisor for permission to go to the bathroom, and being reprimanded for long evacuations are all examples of these reminders. (p. 83)

As Sass (1980) notes, it is not surprising that this form of control can induce stress, and he states that "an important cause of stress in the workplace is the lack of control over the environment, including tight rigid schedules set out by others, close supervision and little physical or intellectual mobility" (p. 57).

Stress is not only created by the monotony, repetitiveness and control within the working situation. Work in itself can also impinge upon and control life outside of work. As a consequence of job site fatigue, a worker's ability or desire to enhance a healthy state during leisure time may be severely reduced. For example, those workers experiencing intensive working conditions, including

"overload" or "compulsory overtime," may find their ability to relax during off-work hours threatened or reduced.

The quality of leisure time may be affected not only by the system of work and production, but also by the subliminal pressure for individuals within capitalism to consume in order to to support the mode of production. With regards to the stress created by the economically fostered need to consume, Freund (1982) notes:

> Frenzied consumption kills time in that time spent consuming, or around commodities, must be structured in the same way as work time. Not only is time devoted to compulsively "enjoying" commodities, but the activity of consumption requires that commodities be bought, kept and maintained. This means more time to be scheduled and compartmentalized to allow for shopping, getting to sales on time, having things repaired, waxed, shampooed, trimmed and polished. Time spent consuming must to some extent be scheduled time, and in this way, leisure time becomes regimented too. (p. 100)

The emphasis placed upon consumption may also result in material acquisition being valued more highly than quality human relationships, leading to a general, and perhaps even unrecognized, state of alienation from others.

In addition to the stress-related ailments of work, extensive physical injuries result directly from hazards within the working environment. Before examining the approach commonly adopted in health education to job site dangers, I will briefly outline the extent of these hazards.

With reference to Canada, statistics reveal that the number of injuries resulting from workplace accidents are indeed substantial.

> In 1978 there were over one million injuries and illnesses among some 8.5 million Canadian workers. If we add 25% to the number of injuries and illnesses to adjust for coverages of all workers in Canada, a total of about 1.33 million injuries occurred in 1978.

> Therefore 16% of the workforce in Canada sustained an injury or illness on the job. (Reasons, 1981, p. 25)

Sass (1980) reiterates the prevalence of work-related injuries in Canada, and provides empirical data illustrating the extent of human suffering involved in work-related injuries:

- every 15 minutes, 130 workers in Canada are injured on the job
- every year, up to 1500 workers are killed on the job
- every year, 20000 workers are permanently disabled
- In the next 20 years, 2 million workers will be seriously injured or die young because of industrial disease or accidents (p. 182).

In the United Kingdom the situation is equally dismal. Waterson (1986) states that:

> In 1980 officially recorded non-fatal accidents reported to the health and safety commission totalled 274800; each year between 1980 - 1984, approximately 630,000 working days were lost to industry due to occupational skin disease; 1,000 people became eligible to claim benefit for occupational asthma and 764,000 working day were lost in the N. H. S. because of back pain among nurses. (p. 78)

Although there has been debate about the statistical validity of documenting occupational hazards, there is little doubt that hundreds of workers are either injured or killed as a direct result of the dangers within the working environment. Indeed, Waterson (1986) notes that "the pain, suffering and economic damage experienced through occupational health and safety problems are enormous and shameful" (p. 78), and Labonte and Penfold (1981) state:

> occupational disease kills twice as many people on the highway, or that during the entire Vietnam war, over 1,114,000 U.S. workers died from job related diseases, almost 20 more than the total number of Americans killed in the war. No matter where one might go to seek data, the story is awesomely self-evident: work kills. (p. 37)

It might be expected that major structural changes would have occurred within the workplace in an attempt to reduce significantly occupational hazards. On a general level, however, this has failed to occur, and individualistic solutions have been adopted. In terms of occupational health and safety, many approaches replicate that of the traditional model of health education. Inherent in this individualistic perspective is the implicit notion that responsibility for accidents within the workplace is the individual worker's rather than the company's. That is, emphasis is placed upon the "bad" habits or unsafe practices of the individual, and not upon the faults or dangers within working environments. The result is a form of victim-blaming, and a concurrent failure to address the cause or root of the problems contributing to occupational hazards. The worker must "cope" with working conditions, and if unable to do so, he or she is to blame (Postinkoff, 1984). Labonte and Penfold (1981) note that in British Columbia the government has traditionally responded to occupational hazards by mounting expensive information campaigns to encourage workers "to wear their protective gear, look out for their eyes, plug their ears and hold their noses" (p. 38). Although it is valid for workers to be individually encouraged to protect themselves in the workplace, it must be recognized that not only the symptoms, but also the cause or root of hazardous conditions must be addressed and acted upon in order to diminish job-related dangers to workers. As Schneider (1981) notes, the inactment of superficial solutions to complex health problems will do little to eradicate the primary causal origins of worker injury or stress.

> As long as the working class does not rebel against these new and intensified forms of exploitation, health, stomach, and circulatory disease of individual workers will rebel for them. Even though the worker may still "go along," his circulation, in any event, will not. Even

> if he says "actually I feel alright," his stomach ulcer will prove the contrary. (p. 138)

By conceptualizing prevention solely in terms of individual worker responsibility, health educators have in fundamental ways ignored the hazardous health conditions to which many workers are subjected. As a result, workers are implicitly or explicitly blamed for careless behaviour and unsafe practices. The fact that hazardous working environments may well contribute to these "unsafe" practices is rarely addressed (Waterson, 1986). Indeed, occupational health education that is based on the individualistic ethic has contributed to masking the deeper rooted problems within the workplace. That is, by instructing workers to behave in ways that are not "foolish" or "careless," health promoters have failed to highlight the need for changes required to occur within the work process or job site which may contribute to ill-health. The failure to draw attention to the need for social and political action to seek more substantive changes in the workplace merely maintains the status quo. The potential of health educators to strive for more extensive change within the workplace is therefore not achieved[1]. Worse still, this approach to health education lends support to employers who can further place blame upon the worker. As Waterson (1986) notes:

> Many health educators do not challenge the employer by locating the cause of accidents in the structure of the work process. Not surprisingly, they are accepted, if not welcomed by the employer. If the worker is the problem, then apparently cheap solutions geared at

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[1]There have been a number of exceptions to the traditional approach mentioned above. In the U. K., for example, health educators of the Sheffield Occupational Health project have begun to collaborate with trade unions in order to improve work sites. This approach involves the incorporation of a political emphasis, where workers are informed of dangers in order to encourage action by workers to fight for changes in the workplace. As Waterson (1986) notes, "trade unions and individual health educators have produced an analysis of hazards at work which eschews the traditional superficial victim-blaming, careless worker, accident approach" (p. 95). He further notes that this approach has led to "trade unionists and general practitioners working together not only in health centre surgeries, but also in the clubs and pubs in the city, talking to people about their working conditions and the diseases related to those conditions" (p. 95).

> training the worker to behave more safety will be readily accepted. (p. 85)

Instead of challenging the hazardous conditions within the working environment, health educators tend to spend substantial amounts of time encouraging workers to wear ear muffs, stop smoking and eat health food. Although it may well be valid to promote such preventive measures, encouraging alteration of personal behaviour alone is inadequate in terms of alteration of dangerous and hazardous conditions within the job site which may also contribute to occupational disease and ill-health. What is required, in addition, is for health educators to challenge the deeper rooted, primary hazards in the workplace.[2]

A further problem in concentrating on superficial solutions that address only individual worker behaviour, encompasses the extent to which workers will take seriously or heed valid health education information. For example, it seems open to question how effecttive a "healthy eating" campaign would be, given that the pressure of time and general fatigue make fast food an easy alternative for many workers. As another example, Beaty and Corby (1990) in their article entitled "Stairway to Health" suggest that employees adopt what they term a "simple idea to keep fit at work that can be easily assimilated into the working day. It involves a minimum amount of time away from the desk, and requires no expenditure on equipment or clothing" (p. 212). This "simple idea" refers to a project at I.C.L., a large U.K. corporation, that encouraged a selected group of workers to walk up and down stairs within the building, as opposed to using the lift. This health measure

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[2]This will also involve health educators challenging many of the approaches currently implemented to deal with occupational hazards. For example, with regards to the above example, the adoption of "cheap" solutions, often based solely on profit, is unethical. That is, a group of people, possibly company owners or management, are making large sums of money at the expense of other workers within that system who may be experiencing dangerous conditions leading to occupational disease and ill-health.

was apparently successful in promoting a degree of worker health, and Beaty and Corby conclude by suggesting that:

> It does seem that we can demonstrate a positive effect on health from something as easy and painless as taking the stairs instead of the lift at work. Those taking part have been convinced anyway -- they all say they will continue to use the stairs whenever possible. (p. 212)

Although few people would doubt the physiological and possibly psychological benefit of walking up stairs, whether these particular workers will continue to avoid lifts when under extreme pressure of time is doubtful. And, the extent to which these "health" programs provide a substantive means by which to improve the health conditions of most workers does seem open to question. At companies like I.C.L., health problems arising from work overload or compulsory overtime are not addressed by such tokenistic exercise programmes.

