

3 Choosing lifestyles

Health is indivisible . . . the domain of personal health over which the individual has direct control is very small when compared to the influence of culture, economy and environment. (Hafton Mahler, former Director General of the World Health Organisation, cited in Parish, 1995)

Learning objectives

This chapter focuses on behaviours that are part of an individual's lifestyle, such as eating, smoking, drinking, taking drugs, using condoms and so on. It reviews different approaches to attempts to influence lifestyles (through health promotion efforts) and reviews research on the contextual nature of individual behaviour. By the end of this chapter you should be able to:

- identify and describe social cognition approaches to the study of lifestyle behaviour;
- compare and contrast individual and structural-collective perspectives on improving lifestyles and health;
- outline and explain some of the limitations of traditional approaches to health promotion efforts;
- describe the implications of strategies that have been employed to influence individual lifestyles;
- explain the importance of social situation and cultural context in understanding behaviours that make up individual lifestyles.

What are lifestyles and how do they relate to health?

What kind of lifestyle do you have? Reasonably affluent, relaxed, busy, 'on the edge', chilled out, stressed, fun, sporty? Does your lifestyle affect your health? Will it affect your health one day in the future? Do you ever think about changing your lifestyle for health reasons? What does a 'healthy' lifestyle mean? Does it equate with doing nothing that is exciting or fun? The concept of 'lifestyle' is a slippery one, but it is central to any discussions about the consequences of how people live and behave for their physical health.

The term **lifestyle** has been used in many contexts, and has referred to conditions of living, product brand names and television programming (Davison *et al.*, 1992). Traditionally in social science work, the concept of lifestyle was about the social distribution of wealth, status and power, and how these affected individual subjectivity. Today, however, the concept is vague and seemingly everything can belong to the sphere of 'lifestyle' (O'Brien, 1995). Lifestyle is often linked with individual health and is widely used in the fields of health promotion, preventive medicine and health research (Backett & Davison, 1995). Here we use this concept to denote the idea of specific behaviour and ways of living that may be related to physical health.

As we have already noted in ch. 1, how we live and what we do affects our health. Public health initiatives such as sanitation and clean drinking water improved the health of populations in the West early in the twentieth century, dramatically reducing deaths from infectious diseases and leading to longer life expectancies. In Western societies today the main causes of illness and death are related to individual lifestyles (McKeown, 1979). For example, smoking cigarettes, drinking excessive amounts of alcohol and eating a poor diet have been linked to heart disease, stroke and cancer (Matarazzo, 1984). As described in research in focus box 3.1, correlational studies explicitly highlight the links between health-related behaviours and later health status and mortality (Belloc & Breslow, 1972; Breslow, 1983).

Another example comes from a recent large, ten-year longitudinal study carried out in seven European countries. This study examined the effect of engaging in three particular kinds of **health behaviours** (non-smoking, being physically active and eating a good diet) on survival in over 1,200 older people aged between 70 and 75 years. Results showed that each of these behaviours was positively related to survival over the ten years, while engaging in all three was even more strongly related to survival. Conversely, people who did not engage in any such behaviour were three to four times more likely to die in the following ten years (Haveman-Nies *et al.*, 2002).

Recognition of the inextricable link between lifestyle and health has meant that over the past three decades people in governments and academia, as well as commercial and popular arenas, have been focusing heavily on the ways in which people live (Burrows *et al.*, 1995). Indeed, the health and well-being of individuals is viewed by the those in the health promotion field as a product of their lifestyle (O'Brien, 1995). Health psychologists have been particularly interested in the kinds of health behaviours that make up unhealthy lifestyles, not only because they affect people's health, but because they may be amenable to change. They make a distinction between **positive health behaviour**, which is health enhancing, and **negative health behaviour**, which is detrimental to health. If health psychologists (and other health professionals) can influence people to behave in ways that are healthier, then particular forms of illnesses may be able to be prevented, life expectancy may be increased, quality of life enhanced and the onset of chronic illness delayed (Taylor, 1999).

The ways in which an individual lives his/her life, including specific behaviours s/he engages in.

Any activity that is undertaken by people to enhance or maintain their health.

Behaviour that is beneficial for a person's health.

Behaviour that is detrimental to a person's health.

Research in focus

3.1 Lifestyle affects mortality almost 10 years later

Breslow, L., & Enstrom, J. E. (1980). Persistence of health habits and their relationship to mortality. *Preventive Medicine*, 9, 469–83.

In 1965 two researchers (Belloc & Breslow, 1972) began a large study to explore the relationship between people's lifestyles and their health. Almost 7,000 adults (ranging from 20 to over 75 years of age) answered two sets of questions, one about their health over the past twelve months, and another set about their lifestyle. Seven questions about lifestyle were particularly important, and these are given below. Complete these and see how well you score.

This survey assesses seven aspects of your *usual* lifestyle. For each of the listed behaviours, answer yes if it describes what you usually do.

- I sleep 7 or 8 hours a day
- I eat breakfast almost every day
- I rarely eat between meals
- I am at or near the appropriate weight
- I never smoke cigarettes
- I drink alcohol rarely or moderately
- I regularly get vigorous physical activity

According to Belloc and Breslow's findings, the more of these behaviours that you engage in now, the better your health is likely to be later in life.

Outcomes

Belloc and Breslow's original findings showed that across all age groups, health was typically better among people who reported that they took part in more healthy behaviours. More surprisingly, however, were the results from the follow-up studies. One such follow-up study examined which people had died nine and a half years later (Breslow & Enstrom, 1980). The results showed that the people who had reported practising more healthy behaviours (as measured by the seven questions listed above) had lower mortality rates than those engaging in less healthy behaviour. This relationship held for men and women, and all age groups, but it was strongest among older people and males. These results have also been replicated in other samples (e.g. Brock *et al.*, 1988). This study shows quite starkly how lifestyle is related to people's health and survival.

Reflection

This is a well known and extensively quoted study, which has been replicated by other researchers. It is surprising that such a seemingly

simple pen and paper measure can be related to health outcomes so clearly. However, it must be remembered that this was a correlational study, so cause and effect has not been shown. The relationship could be caused by some third, unknown factor, or perhaps people who were not so well (even at subclinical levels) at the start of the study responded differently to these statements from those who were healthy.

Lifestyles have therefore become appropriate targets for health intervention and for health professionals.

Health promotion and attempts to influence lifestyles

Much of the twentieth century was devoted to disease prevention, an approach to **health promotion** stemming from a traditional biomedical view. The medical view of health and illness is reductionist and mechanistic, in that it focuses on physical functioning only (see ch. 1). From this view, there are two major pathways through which disease can be prevented (Kaplan, 2000). **Primary prevention** is the promotion of healthy lifestyles to prevent the development of disease, and is the focus of this chapter. **Secondary prevention** is the detection, diagnosis and treatment of disease as early as possible, a topic discussed in ch. 4.

In contrast, the latter part of the twentieth century saw health promotion focus more broadly on a social concept of health (Kelly & Charlton, 1995). This was reflected in the WHO's concept of health as a complete state of physical, mental and social well-being (WHO, 1946). The WHO has been an influential driving force behind health promotion, first employing the term in 1974 (Richmond, 1998). Health promotion is a way of trying to improve people's health using a variety of strategies, which can range from the individual through to the national and global. The WHO has encouraged the use of diverse strategies to improve health, from educating individuals about health matters through to changing community environments. However, most Western countries have approached health promotion by focusing on individual behaviour and attempting to change individual lifestyles (Richmond, 1998).

Attempting to change what people do and how they behave is difficult, because often behaviour is not simple or straightforward (very few of us would engage in regular, enjoyable behaviours solely for health purposes). Attempts to change behaviour for health reasons are often attempts to change ways of living and being. Therefore we approach the topics of health promotion and primary prevention from the concept of lifestyle. This concept emphasises people living their lives in a social world, and also implies that people have a choice about how they behave (although this is a problematic assumption,

Interventions designed to promote changes to improve good health in individuals, communities or populations. These interventions can range from the governmental, environmental and legislative through to the behavioural and individual.

The promotion of healthy lifestyles to prevent the development of disease.

Medical-based prevention aiming to identify disease at an early stage and treat it.