In the next section I will discuss how the individualistic focus is not only adopted by many health educators, but also reinforced by the marketing approaches often incorporated into health and safety campaigns. This approach, by utilizing slogans often representative of victim-blaming statements, lends support to many contemporary programmes in occupational health. Therefore, not only are a number of programmes based on the individualistic ethic, but the method of presentation often reinforces this conception of health and safety promotion.

"Hard Sell" Techniques in Health and Safety

The "hard sell" approach evaluates health education messages or slogans within an advertising/propagandist framework. Such individualistic health education slogans are presented within a simple, brief format that makes use of

bold appealing images reminiscent of images used by the advertising industry to promote consumer goods (Farrant & Russell, 1986). Again, these sleek attempts to advertise health reinforce the notion of the individual as the arbiter of his or her own health or ill-health in the workplace. No acknowledgement is given to the factors beyond individual control which may result in occupational illness. In addition, many of the slogans and visuals utilized within this individualistic framework can be widely inappropriate in that they may appeal only to a certain sector of the workforce. A particular example of an inappropriate use of this marketing approach to health and safety within the workplace is the 1990 British Safety Council's (B. S. C.) "advertisement" for back pain. The slogan states:

> Back pain out ... lift with your legs. 46.5 million days are lost to back problems last year.

Apart from the fact that this statement suggests that the human back can be protected solely through worker knowledge as to the best way to lift heavy loads, the visuals accompanying the written message are inappropriately exploitive of women. The poster depicts a back view of a tatooed female who is standing in a sexually provocative manner. As another example of this form of advertising, the visuals accompanying messages for safety showers in the U. K. "shows a picture of an alluring blonde wearing a pair of very scanty dungareers, asking the seductive question: "COSHH. Are you covered?' Snigger. Snigger." (Kennedy, 1990, p. 290). Along similar lines of marketing, the B. S. C. began its eye protection campaign by a 'Miss Beautiful Eye Beauty Contest'. This style of presentation is seen as a useful means to "sell safety." Indeed, according to B.S.C. James Tye (1990), the female sexual form can be utilized very effectively. He states that:

> Before you can remind people of anything you have to get their attention and this is where the pretty girl comes in -- without raising levels of anxiety or bringing on the psychological cut-out by shock-horror posters, she attracts attention and stimulates interest so that the remainder can be absorbed. (p. 291)

Tye (1990) further justifies his position on utilizing the female sexual form as a means to sell safety by suggesting that the B.S.C. should adopt marketing techniques used by the U.K. popular press, and suggests:

> The same principle applies to using attractive models in press campaigns. Most industrial accidents are sustained by those at the sharp end, the shop floor, and if I want to reach them obviously the formula of *The Sun, The Mirror* or *The Star* which have the highest circulation is the one to follow. We are all free to choose what we want to read. The media reflect public taste, and what sells newspapers can also sell safety. (p. 291)

Although of course it is important to relate the "health message" to the targeted audience, to adopt the marketing approaches of the U.K. popular press -- who often appeal to readers through sexist and sensational means -- is absurd. Also, the justification given here by Tye is clearly exploitive of women. In her article "Does Sex Sell Safety," Kennedy (1990) disagrees with the approach adopted by Tye and the B. C. S. with regards to the advertisement on back pain. She states:

> Why did a pair of female buttocks have to be so glaringly included in the poster? Could they not have been omitted from the Sacaram down? Would they have been as quick to show a male pair of buttocks, I wonder? (p. 289)

In addition to an inappropriate use of the female sexual form, this kind of "hard sell" advertising in health and safety may alienate women workers, and therefore be ineffective as a means of conveying a health and safety message to the large portion of the population who are female (Kennedy, 1990). Even for those to whom it does appeal, presumably men, it may be the case that the use of

the female sexual form will divert attention from and trivilize the safety message, therefore making the "slogan" ineffective in the first place (Kennedy, 1990).

'Healthism' and Corporations

Individualism is not only the central focus of health education and promotion within the workplace, but it is also reinforced by many corporations who have become significantly involved in the emphasis on "lifestyles". In the following pages, I want to show the inadequacy of this emphasis on "healthism". By making reference to a number of examples, including stress management programmes, I will suggest that many of these programmes ultimately act to insidiously mask the deeper rooted problems and hazards of the workplace.

Worker Control, Health and Lifestyles

Corporate interest in worker health and lifestyles is increasingly evident. Numerous companies have begun to sponsor fitness training, biofeedback and cardiac check-up clinics, and meditation lessons. Further, many companies have initiated increased monitoring and controlling of employees' health behaviour. In its most extreme form, these controlling tactics may involve keeping track of employees' health habits in their private lives. The article, "What Private Lives? -- smokers, obese on firm's hit list," (Knight-Ridder,1991), gives some examples of health controls and regulations placed upon workers:

- Cable News Network won't hire someone who smokes an occasional cigarette at home.
- U-Haul have started to fine their employees for off-hours smoking and for being overweight.

- In Rhode Island, a 145 kg (320 pound) hospital attendant named Bonnie Cook applied in 1988 for the same position she had left two years earlier. The State refused to hire her unless she shed 9.5 kg. Instead the cook filed a law suit.

- A Houston-based manufacturer of oil-field equipment, Baker Hughes Inc., last year began collecting $10.00 a month from any of 12,000 employees who had used tobacco in the previous six months.

- Workers at Safeway's bakery division in Clackermas, Oregon, are excluded from company picnics and parties if they fail to participate in the company's health program -- which includes cutting out coffee, and limiting fast foods to once a week.

Although the above list provides a degree of reader amusement, the serious point is that this focus on "lifestyles" embraces nothing other than an extreme form of victim-blaming. According to this view, workers' "destructive" lifestyles are the direct cause of ill-health in the workplace (Taylor, 1982). By focusing on the private habits of the individual worker, the net results are first, to obscure the changes required in the workplace, and second, to ignore the wide range of occupational hazards resulting from factors other than those arising from the so-called "bad habits" of the individual. This is not, of course, to suggest that it is wrong to encourage workers to smoke less or eat healthier food or that providing elaborate health and fitness facilities within the workplace is a useless initiative. Yet it is important to recognize that these measures should not occur at the expense of obscuring the need for wide-scale structural change in the workplace. As one example of an attempt to conceal these changes, a number of companies have focused upon the lifestyle of the executive, and emphasized the supposed degree of stress experienced by individuals within this group. As a direct result, many companies offer fitness packages and medical treatment for executives alone. Indeed, "executive health" is now a big marketing business, and Stencel (1984)

notes that one company dealing with "health" advertises specifically for executives and names itself Executive Health Examiners of New York City.

By focusing on the executive alone, and the vulnerability of the more privileged executive group to such illnesses as heart disease, many companies have managed to draw attention away from the health hazards faced by other, less advantaged members of the blue collar workforce. Indeed, as Taylor (1982) notes:

> By focusing on heart disease as the real threat to workers health and by promoting the relatively low-cost strategies required to foster preventive care in this area, companies direct attention away from those diseases that claim as many lives, but that affect "less valuable" workers and are potentially more expensive to alleviate. An estimated ,00,000 workers die each year, according to OSHA, and three or four times than that number are disabled, as a direct result of occupational disease (illnesses attributable to new chemicals being introduced into industrial products and processes) as opposed to workplace accidents, which occur at a rate of 2,000 a month. (p. 35)

The emphasis placed upon the "harried" lifestyle of the executive is somewhat misplaced given that occupational disease is more prevalent among blue collar workers. In his article, "Myth of the Unhealthy Executive," Boroson (1978) states that "every major study comparing the longevity of executives with the longevity of people in other occupations has shown that executives lead charmed lives" (p. 11). Overall then, this emphasis placed upon executive health may obscure the need for changes to occur within the blue collar sector.

Similar to H. B. P. E., a restrictive individualistic view of prevention is favoured. It is the individual who is required to alter his or her habits. Little or no acknowledgement is given to the social context in which individuals find themselves. As mentioned, this perspective is often reinforced by occupational health and safety programs. Taylor (1982) quotes an excerpt from the Conference on Health Promotion in Occupational Settings sponsored by the department of

Health, Education and Welfare in 1979. Although environmental factors contributing to ill-health in the workplace are acknowledged, individualistic solutions are overwhelmingly adopted. Emphasis is placed upon the way in which individuals can be motivated to change personal habits in some way. With regards to occupational disease and recommendations for change, the conference statement concludes as follows:

> It is a combination of factors within and outside the work situation that interact and contribute to disease.... Certain personality, cognitive and behavioural characteristics of an employee interact with characteristics of the environment and influence this association. An occupationally based stress reduction program would cause people to *change their lifestyles* for the sake of their health and at the same time reduce absenteeism, enhance productivity, and decrease insurance and medical costs. (McGill, 1979, original emphasis Taylor, 1982, p. 36)

The advocacy of individual behavioural change has become increasingly prevalent in recent years. Employees are encouraged to cope with alienating working conditions by adopting "coping" procedures or becoming involved in "assertive" training. Failure to cope with adverse conditions at work therefore becomes a failing on the part of the worker to adopt the appropriate coping procedure within an alienating or hazardous job site environment. As a consequence, environmental conditions contributing to ill-health remain unchallenged, and the individual worker is held ultimately responsible for ill-health in the workplace.