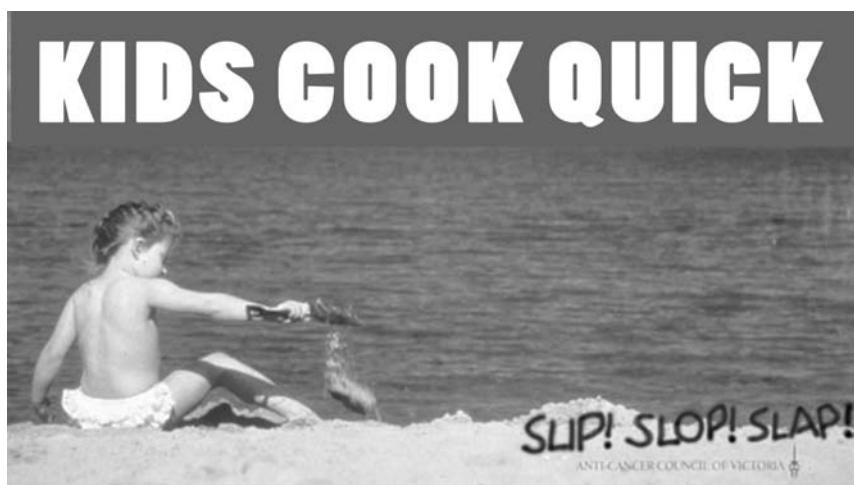


Figure 3.1 *Billboard promoting the use of sunscreen in Australia (from the SunScreen skin cancer prevention program). From: <http://www.sunsmart.com.au/s/media/advertising.htm>*

as discussed later in the chapter). For health psychologists, however, a focus on lifestyle should keep us grounded in the realities of people's everyday lives.

There are a huge number of health promotion strategies. These can be usefully conceptualised on a continuum from those with a purely individual focus through to those having a community, legislative and bureaucratic focus. One example of a health promotion programme is the 'Slip, Slop, Slap' campaign in Australia to encourage people to cover up, wear sunscreen and put on a hat and thus prevent skin cancer (and to encourage people to ensure that children wear sunscreen; see fig. 3.1).

For the purposes of this chapter we will follow Richmond (1998), and dichotomise different health promotion strategies into two polar approaches, namely the 'individualist approach' and the 'structural-collective approach'. The major differences in these approaches are outlined in table 3.1. These opposing approaches have generated much debate about the extent to which individuals should be viewed as responsible for their health (individualist approach) and the extent to which health is viewed as a collective responsibility of communities and societies (structural-collective approach).

Influencing lifestyles: individualist approaches

A great deal of research has been conducted in recent years by health psychologists and other allied health researchers to identify factors which influence people's health-related behaviour (see Bennett & Murphy, 1997;

Table 3.1 Two differing approaches to health promotion

Approach	Individualist	Structural-collective
Focal points	Individual, community, nation 'top-down' (giving health education information to individuals which has been developed by 'experts'), authoritative	Community, nation, world 'bottom-up' (gaining health knowledge from and involving individuals in health promotion efforts), participatory
View on disease causation	Illness caused by individual behaviours (e.g. smoking, lack of exercise, poor diet)	Illness caused by structural (social, economic, political) inequities (e.g. poverty, unemployment, working conditions)
Goals	To change individual behaviour through health education and knowledge	To improve people's health through modifying social, economic, political and physical structures
People involved	Health and allied professionals such as doctors, nurses, psychologists, media and marketing experts	Community groups, pressure groups, workers, community health psychologists, governments
Intervention examples	Mass media campaigns to educate people about the health risks of smoking cigarettes Pamphlets and information given to all new parents educating them about the importance of immunising their children	Legislation to restrict cigarette smoking in public places, and to restrict the advertising of tobacco State-run immunisation programmes backed by registers at general practitioners with recall systems in place

Adapted from Richmond (1998).

Conner & Norman, 1995; Rutter & Quine, 2002). This research aims first to further our understanding of why people behave in the way they do and, second, to use this understanding as a basis for designing interventions to change negative health behaviour and promote positive health behaviour and therefore improve health. Often such interventions are aimed at increasing people's knowledge about the health consequences of their behaviour, as they assume that holding the 'correct' knowledge will lead to automatic changes in behaviour. However, this assumption is problematic, as we will see later in this chapter, and knowledge can be taken up in unintended ways (see sidebar 3.1). As would be expected, individualist approaches focus primarily on factors that are intrinsic to the individual, such as personality, learning, socialisation, emotional factors, personal goals, perceptual and cognitive factors.

Social cognition approaches

Without a doubt, perceptual and cognitive factors have received the most attention in research into what determines health behaviour (Taylor, 1999), and many psychologists view cognitive factors as the ‘most important proximal determinants’ of behaviour (Conner & Norman, 1995, p. 2). Before we begin, however, it is worth noting that research in this area has examined a diverse range of health-related behaviours, from tooth-brushing, condom use and taking the oral contraceptive pill through to smoking, exercise and alcohol consumption. Social cognition approaches have also been employed

3.1 Is your glass of wine equivalent to a standard unit of alcohol?

Alcohol consumption is often assessed using standard ‘units’ of alcohol in the UK, and people are given advice about how many ‘units’ are safe for men and women in various situations (across a session of drinking, over a week, for drink-driving, etc.). A study conducted in Scotland found that a ‘standard unit of alcohol’ did not correspond very well to the actual amount of alcohol people poured themselves in their usual drink (of wine or spirits). Specifically, the average amount of alcohol in a wine drink was 1.92 units, while the average amount of alcohol in a spirits drink was 2.3 units! The researchers queried the assumption (held by researchers and lay people) that a ‘drink’ is equivalent to a standard unit of alcohol. (Gill & Donaghy, 2004)

extensively to examine more medically oriented behaviours, such as visiting physicians, adhering to medical advice, following medical regimens (such as taking medication and changing dietary habits). As will be shown in ch. 4, these approaches have also been extensively applied to efforts to influence preventive and screening behaviour, such as breast and testicular self-examinations, ante-natal screening and genetic screening. Here we review the major social cognition theories and models that have been applied to the health behaviour field.

Health locus of control

Health locus of control is a construct that has been widely applied to research into health behaviour (Wallston, 1992). It is based on the premise that people who believe they have control over their health will be more likely to behave in ways that are health promoting (Norman & Bennett, 1996). Health locus of control has its origins in social learning theory (Rotter, 1954), which posits that whether or not a person will behave in a particular way depends upon two cognitions, one about expectancy and one about value. Thus, the behaviour is dependent upon:

- the individual’s expectancy that this behaviour will achieve a certain goal or outcome (if I eat less salt and fewer fatty foods it will be good for my health);
- an individual’s positive evaluation of that outcome (I want good health).

Rotter (1966) went on to develop the idea that people can have generalised expectancies about their actions and consequent outcomes. He distinguished

between people with an internal locus of control, who believe that events are the result of their own behaviour and therefore under their control, and people with an external locus of control, who believe that events are not related to their behaviour and are therefore outside their control. Two kinds of external control have been posited: control exercised by chance or fate (Rotter, 1966) and control exercised by powerful others (Levenson, 1974).

Health locus of control is measured with the Multidimensional Health Locus of Control Scale (Wallston *et al.*, 1978), which examines the three dimensions of control, specifically applied to physical health. These three dimensions are shown below, with example items from the scale:

- internal health locus of control: 'I am in control of my health';
- powerful others' health locus of control: 'my family has a lot to do with my becoming sick or staying healthy';
- chance locus of control: 'my good health is largely a matter of good fortune'.

Much research has applied health locus of control to a range of health-related behaviour. For example, one large study conducted in eighteen European countries found that young adults with a high internal locus of control were more likely to engage in healthy behaviours (e.g. exercise, smoking, seat belt use, etc.) than those with a low internal locus of control. Young adults with high chance locus of control were less likely to engage in healthy behaviours than others (Steptoe & Wardle, 2001). Similarly, Friis and colleagues (2003) found that among the elderly, those with a higher internal health locus of control were more likely to walk one mile per week than others. Such studies suggest that interventions to increase people's internal health locus of control may be effective in increasing positive health behaviours.