In the following section my intention is to elaborate in more detail upon the inadequacy of these individualistic approaches. Specific reference will be made to one very prevalent individualistic measure -- stress management techniques. Advocates of stress management techniques make the assumption that it is the individual who is wholly responsible for adaptation to stressful conditions, even

though many of the conditions causing stress may be socially and environmentally induced. Such an approach provides a good example of how the ethic of individualism and the ideology of healthism are manifested in their extreme forms.

Stress Management

Stress management courses are becoming increasingly popular with many individuals. A huge array of cassette tapes are now available, marketed to help individuals manage stressful working environments. Although many of these tapes acknowledge the external factors within the environment that contribute to stress, the essential taped message is that the reaction of the person to stress, and the ability of that person to reduce and manage stress, are based only on the internal dynamics of the person.[3] As a result, there is no attempt to challenge the social relations or structures that underlie and contribute to the patterns of behaviour indicative of stressful conditions. Alternatively, adaptation to stress comes about through behaviour modification initiated by the individual. As is clear from excerpts below, it is the individual who, if unable to cope with stressful conditions at work, is at fault. Both quotations below are excerpted from a tape on "Stress Management" targeted to people in the workforce.

- Maybe we need to look in the mirror and figure this person out first, we are so convinced we get so tied up in our situation, e.g., management just doesn't understand, this company is so unconscious, maybe, but maybe if we were in their position you'd see it differently.

- If you work for a company that is willing to implement consequence, because consequence is critical in the building of

[3]That is, the individual is perceived to act in a vacuum. The individual's ability to cope with stressful conditions is understood to be internal to the person, and not necessarily dependent upon the external social and environmental factors which may also be significant.

> self-confidence -- when you don't think you can do this much work and you do it, what happens is that you learn you can survive what didn't seem survivable -- that's what builds self-confidence.
>
> (Mellot, 1989)

Although some of what is stated in the above quotations makes sense, for example, the notion that if an individual thinks himself or herself unable to do a task and then completes it, he or she may increase self-confidence to complete that task on subsequent occasions, the ultimate message is that individuals must alter their behaviour to cope with stressful conditions. Indeed, the tape concludes by recommending "change skills." This is wholly inadequate, however, as a means to challenge stressful conditions at work, and if anything, gives support to employers and corporate owners who can further blame the worker. For example, with regards to the above quotations, the first excerpt gives support to management, and the second supports the notion of increased accountability at work. And although a degree of accountability may have some value, clearly its overuse can actually increase stress. What is required is the need to highlight conditions causing stress. This requires changes beyond alteration of only individual behaviour.

In a similar vein to stress management tapes, the huge array of literature promoting relaxation advocates that the individual learn to modify his or her behaviour in order to cope with stress. For example, in the article, "Learn to Relax and Counter Stress: Occupational Health," Easton (1990) recommends the use of relaxation tapes, yoga, meditation, and so on, to reduce stress at work. While such activities may provide a degree of adaptation to stress, to advocate them alone leaves unchallenged the stressful conditions causing stress (Eyer, 1975). Also, this "relaxation response" fails to examine the ways in which certain behaviour may

reflect the social context of which the individual is a part. With regards to the latter point, the behaviour of Type A individuals is often seen as the sole causal agent of personal ill-health[4]. An example of blaming Type A individuals is illustrated in this quotation by McNamara (1979) who states:

> It appears that Type A individuals are their own worse enemies in subjecting themselves to a style of life with which a high degree of risk for cardiovascular disease is associated. (p. 4)

That the emergence of this kind of behaviour could be a resultant factor of the socialization of individuals within a highly powered capitalist and consumptive system is not addressed (Postinkoff, 1984).

An additional problem inherent in the promotion of stress management and relaxation techniques is the subsequent failure to recognize the extent to which an individual's ability to relax is largely determined by that minority of people who have the social maneuverability, or the "social choice," to be able to do so. It seems open to question how many individuals could easily provide the conditions for relaxation recommended by those advocating many of these techniques. As a particular example, it would seem that the ability to provide optimum conditions for relaxation recommended below by Easton (1990) would be attainable only by the select few and influenced substantially by the social context in which individuals find themselves:

> A helpful environment is needed; the individual needs to be able to listen to the tapes in quiet surroundings where they will not be disturbed, unless a genuine emergency arises. This means letting someone else answer the telephone, and returning calls after the relaxation session. (p. 174)

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[4]Type A behaviour is characterized by high levels of aggression, competition, and drive. This type of individual will often race against the clock, regardless of what he or she may be doing. (Fox and Mathews, 1981).

To assume that all people have equal opportunity to relax is frankly absurd. In addition to the failure to acknowledge the social context of stress and relaxation, the belief that relaxation tapes or other individual preventive measures can eradicate the deterimental effects of an alienating work environment is limited in its conception. While relaxation tapes or other individually motivated health tactics may provide a superficial means to temporarily alleviate stress problems, they fail to solve long term problems of stress-induced illness in the workplace. A genuine attempt to reduce worker stress would require altering the immediate social conditions that contribute to stress. This would involve the restructuring of the work sites, and, in addition an examination of the economic and social conditions leading to stressful and alienating environments.

Alternative Approaches

Minimization or removal of hazards in the workplace therefore requires more substantive changes than encouraging workers to develop personal "coping" strategies. Work must be embedded within the wider social and political structure of which it is part, and working hazards cannot be blamed solely on the individual. Authentic health improvement requires structural changes that encompass attempts to improve working conditions for individual workers. Unfortunately, with exception of Scandinavia, few western countries have moved beyond the traditional victim-blaming approaches. Freund (1982) notes that Scandinavian countries do not focus exclusively on internally motivated change, but also on externally directed efforts to ameloriate working conditions. He states that:

> The Scandinavian countries are the most progressive of western capitalist societies in protecting their workers and encouraging worker participation. The Saab-Scania plant and Volvo factories in Sweden

> are the first car factories to eliminate conveyor belts. Small autonomous groups do the assembly at their own pace, often in their own buildings. Production has been scaled down to a human level with the aid of microcomputers (Seri, 1981; Kahn, 1981). The Swedish unions have long been concerned with assembly line boredom and speed-up, and Swedish occupational health is among the most advanced in the world. Workers participate more fully in decision making, in reviewing corporate medical records, in deciding on how the health budget will be used, and in retoing or approving plans for new machines. (p. 146)

What is required is the need to provide conditions for greater worker autonomy. This may involve an increase in decision making, and enhanced political power to facilitate substantive changes in the workplace. In terms of occupational health, educators will therefore be required not only to inform workers as to how they can cope with the working environment, but additionally to inform individuals as to how they can collectively work to improve the conditions within the workplace. In addition to increased worker autonomy in the form of enhanced decision making and political power, workers should also be given opportunity for greater "physical freedom." This may involve providing more breaks, free-time, leisure time and increased vacation time. Ideally, a situation should be provided where there can be a definitive break between free time/leisure time and work-time. This may involve providing a situation where work does not impinge upon and entirely control life outside of work. Such is often not the case, however, and even those people who may participate extensively in leisure-based pursuits outside of work are often constrained to a large degree by the system of work and indeed have little opportunity to pursue activities except in the period of time that work allows. (In this sense it might be referred to as "conditioned freedom.") And although to a greater or lesser extent this form of constraint may always be present, it would seem more satisfactory in terms of worker health to provide a situation

where work does not entirely rule leisure time and free-time outside of work. To provide such conditions, however, may require corporate owners to decrease profit levels in order to enhance worker health. This may involve going beyond merely focusing on the individual for change, but also incorporating structural changes in the workplace to enhance worker health.

Conclusion

In this chapter I have to examined the inadequacy of the individualistic ethic often underpinning many "health" programmes in the workplace. By highlighting occupational health it is clear to see that in the broader sphere individualism is also a major focusing concept. Hopefully, by revealing a vision as to alternative approaches to individualistic strategies of health prevention in the workplace, it provides some idea as to how we may proceed in schools -- that is, a focus which involves looking beyond sole emphasis on the individual's health behaviour, but considers, in addition, the wider social context. In the final chapter I shall further highlight the failings of the individualistic creed, and provide some recommendations for an alternative approach to Health Education, including Health Based Physical Education.