On the whole, however, findings with health locus of control have been inconsistent and conflicting, and this construct has not proved greatly predictive of behaviour (see Norman & Bennett, 1996, for a review). Even when the research includes measures of the value people place on their health (the second part of the theory), this construct lacks predictive utility (e.g. Bennett *et al.*, 1997). The construct itself is also problematic: Wallston (1992) notes that the chance dimension merely mirrors the internal control dimension, while Allison (1991) has argued that there is an inherent assumption that internality is good, whereas this is not always the case (for example, believing in powerful others may be useful if you have a chronic illness). Further, the outcome in health locus of control research is health, yet this may be too general to be useful, especially taking into consideration the different types of behaviour to which it is applied. The inconsistent and negative results in this area are hardly surprising: it would be a great feat indeed for a single construct to be predictive of complex social behaviours.

Self-efficacy

Self-efficacy is similar to health locus of control in that both constructs emphasise the importance of perceptions of control, and both are based on expectancy.

EBSCO Publishing : ebook Collection (EBSCOnost) - printed on 3/7/2016 11:19 AM via UNIVERSITY OF WALES TRINITY

SAINT DAVID

AN: 149832 ; Lyons, Antonia C., Chamberlain, Kerry.; Health Psychology : A Critical Introduction

Account: s4793139

cognitions. However, self-efficacy has been more successful in predicting health-related behaviour. Self-efficacy is a key construct in social cognitive theory (Bandura, 1977), and posits that behaviour is determined by three types of expectancies:

- situation-outcome expectancies: beliefs people have about what will happen if they take no action;
- action-outcome expectancies: beliefs people hold about what will happen if they behave in a particular way;
- efficacy-expectancies: beliefs people hold about whether they have the competence to perform a particular behaviour to achieve the desired outcome.

Thus, if individuals perceive a link between their smoking cigarettes and lung cancer (situation-outcome expectancy), believe that if they give up smoking they will reduce their risk of getting lung cancer (action-outcome expectancy) and feel they have the necessary skills and willpower to give up smoking (efficacy-expectancies), then they are more likely to attempt quitting smoking.

Self-efficacy and outcome expectancies have been found to be predictive of diverse types of health behaviour (see Schwarzer, 1992; Schwarzer & Fuchs, 1996 for reviews), leading Schwarzer (1994) to suggest that these form the major determinants of many behaviours related to health. However, this theory has been criticised for its failure to incorporate social influences as well as the value component of outcome beliefs (Conner & Norman, 1995). Nevertheless, its consistency in predicting health behaviours has meant that it has been incorporated into a number of other social cognition models, such as the theory of planned behaviour (Ajzen, 1991) and protection motivation theory (Rogers, 1983), and it is likely that it will continue to be a key variable in the social cognition approach (Conner & Norman, 1995).

Attitude models

The relationships between attitudes, beliefs and behaviour have been of particular interest to social psychologists for decades, and more recently to health psychologists. This interest led to the development of specific models which aim to predict behaviour. Some of these models were developed for predicting general behaviour, while others have been developed specifically for health behaviour. All of these models view attitudes, perceptions, knowledge and beliefs as having a central role in determining behaviour. These factors are conceptualised as 'enduring characteristics of the individual which shape behaviour and are acquired through socialization processes' (Conner & Norman, 1995, p. 5) and therefore as open to change. Attitude models are based on the assumption that whether or not a person will act in a certain way depends upon specific types of cognitions. There are many attitude models, and here we consider two that have been widely used in health psychology.