CHAPTER 5

Prospects and Possibilities for Health Education and Health Based Physical Education

Throughout this thesis I have attempted to highlight the inadequacy of the notion of individual responsibility as the only means to improve health. Before providing recommendations for an alternative approach to health education, and specifically H. B. P. E., I will briefly outline the implications of the adoption of the individualistic creed in the system of health education, and suggest some reasons for the apolitical attitude of health educators.

Individualism in Health Education

As I have attempted to reveal throughout this thesis, the assumption that the individual must adopt sole responsibility for the maintenance of his or her personal health is what underlies, either explicitly or implicitly, the health promotion policies of numerous educators and health policy spokespersons. At their most extreme, such pronouncements concerning health practice have emphasized, not only the importance of behaviour and lifestyle management to the maintainance of good health, but, in addition, the significance of a person's thoughts and feelings as contributing factors in ill-health and even death. While few would contest the importance of an optimistic or "positive" attitude for the unhealthy or chronically ill individual, it is overly simplistic to assume that every human action, thought and feeling is consciously and freely chosen. Lowenberg (1989) notes that when the individualistic creed infiltrates health care promotion in an uncritical and near idolatrous fashion, unhealthy individuals can be erroneously accused of "choosing or not choosing to get well," and actively combatting or succumbing to particular

disease states. As an example of such an extreme perspective, Lowenberg (1989) makes reference to Scarf (1980) who, in his book The Will to Live, states that "we ourselves choose the time of illness, the kind of illness, the course of illness, and its gravity" (p.33; cited in Lowenberg, 1989, p. 169). According to this viewpoint, every human action and reaction--both within the cognitive and the affective realms--is directly attributable to the supremacy of the individual's free will. An example illustrative of this belief in ultimate individual responsibility is contained in Love is Letting Go of Fear, wherein the author asserts:

> I am responsible for all I see and experience.
> We are what we believe.
> We're responsible: everything I am, I asked for.
> I am not the victim of the world I see.
> (Jampolsky, 1979, p. 91; cited in Lowenberg, 1989, p. 170)

At its most immoderate degree, perspectives such as the one illustrated above can lead to the outlandish (or at least highly questionable) claim that an individual's freely selected emotional state or attitude is the prime causal agent in the act of yielding to disease or death. Scarf (1980), an avid proponent of this view, states that "none of us gets cancer; we reach a point at which our deepest need and wish is to withdraw from life, and we therefore choose to develop cancer" (p. 37). As Lowenberg correctly notes, Scarf perceives cell malignancy as a bodily manifestation of despair, and thus asserts that the afflicted individual has willingly opted to develop a life-threatening disease. Although it is quite probably the case that extreme personal stress or depression can either initiate or accelerate the development of cancerous body states, the overriding message espoused by Scarf (1980) and others (Jaffe, 1980; Spear, 1977) is that people psychologically *will*

disease upon themselves, and therefore bear ultimate respnsibility for their ill-health (Lowenberg, 1989).

It is clear, however, that the belief that all forms of disease can be attributed to individual will or desire is extremely short-sighted, if not completely erroneous. As I have previously suggested, such a stance on health ignores the genetic, social and environment constraints that are operative upon and often determine individual action and belief. In addition, it denigrates or ignores those causal agents of disease that lie beyond individual control or dictate. As a consequence, unhealthy individuals, including the chronically ill, may well experience self-induced shame and guilt as a direct result of having contracted an illness, thus jeopardizing their own chance of recovery. Futhermore, if the public comes to view certain specific illnesses as primarily or solely self-inflicted, a generalized moral indignation may be directed towards particular groups of unhealthy or at-risk individuals. As Lowenberg (1989) notes:

> Those who do not exercise regularly or meditate come to be seen and subtly criticized as morally inferior. Both lifestyle and illness become culpable, and processes of societal censure and institutional control become justified. (p. 161)

At their extreme, such moralizing judgements against the sick could result in a self-righteous indifference on the part of health care workers, whose therapeutic programs of care should ideally be directed towards healing, and not condemming, the ill. One likely example of the probable consequences of such indifference or disdain might be health professionals' hypothetical refusal to treat patients afflicted with, for example, emphysema or related lung diseases.[1] The fact that social forces

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[1]As one example, it is important to address the reasons why so many teenage girls as opposed to boys are now beginning the habit of smoking. This requires a sophisticated understanding of the

may well have had a potent influence on a smoker's reluctance to abstain from his or her life-damaging cigarette habit would simply not be addressed. Ultimately, as Shapiro and Shapiro (1979) suggest, the sick or dying could be essentially abandoned by medical practitioners, and forced to rely upon their own self-devised cures:

> The most likely outcome of this strategy will not be self-responsibility, but only self-incrimination. The approach produces guilt feelings about failure of will power, and also guilt feelings about what becomes by definition a self-destructive impulse. This philosophy provokes a sense of abandonment and self-condemnation. Patients are isolated and left to their own resources. (p. 21)

Once again, I am not suggesting that the ill (or, in this particular case, heavy smokers who develop emphysema or lung cancer) should accept no responsibility for their debility or death. However, when treating such diseases, health care professionals have a moral obligation not to inflict further pain upon those already suffering. Indeed, as Lowenberg (1989) notes, health workers have traditionally upheld an ethic of obligation and responsibility to attempt to heal even those patients whose past choices and actions have largely caused their own illness. (Equally, it must be stressed, the patient has a reciprocal obligation to the physician to attempt to get well.) It would appear, however, that a too dominant emphasis placed upon individual "lifestyles" and the ideology of "free choice" could potentially result in situations whereby the physician or health worker would no longer be held accountable for the well-being of particular patients. Accountability on the part of health care employees could feasibly decrease, since the sole blame for disease might ultimately be placed upon the patient.

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many factors which are involved in girls beginning smoking. This involves going beyond moralizing about the habit of smoking and teenage girls.

In addition, the emphasis placed upon individualism in health care may quite conceivably affect existing public health care and maintenance policies. It is likely, for example, that governmental or community service institutions might withold resources from those groups of people who are perceived as wholly responsible for their current diseased states.[2] As a futher consequence, the social responsibility we have traditionally entrusted to various health agencies (or, indeed, to industrial companies with regard to the safety and well-being of their employees) may diminish or become obscured, and the state and its corporations freed from any obligation to prevent ill-health among the general populace. Blame for disease would rest instead with each and every individual member of society.[3]

The Apolitical Perspective of Health Educators

The notion of individualism in health is given support not only by writers espousing the need to emphasize the importance of self-responsibility in health maintenance, but also by a number of health educators who fail to acknowledge the social and political basis of their work[4]. As a result, many health educators

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[2]Institutions, and in particular insurance companies, could refuse to administer life insurance to those who are perceived to have "bad" or "unhealthy" habits. The fact that many conditions may well be related to socio-economic conditions is ignored.

[3]In such a case, for example, Petrochemical companies, who need to accept responsibility for ill-health in certain circumstances, may well be alleviated from pressure to curtail pollution or other related work and environmental hazards, if focus is placed upon each and every individual in society. As a result, there may be nothing substantialy done to alter the pathogenic aspects of the social and economic structure which places the individual person at risk in the first place.

[4]By social and political basis of health education work I am referring to the notion that health education is concerned to enhance the health of individuals and communities, and this encorporates a social and political element. Although individual behaviours may contribute to ill-health, many activities are socially and structurally determined. Many health educators, however,ignore these social and political elements. As one example, in terms of Coronary Heart Disease (C.H.D.) health educators often concentrate only on individual behaviours and traditional risk factors of C.H.D. at the expense of ignoring other socially and structurally influencing factors in C.H.D. mortality. Indeed, as Martin and McQeen (1990) note "heart disease like almost all disease categories is strongly associated with social class. A study of C.H.D. mortality rates among different civil service grades found that higher status or grade was linked with lower C.H.D. mortality. ...the traditional risk factors only accounted for a small

refuse first, to challenge pervading social policy in health care, and second, to highlight the relationship between broadly encompassing political and economic strategies on a wide societal scale and the social determinants of ill-health. A good example of an "apolitical" stance adopted by a health education organization is the U. K. Health Education Council's B.B.C T. V. programme entitled "Plague of Hearts." Although the preliminary program draft made direct allusion to the possible social and economic determinants of illness, the final television script made no significant reference to the political and social context. The first draft suggested that the programme was to be aimed "at the general health of the public, individually and collectively, decision makers and opinion formers, in order to encourage changes in the lifestyle and *environmental and social characteristics* that are underlying causes of of mass CHD." (p. 35). However, the final summary of the programme's intent make no significant allusion to the political and social determinancy of illness. It is stated that the programme's aim is to "examine the likely causes of the disease and see what changes individuals or the government could make to reduce its incidence" (Farrant & Russell, 1986, p. 36). Although "the role of the government (as an overseer of health is cursorily) is mentioned, no attention is given to challenging existing social or health policy (Farrant & Russel, 1986). The overwhelming "apolitical" stance of the final programme is clearly evident in the following remarks of a senior Health Education Council (H.E.C.) officer who, in reference to the leaflet "Beating Heart Disease" that accompanied the T.V. programme states:

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part of the variations in relative risk of C.H.D. mortality (Rose and Marmont 1981)...the individualising of health and illness has, in effect, removed the social dimension from consideration of disease causation and, hence, from prevention."(p.4)

> These booklets are not designed to influence the politicians -- that is a different thing ... if you want to tackle food policies you do it in a different way, not through individuals who are concerned about heart disease ... [and] if you are going to tackle social class inequalities in health you are not going to tackle it by a booklet on heart disease, or indeed a booklet on any other disease. (Farrant & Russell, 1986, p. 36)

A number of reasons might be put forth for the reluctance of health professionals to acknowledge the inherent political nature of their enterprise. O'Neill (1990) suggests that there is a "quasi-moral" reluctance among many health professionals to become involved in political activity as related to health issues. He suggests that a large number of health professionals are motivated by a genuine service or helping ideal, and that this orientation is not always compatible with an understanding of "the political" and the need for political intervention. He notes that:

> Being largely a woman's profession which has its own peculiar perception of its role, politics is often seen by nurses as dirty and nasty; hence these professionals usually tend to negate the presence of social conflicts, given their "do-gooder" orientation, and to leave to others the job of intervening in this area. These dilemmas do not concern nurses exclusively; most other professionals working in community health (physicians, social workers, etc.) are trained within the same kind of ideological framework. (p. 226)

In addition Farrant and Russell (1986) provide some direct and concrete examples of why many health educators choose to ignore the political ramifications of health. When asked to respond to a number of hypothetical cases concerned with political and social approaches to health prevention, the following responses were indicative of health workers' reluctance to mix health promotion with political action or reform:

> That's politics, not health education. I'm employed by the health authority. I wouldn't see it as my role.

> You have to have some loyalty to your employer. I don't want to be viewed as a political animal. I know there is a move [in Health Education] towards thinking we should be used to promote change, but I won't be used in a subversive way ... I know there are shortcomings in the services, but I won't join a group arguing for change like that. (Farrant & Russell, 1986, p. 178)

Such "apolitical" attitudes may derive from authentic concerns about professional health values or ethics, and to the belief held by many health authorities to avoid anything which might be labelled "political." In addition, health education is often perceived by many professionals and health promotion organizations to be concerned with the transmission of "objective" and "neutral" health information, as opposed to the need to educate individuals for social and political change. However, the result of focusing primarily on individual behavioural change and of conveying messages of political neutrality, is that "health educators direct attention from the opportunity for social prevention and from the relationship between forms of social organization and the prevalence of illness" (Morgan, 1981, p. 181).

Furthermore in addition to the failure of many health educators and physical education teachers to acknowledge that "health" and "health education" are, at least in certain significant aspects, political enterprises requiring (at least in part) political remedies, there exists likewise numerous technical and structural constraints that may well propagate the apolitical attitude referred to above. For example, many health education courses have traditionally placed emphasis on a technocratic orientation biased in favour of epidemiology, biostatistics and medical care organization. Consequently, there has been a failure within many medical and health promotion courses to address issues concerned with analyzing and utilizing political forces in terms of social change and health policy. The

relationship of political and social action as a possible means to improve health conditions within our society is thus repeatedly ignored. O'Neill (1990) notes with reference to current health promotion courses that,

> their first and most essential function is one of social control, more than one of radical or even reformist social change. It is not surprising, then, to realize that, in many countries, the skills and attitudes required to intervene politically in health promotion are not taught to the community health workers, who are clearly expected to help maintain the status quo rather than challenge it. (p. 227)

Linked to the above notion of workers' inherent and unexamined acceptance of the status quo, there are also structural constraints which may inhibit political action directed towards policy changes in health. Since the mid 1980's , the regional or federal governments of many Western countries deliberately legistated reduced welfare programs for their citizens. As a consequence "the present time is not perceived by many workers as a good one in which to acquire skills which would make people and organizations even more vulnerable to critics and more exposed to cutbacks in scarcer than ever governmental monies. (O'Neill, 1990, p. 227)[5]

Possible Alternative for Health Education and Health Based Physical Education

Having outined the problems inherent in the creed of individualism as it applies to health education and health care, and suggested some of the reasons for the adoption of an 'apolitical' attitude among many health professionals, I will

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[5]For example, in the U.K., although the last ten years of a conservative government has seen an increase in spending of 24% on the National Health Service (N.H.S.), (leading the government to say "the health service is safe with us") in terms of health service needs, (e.g. the requirements for an increasing elderly population and an escalation in labour costs) there has actually been a failure to maintain growth to meet these needs. Therefore despite the increase in spending, there has actually been a fall in the level of resources available to many services in the N.H.S. (Thills 1987). For more detailed analysis of spending on the welfare state in the U.K. see "The Growing Divide - A Social Audit 1979 - 1987, Eds. Walker and Walker (1987).

now suggest certain possible new directions that an alternative approach to health education and in particular health based physical education, might take.

First, it is important that health educators acknowledge the political and social basis of their enterprise. As I have attempted to show throughout this study, it is inadequate that health educators focus exclusively on alteration of individual behaviour at the expense of ignoring the social context in which this behaviour takes place. Labonte (1981) correctly suggests that health improvement within our society is not simply concerned with the amendment of individual lifestyles and behaviour. He states that

> Poverty, unemployment and pollution are playing a growing role in the health problems of our society, and we are coming to recognize that neither lifestyles nor the modern epidemic of chronic disease can be viewed in isolation from our social, economic, industrial and political structures. (p.235)

With reference to the education and training of health professionals, a restructuring of training courses may be necessary in order to draw attention to the wider social and political dimensions of health prevention. Health educators, for example, might be introduced to alternative means of health promotion that do not focus exclusively on individual behaviour modification and lifestyles, but incorporate as well a political and social emphasis on strategies for health prevention. One example of a social and political orientation to health prevention might involve political lobbying, which would involve health professionals in a collective campaign directed towards ameliorating those social conditions that impinge upon health. Such lobbying strategies would attempt to examine factors other than merely the various behaviours of healthy or unhealthy individuals, and would be based on an understanding of the many social and political aspects that

impinge upon the prevention of disease and promotion of health (Amos & Ineson, 1990).

An example of a viable political lobbying approach is one recently and successfully adopted by the British Medical Association (B.M.A. 1986). The B.M.A. launched an anti-tobacco campaign which was aimed at forcing the British government to implement previous report recommendations issued from the Royal College of Physicians (1986). The major emphasis of the college's report was an attempt to ban all tobacco promotion within the media. Two areas of particular concern to the Royal College were the marketing strategies employed by the tobacco industry and, in particular, the increase in advertisements targeted at cigarette consumption by women.[6] While several years of political lobbying on behalf of the B.M.A. did not result in the total banning of all tobacco promotions, one effect of the associated media coverage was that "the public received a considerable amount of information about women's smoking and some of the tactics being developed by the tobacco industry to initiate and maintain cigarette consumption" (Amos and Ineson, 1990, p.170). As a consequence of this deliberate lobbying technique, a voluntary agreement concerning tobacco promotion was made between various popular women's magazines and the British government. The result was that nine major British magazines, despite the loss of revenue that would result, refused to continue to accept tobacco advertisements.[7]

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[6]In the U.K. womens' magazines are used as the key media format through which to promote cigarette usage.

[7]The magazines and their readership number (age 15 years and over) are as follows. Cosmopolitan (1815000); Vogue (1668000); True Romances (1077000); Options (1041000); Woman's World (834000); Company (701000); Over 21 (694000); Ms London (267000), Girl About Town (217000); (Amos and Ineson 1990).

The impact of such lobbying strategies should not be underestimated. Following the deliberate challenge to tobacco companies by the B.M.A. there has subsequently been a number of newly introduced courses in medical schools whose purpose is to inform pre-medics about the social and political approaches to health prevention. For example, at both Edinburgh and Southampton Universities, medical school students are currently introduced to issues related to the politics of the tobacco debate, and initiated into the means by which to lobby politically for renewed strategies to improve the health of the general community.