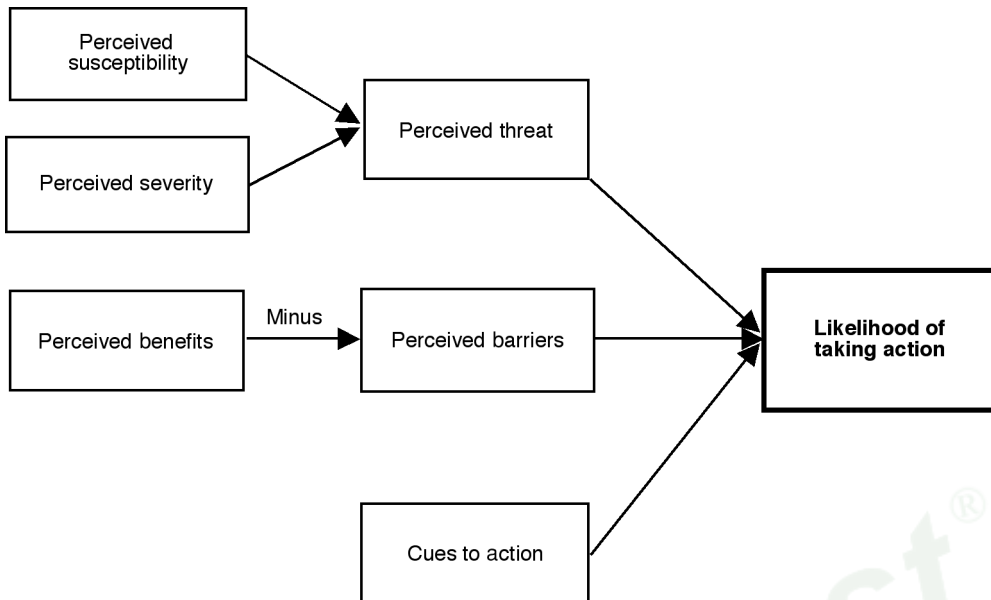


Figure 3.2 *The Health Belief Model*

The Health Belief Model

The Health Belief Model was developed specifically for health education programmes (Rosenstock, 1974) and is probably the oldest and most widely used model in health psychology (Conner & Norman, 1995). According to this model, and as outlined in fig. 3.2, whether or not an individual adopts a health-related behaviour depends upon two kinds of cognitive appraisal, as well as trigger factors:

- an appraisal of how threatening a health issue is, based on beliefs about susceptibility (how susceptible am I to this disease?) and severity (how severe would the consequences be if I had this disease?);
- an appraisal which evaluates behaving in ways to reduce the threat of the disease, based on perceptions about the costs and benefits of the behaviour (what will it cost me to behave in a particular way, how much time, how much effort, how much money? Will this behaviour make me healthier, reduce my risk of the disease?);
- cues to action are triggers to take part in the behaviour, and they may be internal, such as physical symptoms, or external, such as mass media campaigns, advice from others, or the illness of a family member.

Thus, if an individual believed that she might end up with heart disease later in life (susceptibility), and believed that heart disease was a serious illness (severity), and also thought that exercise would make her feel good and would reduce her risk of getting heart disease later on (benefits), and that this would