The introduction of health professionals to political and social approaches to health prevention might therefore provide one means to highlight the relative importance of public policy and the social and economic conditions involved in contributing to ill-health. Such measures could in turn provide health educators with an understanding of the importance not only of lifestyles and behavioural factors in health prevention, but also highlight the significance of the social conditions within our society involved in the prevention of health and the creation of illness. This may result in health educators not only helping individuals to develop personal skills to improve their own health, but also lead to community action to improve the environmental and social conditions which are significant in determining the health of individuals within those communities.[8]

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[8]This may involve the application of Paulo Freire's notion of critical consciousness, where individuals are empowered to bring about changes in their environment to enhance health. For a more detailed analysis of the application of Paulo Freire's ideas to health promotion and community development strategies see Brown and Margo (1979) and Malone (1988). Although the notion of community based empowerment strategies in health promotion provide one means to improve the social and environment conitions contributing to ill-health, it should also be recognized that there are a number of limitations to such an approach. Little (1990) suggests that the diversity and complexity of communities often inhibits combined political action, that is, "different small groups make decisions on different community problems , and therefore consensus on a health promotion package, which will involve decisions of community life is unlikely" (p. 51). Further, Little (1990) notes that the majority of people within the community are not interested in political lobbying and participation, and those who do engage in activities are often from the most advantaged groups. Therefore, the "voice" of many

Conclusion

Having proposed some viable options for health educators in terms of developing social awareness and becoming politically involved in health prevention, I will now conclude this study by making some recommendatins for related future developments in Health Based Physical Education. Although I will reveal some suggestions for future curriculum content and endorse a particular conception of the teaching of health education, it is beyond the scope of this thesis to provide detailed prescriptive guidelines in terms of the teaching methods and exact curriculum content of H.B.P.E. It could be argued that this lack of explicit programme outlines is a limitation within this piece of work. However, by revealing some of the taken-for-granted assumptions of H.B.P.E., this study does provide direction in terms of possible preliminary H.B.P.E. curriculum development, a direction that communicates to P.E. teachers some of the meanings, messages and constraints underlying contemporary practice in H.E. and H.B.P.E. (Colquhoun 1991).

A main emphasis of this study was to show that H.B.P.E. programmes are based upon an individualistic conception of health, and, as such, many of these programmes are involved in reproducing an unjust, ill-conceived concept of health, in other words one lacking in an understanding of the social and political contraints of individual health behaviour (Tinning 1991). As I have already stated, the promotion of an individualistic view of health or healthism is in the interests of governments which can divert social or state responsibility in health prevention to

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individuals withing the community may not be heard. This is not to suggest that the notion of community 'action' is not valid. it is one useful means for health improvement. However, in order to increase the efficacy of community strategies for social change in health, its limitations should be noted in order that these constraints can be overcome with the result of improvement in the power of community action.

individual measures. It has resulted in a proliferation of consumerism in health (including commercial fitness centres where membership must be purchased and drug companies that manufacture and aggressively market diet pills, to name but a few).

The challenge for P.E. teachers at the present time should therefore be first to become aware of the implicit meanings and messages associated with "healthism". This may require teachers to initially analyze H.B.P.E. materials, and specifically to become aware of the extent to which specified curriculum content reproduces an individualistic conception of health.

Further the content of H.B.P.E. programmes, should be improved to incorporate a wider range of issues that reflect a broader social definition of health prevention, and emphasize not only the importance of individual behaviours and lifestyles, but also other health determinants (including consumerism and advertising in health) that are significant in controlling individual actions and attitudes. According to Combs (1989), the teaching of health education should be developed with the belief that

> Health education experiences are rooted in complex influences operating at the interlinked levels of the individual, the local community and the wider organization of society (its social, cultural, economic and political structures) - in other words, a critical approach [should be adopted] which acknowledges gradients of choice, the multidimension of responsibility and the meanings and functions of health related behaviors. (p. 75)

Despite the above suggested directions for H.B.P.E., a new approach in H.B.P.E. may not necessitate a profound and radical alteration in curriculum programme materials. But what is required is a more thoughtful, critical appraisal of H.B.P.E. content. Therefore, although the substance of what is taught may not

alter radically, the treatment of the substance must change significantly. For, example, rather than merely informing students about the benefits of exercise to general health maintenance, students might also be asked to consider the social context that often limits the opportunity to exercise or its ultimate benefits. In H.B.P.E. programmes students are currently informed about the benefits of exercise in weight control, yet rarely, if ever, are they asked to consider the political and social restrictions that impinge upon exercise and often make weight control through exercising measures *not* equally accessible to all people in the first place. As Tinning (1991) suggests

> The opprtunities to exercise as a form of weight control are not equally available to all individuals. Mothers who work both in and outside the home, shift workers, certain ethnic groups, economically impoverished families to name but a few, have less "individual choice", with respect to exercising than, for example, a single male [or female] primary school teacher who is relatively well paid, and who has generous leisure time. (p. 46).

Students should be given the opportunity, then, to analyze some of the wider social and cultural influences impinging upon health behaviour. One potential site for analysis would be the increasing financial and consumer orientation in health maintenance.[9] Students might be asked to consider some of the media messages associated with "health", and attempt to decode the visual and commercial imagery which is rarely obviously apparent. As an example, students might be asked to discuss commercial advertisements from teenage popular culture and analyse certain prevalent visual messages in light of mass media presentations of 'the ideal body' image. Questions for consideration could include the following: How

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[9]The critique of consumerism in health presents P.E. teachers with a major task, particularly when we consider that 'health as release' is becomming a major focusing concept of H.B.P.E. (see chapter 3).

am I influenced by media portrayals of the ideal body shape?; What is this ideal shape and how attainable is it?; and what kinds of messages or conformity are being portrayed in these advertisements? In this way, students can be informed about the many influencing aspects of consumerism which are detrimental to attaining health, including for example, the fostering of an obsession with many females, and increasingly males, to achieve the idealized 'physical form' or the perfectly 'crafted' body.[10]

In addition to an analysis of the obvious consumer orientation in health maintenance, H.B.P.E. courses could further incorporate information on factors within the social context that restrict individual 'free-choice' in attaining health. Sites of analysis could be victim-blaming posters or magazine advertisements which embody moralistic messages about individual responsibility and blame, yet fail to consider the social context in which certain health behaviours take place -- the recent B.C. advertisment and accompanying slogan 'Drugs - don't be dumb' (funded by the provincial government) provides one example. The poster, aimed at altering individual behaviour, unfortunately fails to recognize the role of broader social forces in shaping individual behaviour and choice. As another example, as well as informing young people as to the hazards of smoking, students could also be made aware of the social and cultural forces which may influence and promote nicotine addiction. The commercial strategies and consumer images used by tobacco industries could again provide one area of discussion.

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[10]In terms of P.E. teaching, it should be noted that this form of critical approach to H.B.P.E. does not involve accepting advertising and popular culture as an art form or something we should accept as a good thing. Quite the opposite, it is important that the consumer culture in health is accepted for its manipulation of audiences, its materialistic focus, and the negative influences it may have upon health maintenance. (For a more detailed analysis of some of these negative influences in health see Chernin, K. (1981) "The Obsession - Tyranny and the Cult of Slenderness".)

In considering these suggestions for H.B.P.E., it is important that health educators recognize a number of possible limitations to a critical approach. P.E. teachers must be aware that unless changes in school H.B.P.E. are accompanied by a widescale social change in health, and a significant challenge made to highlight the failings of the individualistic creed in health, improvements in schools at the P.E. curriculum level are likely to be to tokenistic or superficial. Combs (1989) notes that the problem may arise where "behind the facade of innovation, this kind of change [in health education] merely supports the prevailing ideology [of individualism]" (p. 25). Therefore, although the approach I have suggested could increase the social and personal awareness of individuals in terms of the social, cultural and environment factors influencing individual health behaviour, it could also result in despair and alienation if individuals become more critical of the social context of health, yet the individualistic approach in the wider context prevents any possible and substantive changes from occurring.

This is not to end on a negative note, but rather to suggest that P.E. teachers should be aware that although Health Based Physical Education programmes do provide a small, but important means to educate students, if the critical approach to Health Education in schools is to be significantly widespread and influential, it should be accompanied by wider scale changes that attempt to reduce social inequalities in health. That is, social and political changes that make a significant attempt to prevent ill-health within our society are required.

BIBLIOGRAPHY

AAHPERD. (1980). AAHPERD health-related fitness test manual. Washington, D. C.: AAHPERD.

Alcohol and Drug Programs. (1988). Try - The responsibility is yours. Victoria, British Columbia: Ministry of Labour and Consumer Services.

Allsop, J. (1984). Health policy and the national health service. London: Longman.

Almond, L. (1983). A rationale for health related fitness. Bulletin of Physical Education, 19(20.

Almond, L. (1988). Health and physical education in the national curriculum. P. E. Review, 11(2), 119-122.

Arlene, B. (1987). Secondary physical education Active Health resource book, Grades 8-12. Victoria, British Columbia: Ministry of Education.

Armstrong, D. (1983). The social role of medicine. In P. S. G. Wright (Ed.), An outline of sociology as applied to medicine.

Armstrong, D. (1987). Bodies of knowledge: Foucault and the problem of human anatomy. In G. Scrambler (Ed.), Sociology theory and medical sociology. London, England: Tavistock Publishers.

Armstrong, N. (1987). The physiological foundations of health-related fitness. Health and Fitness in the Curriculum Perspectives, 31, School of Education, University of Exeter.

Aronowitz, S., & Giroux, H. A. (1985). Education under seige: The conservative, liberal and radical debate over schooling. London: Routledge, and Kegan Paul.

Ashton. (1984). Health in Mersey: A review. Department of Community Health, University of Liverpool.

BAALPE. (1988). Health-focused physical education. Leeds: BAALPE.

Bain, L. (1990). A critical analysis of the hidden curriculum in physical education. In D. Kirk & R. Tinnings (Eds.), Physical education, curriculum and culture: Issues in the contemporary crisis. London, England: The Falmer Press.

Baldwin, and Wells. (1979). Active tutorial work. Oxford: Basic Lackwell.

Beaty, M., & Corby, J. (1980, July). Stairway to health. Occupational Health.

Berbenian, R. M., et al. (1976). The effectiveness of drug education programs: A critical review. Health Education Monographs, 4, 377-398.

Berger, J. (1972). Ways of seeing. London: British Broadcasting Company and Penguin Books.

Berliner, H. S., & Salmon, J. W. (1979). The holistic health movement and scientific medicine: The naked and the dead. Socialist Review, 43(9)(1).

Black Report. (1980). Inequalities in health: Report of a research working group. London, England: D.H.S.S.

Bourdieu, P. (1990). The logic of practice. London: Polity.

Bradshaw. (1982). Area variations in infant mortality 1975-77. Journal of Epidemiology and Community Health, 36, 11-16.

Biddle, S. (1983). The "why" of health-related fitness. Bulletin of Physical Education, 17, 28-31.

Bowson, N. (1978). The myth of the unhealthy executive. Across the Board, 15, 10-16.

British Columbia, Province of. (1989). Secondary physical education active health resource book grades 8-12. Victoria, B. C.: Ministry of Education.

Brown, E. R., & Margo, G. E. (1978). Health education: Can the reformers be reformed. International Journal of Health Services, 8(1), 3-25.

Brubaker, B. M. (1983). Health promotion: A linguistic analysis. Advances in Nursing Science, 5(2), 1-14.

Butler, R. N., Gertman, Oberlander, D. L., & Schindler, L. (1979-80). Self-care, self-help and the elderly. International Journal of Aging and Human Development. 10(1),

Canada Fitness Survey. (1982). Fitness and aging. Ottawa: Canada Fitness Survey.

Canada Fitness Survey. (1983). Fitness and lifestyle in Canada. Ottawa: Canada Fitness Survey.

Canada Fitness Survey. (1984). Changing times: Women and physical activity. Ottawa: Canada Fitness Survey.

Canada Fitness Survey. (1985). Physical fitness of Canadian youth. Ottawa: Canada Fitness Survey.

Canada Fitness Survey. (1986). Physical activity among activity-limited and disabled adults in Canada. Ottawa: Canada Fitness Survey.

Chernin, K. (1981). The obsession: Reflections on the tyranny of slenderness. New York: Harper & Row.

Coburn, D. (1981). Work alienation and well being. In D. Coburn, C. D'Arcy, P. New, & G. Torrance (Eds.), Health and Canadian society. Toronto, Ontario: Fitzhenry and Whiteside.

Cohen and Cohen. (1978). Health education: Panacea, pernicious or pointless? The New England Journal of Medicine, 28, 718-721.

Colquhoun, D. (1989, Autumn). Health-related fitness and individualism. British Journal of Physical Education.

Colquhoun, D. (1990). Images of healthism in health based physical education. In D. Kirk & R. Tinnings (Eds.), Physical education, curriculum and culture. London, England: Falmer Press.

Colquhoun, D., Kelly, P., & Stevens, L. (1990, June). Individualism in school health education: A case study of alcohol education in a victorian primary school. The ACHPER National Journal.

Colquhoun, D., & Kirk, D. (1987). Investigating the problematic relationship between health and physical education: An Australian study. Physical Education Review, 10(2), 100-109.

Corbin, C. (1979). Fitness for life: Teacher's edition. Glenview: Scott Foresman and Co.

Corbin, C. (1985). Fitness for a lifetime. British Journal of Physical Education, 16(2), 44-46.

Cornwall, J. (1984). Hard earned lives: Accounts of health and illness from East London. London, England: Tavistock.

Crawford, R. (1977). You are dangerous to your health: The ideology and politics of victim blaming. International Journal of Health Services, 7(4), 663-680.

Crawford, R. (1980). Healthism and the medicalization of everyday life. International Journal of Health Services, 7, 359-386.

Crawford, R. (1986). A cultural account of "health": Control, release and the social body. In J. B. McKinlay (Ed.), Issues in the political economy of health care. London, England: Tavistock.

Cribb, A. (1986). Politics and health in the school curriculum. In S. Rodmell & A. Watt (Eds.), The politics of health education (pp. 100-120). London: Routledge and Kegan Paul.

Devane, R. S. (1948). The failure of individualism: A documented essay. Dublin, Ireland: Browne & Nolan.

Draper, P. (1977). Health and wealth. Royal Society of Health Journal, 97, 121 & 127.

Douglas, M. (1970). Natural symbols: Explorations in cosmology. New York: Pantheon Books.

Dubos, R. (1959). The mirage of health. New York: Haprer and Row.

Easton, J. (1990, June). Learn to relax and counter stress. Occupational Health.

Enrenreich, J. (1978). The cultural crisis of modern medicine. New York: Monthly Review Press.

Engel, G. L. (1977). The need for a new medical model: A challenge for bio-medicine. Science, 196(4286), 129-136.

Evans, J., & Clark, S. (1989). Changing the face of physical education. In D. J. Evans (Ed.), Teachers, teaching and control in physical education.

Evans, J., & Davis, B. (1986). Sociology, schooling and physical education. In J. Evans, Physical education, sport and schooling: Studies in the sociology of schooling. Lowes: Falmer.

Evans, R. (1982). A retrospective on the "New Prospective". Journal of Health Politics, 7(2), 325-344.

Ewan, S. (1976). Captains of consciousness: Advertising and the social roots of the consumer culture. New York: McGraw-Hill.

Eyer, J. (1975). Hypertension as a disease of modern society. International Journal of Health Services, 5(4).

Farrant, N., & Russell, J. (1986). The politics of health information. Bedford Way Papers. University of London Institute of Education.

Farrant, N., & Russell, J. (1986). Community initiative in health education publications: A role for health education officers? In S. Rodmell & A. Watt (Eds.) The politics of health education: Raising the issues.

Featherstone, M. (1983). Consumer culture: An introduction. Theory, Culture and Society, 1(3), 4-9.

Featherstone, M. (1987). Lifestyle and consumer culture. Theory, Culture and Society, 4, 55-70.

Ferris, B. F., et al. (1987, September). Fitness promotion and research in Canada. JOPEND.

Freeman, K., & Popkewitz, T. S. (1988). Art education and social interests in the development of American schooling: Ideological origins of curriculum theory. Journal of Curriculum Studies, 20(5), 387-405.

Freidson, E. (1970). The profession of medicine: A study of the sociology of medical knowledge. New York: Dodd Mead and Company.

Fitzclarence, L. (1986, Winter). The physical education curriculum: A cultural perspective, Part I. ACHPER National Journal, 116, 16-18.

Foster, A. (1988). Heroes, fools and martyrs. In Vol Ten, 8(28), 54-62.

Foucault, M. (1977). Discipline and punishment: The birth of the prison. London, England: Allen Lane.

Foucault, M. (1980). Body/power. In C. Gordon (Ed.), Power and knowledge. Brighton: Harvester.

Freund, P. E. S. (1982). The civilized body, social domination, control, and health. Philadelphia: Temple University Press.

Fromm, E. (1965). Escape from freedoms. New York: Avon Books.

Goodson, I. F. (1987). School subjects and curriculum change. London: Croom Helm.

Goss, D. G. (1986). Evaluation of active health curriculum in junior secondary physical education program in the province of British Columbia. Unpublished master's project, Simon Fraser University, Burnaby, British Columbia.

Green, H. (1989). Fitness in American culture: An introduction. In K. Grover (Ed.), Fitness in American culture. Amherst: University of Massachusetts Press.

Green, J. (1979). Health promotion policy and the placement of responsibility for personal health care. Family and Community Medicine, 2(3), 51-64.

Green, L. W. (1970). Should health education abandon attitude change strategies? Perspectives from recent research. Health Education Monograph, 30, 27-48.

Green, M. (1986). Fit for America: Health fitness and sport in American society. New York: Pantheon Books.

Haley, B. (1978). The healthy body in Victorian culture. Cambridge, Mass.: Harvard University Press.

Hargreaves, J. (1977). The body, sport and power relations. In J. Morne, D. Jary, & A. Tomlinson (Eds.), Sport, leisure and social relations. London, England: Routledge, Kegan and Paul.

Hargreaves, J. (1986). Sport, power and culture: A social and historical analysis of popular sports in Britain. Cambridge, England: Polity Press.

Harper's Magazine. (1990, December). Harper's magazine index. Vol. 281, No. 1687.

Health and Welfare. (1986). Achieving health for all: A framework for health promotion. Ottawa, Ontario: Health and Welfare Canada.

Health Education Council. (1977). Health education project. Nelson: London.

Hosay, P. M. (1977). The unfulfilled promise of health education. New York University Education, 8(2), 16-22.

Hoyley, B. (1978). The healthy body in victorian culture. Cambridge, Mass: Harvard University Press.

Hoyal, E. (1977). New directions in the sociology of education and implications for physical education. In J. E. Kane (Ed.), Movement studies and physical education. London: Routledge and Kegan Paul.

Hyland, T. (1988). Values and health education: A critique of individualism. Educational Studies, 14(1).

Illich, I. (1975). Limits to modern medicine. London: Lothian.

Illich, I. (1975). Medical nemesis. London, England: Calder & Boyars.

Jampolsky, G.G. (1979). Love is letting go of fear. Milbrae, C.A.: Celestiral Arts.

Jaff, D.T. (1980). Healing from within. New York: Bantam Books.

Kennedy, A. (1990, October). Does sex sell safety? Occupational Health.

Kirk, D. (1986). Health related fitness as an innovation in physical education curriculum. In J. Evans (Ed.), Physical education, sport and schooling: Studies in the sociology of schooling. London: The Falmer Press.

Kirk, D. (1989).. Physical education and curriculum study: A critical introduction. London: Croom Helm.

Kirk, D., & Colquhoun, D. (1990). Physical education, curriculum and culture:: Critical issues in the contemporary crisis. London, England: The Falmer Press.

Knight-Ridder, . (1991, April 5th). What private lives?; Smokers, obese on firm's hit list. Vancouver Province

Knowles, J. H. (1977). The responsibility of the individual. Daedalus, 106, 57-80.

Labonte, R., & Penfold, S. (1981). Canadian perspectives in health promotion: A critique. Health Education, 4, 4-9.

Lalonde, M. (1974). A new perspective on the health of Canadians: A working document. Ottawa: Ministry of National Health and Welfare.

Lazarus, R. (1966). Psychological stress and the coping process. New York: McGraw-Hill.

Lears, R. (1987). American advertising and the reconstruction of the body, 1880-1930. In K. Grover (Ed.), Fitness in American culture. Massachusetts: University of Massachusetts Press.

Love et al. (1984). Beyond individual accountability: Public policy perspectives. In P. Lumsden (Ed.), Community mental health education. Ottawa: The Canadian Public Health Action.

Lowenberg, J.S. (1989). Caring and responsibility: The crossroads between holistic practice and traditional medicine. Philadelphia: University of Philadelphia Press.

Lukes, S. (1973). Individualism. New York: Harper & Row.

Mackay et al. (1980). Active health. Coquitlam, B. C.: Coquitlam School District.

Malone, M. (1987). Health and empowerment: An application of Paulo Freire's theory in a Canadian context. Unpublished master of arts thesis, Ontario Institute for Studies in Education, Toronto, Ontario.

Maxwell, R. J. (1981). Health and wealth: An international study of health care. Toronto, Ontario: Lexington Books.

McKeown, T. (1977). The role of medicine: Dream, mirage or nemesis. Princeton, N. J.: Princeton University Press.

McNamara, J. R. (1979). Behavioural approaches to medicine. New York: Plenum.

McNamee, M. (1988). Health-related fitness and physical education. British Journal of Physical Education, 19(2), 83-84.

Mellott, R. (1989). Stress management for professionals - How to feel better and perform better on the job. Career Track Publications, Boulder, Colorado.

Men's Fitness. (1991, April). Advertisement: Beauty & fitness. Vol. 7, No. 4.

Milio, N. (1981). Promoting health through public policy. Philadelphia: F. A. Davis Co.

Minkler, M., & Cox, K. (1980). Creating critical consciouness in health: Application of Freire's philosophy and methods to the health care setting. International Journal of Health Services, 10(2), 311-321.

Mitchell, A. (1991, March 3). Fashion-conscious women looking for permanent pout. Globe and Mail.

Mitchell, J. (1984). What is to be done about health care. London: Penguin.

Moss, G. E. (1973). Illness, immunity and social integration. New York: Wiley.

Mozerek, D. J. (1989). Sport in American life: From national health to personal fulfillment 1890-1940. In K. Grover (Ed.), Fitness in American culture. Massachusetts: University of Massachusetts Press.

Mrozek, D. (1983). Sport and American mentality 1880-1920. Knoxville: University of Tennessee Press.

Naidoo, J. (1986). Limits to individualism. In S. Rodmell & A. Watt (Eds.), The politics of health education. London, England: Routledge and Kegan Paul.

Navarro, V. (1978). Crisis of the western system of medicine. International Journal of Health Services, 8, 190-199.

O'Neill, M. (1990). The political dimension of health promotion work. In Reachings for a new public health . Edinburgh: Edinburgh University Press

Parry, J. (1987). The concept of health. Unpublished paper, The University of Leeds.

Pate, R. M. (1983). A new definition of youth fitness. The Physician and Sports Medicine, 11(4), 77-83.

Pate, R. R., & Corbin, C. B. (1981). Health-related physical fitness: Implications for the curriculcum. JOPER, 52, 36-38.

Postinkoff, M. G. (1984). The social context of lifestyle. Unpublished master of arts thesis, Simon Fraser University, Buraby, B. C.

Powles, J. (1973). On the limitations of modern medicine. Science, Medicine and Man, 1(1), 1-30.

Pring. (1984). Personal and social education in the curriculum. London: Hodder and Stoughton.

Reasons, F. (1981). Assault on the worker: Occupational health and safety in Canada. Toronto: Butterworth.

Reid. (1981, March 17). Into the mainstream. Times Educational Supplement.

Remington, D. (1990). Life in the fast lane: The health issue of the 1990's. In Health Report, Toronto: Globe and Mail.

Richards, N. D. (1975). Methods and effectiveness of health education: The past, present and future of social and scientific involvement. Social Science and Medicine, 9, 141-156.

Riska, R. (1982). Health education and its ideology content. Acta Sociologica, 25 supplement, 41-66.

Rodmell, S., & Watt, A. (Eds.), (1986). The politics of health education. London, England: Routledge and Kegan Paul.

Schneider, M. (1975). Neurosis and civilization. New York: The Seabury Press.

Sencel, S. (1984). Staying healthy: Nutrition, lifestyle and medicine. Editorial Research Reports, Congressional Quarterly Inc., New York.

Shapiro, J. and Shapiro, D... (1979). The psychology of responsibility: Some second thoughts on holistic medicine. New England Journal of Medicine, 301, 211-212.

Sheffield Health Authority. (1986). Health care and disease: A profile of Sheffield. Sheffield, England.

Smith, J. E. (1976). The philosophy of preventive medicine. Minnesota Medicine, 59, 196-199.

TACAPF. (1981). Free to choose: An approach to drug education. London: Tacade.

Taylor, C. R. (1982, Summer). The politics of prevention. Social Policy, pp. 32-34.

Tinning, R. (1991, Spring). Problem-setting and the ideology of health based P.E.: An Australian Perspective. P.E.Review.

Tones, B. K. (1986) Health education and the ideology of health promotion: A review of alternative approaches. Health Education Research, 1(1), 3-12.

Tye, J. (1990, October). The end justifies the means. Occupational Health.

Townsend, P. (1982). Health and deprivation. London, England: Croom Helm.

Ubell, E. (1972). Health behaviour change: A political model. Preventive Medicine, 1, 209-221.

Walker, A. and Walker, C. (1987). The Growing Divide - A Social Audit. 1987 - 1987. London: Child Poverty Action Group.

Waterson, A. (1986). Occupational health and illness. In S. Rodmell & A. Watt (Eds.), The politics of hazard education.

Watt, A. (1986). Community health education: A time for caution? In S. Rodmell & A. Watt (Eds.), The politics of health education. London, England: Routledge and Kegan Paul.

West of Scotland, Politics of. (1984). Glasgow: Health of a city. Health Group.

Whitehead and Fox. (1983, Summer). Student centred physical education. Bulletin of Physical Education.

Whorton, J. C. (1982). Eating to win: Popular concepts of diet, strength, and energy in the early 20th Century. In K. Grover (Ed.), Fitness in American culture. Massachusetts: University of Massachusetts Press.

Wildersky, A. (1977). Doing better feeling worse: The political pathology of health policy. Daedalus, 106, 105-123.

Williams, A. (1988). The historiography of health and fitness in P. E. H. E. C. Project Supplement.

Williams, et al. (1979). Chronic disease risk factors among children: The "Know Your Body Study".. Journal of Chronic Diseases, 32, 505-513.

Whorton, J. (1982). Crusaders for fitness: The history of American health reformers. Princeton: Princeton University Press.

Wright, P., & Treacher, A. (Eds.) (1982). The problem of medical knowledge. Edinburgh, Scotland: Edinburgh University Press.

Zola, I. K. (1978). Medicine as an institution of social control. In J. Ehrenreich, The cultural crisis of modern medicine (pp. 80-100). New York: Monthly Review Press.