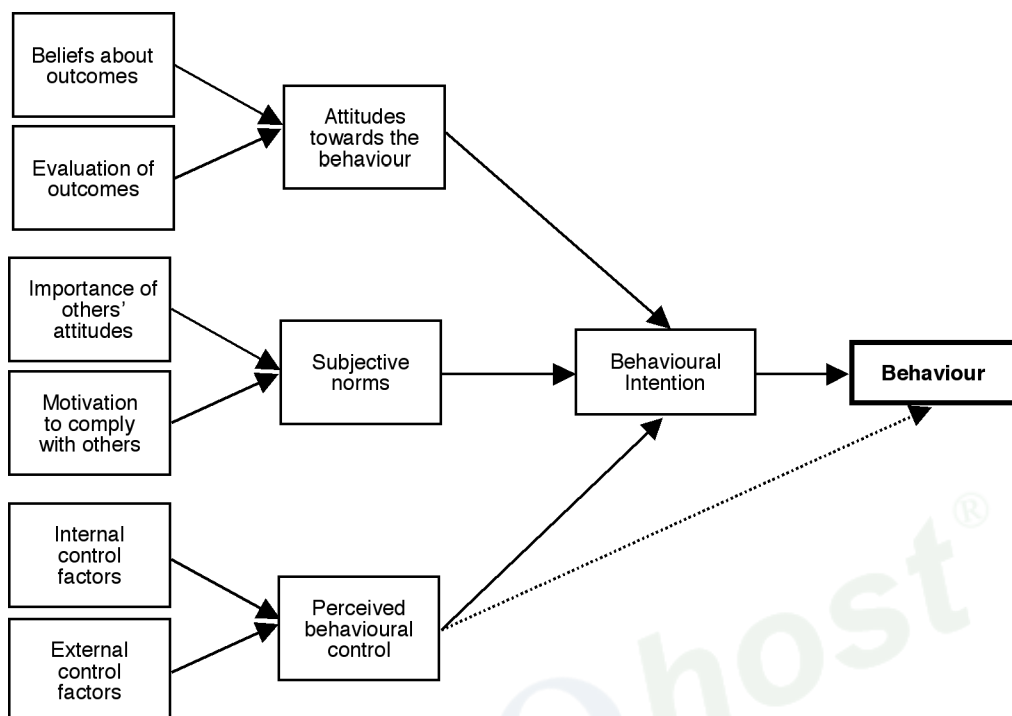


Figure 3.3 *The Theory of Planned Behaviour*

outweigh the cons of taking time and costing money (costs), then she would be more likely to take up some form of regular exercise. Further, media campaigns or other reminders about the importance of regular exercise for health (cues to action) would increase the likelihood that she actually took some action.

As with all of the social cognition models, the health belief model has been applied to a diverse range of behaviours and has been employed in numerous studies. Reviews of such studies highlight the empirical support for this model, and show that the dimensions identified are related to health behaviours (especially beliefs about susceptibility and the costs and benefits of action) (Harrison *et al.*, 1992; Janz & Becker, 1984). However, although associations between the model dimensions and behaviour have been found consistently, these are generally weak (Bennett & Murphy, 1997) and the model has not been so effective in predicting more complex behaviours, such as taking up smoking.

The Theory of Planned Behaviour

The Theory of Planned Behaviour (Ajzen, 1991; an extension of the theory of reasoned action (Ajzen & Fishbein, 1980)) has been applied to a wide variety of general and health-related behaviour. As shown in fig. 3.3, this theory states that the main influence on behaviour is an individual's intention to adopt that

behaviour. Intentions, in turn, are influenced by two types of cognitions as well as by perceived control:

- attitudes are the beliefs an individual holds towards the behaviour in question, and these are determined by beliefs about the outcome and whether or not the outcome is valued;
- subjective norms are determined by perceptions of social norms and social pressures (what do other people think I should do?) as well as how motivated the individual is to do as other people say;
- perceived behavioural control is individuals' perception of whether they have the ability to perform the behaviour in question, and this perception can influence both intentions and behaviour directly.

Thus, if an individual believed that cutting down on the amount of fatty foods he ate would be good for his health (attitude to behaviour), believed that other people in his life wanted him to cut down on eating fatty foods and was keen to meet these expectations (subjective norm), and also believed he was capable of changing his diet (perceived control), then this would predict a high intention to change his diet.

There has been much support for the Theory of Planned Behaviour, and it is certainly widely used in a variety of domains within health psychology. According to a review by Ajzen (1991), the three dimensions of the model are reasonably strongly related to intentions (an average multiple correlation of .71), although the relationship of intentions to behaviour is somewhat lower. This last relationship seems to depend greatly on what kind of behaviour is under investigation. A meta-analysis based on 185 studies concluded that the theory of planned behaviour could explain over a third of the variance (39 per cent) in intentions to perform a specific behaviour, and could also explain almost a third of the variance in actual behaviour (27 per cent) (Armitage & Conner, 2001). However, researchers have questioned how much understanding this theory provides, given the temporal closeness between intentions and behaviour. As Leventhal and Hirshman (1982) commented over twenty years ago, 'it is questionable that we greatly advance our understanding . . . by concentrating on the measurement of factors so proximate to action that we are practically using measures at the beginning of the act to predict the action itself'. The understanding we gain from this model, according to Stainton Rogers (1991), is trivial and is applicable only in highly constrained circumstances.

Stage models

The models described thus far are static: they assume that cognitive processes involved in decision making occur about the same time and together (Bennett & Murphy, 1997). However, stage models suggest that people use different cognitions and processes at different times during lifestyle change (Prochaska *et al.*, 1992). The best-known stage model in health psychology is the

Transtheoretical Model (also known as the Stages of Change Model) developed by Prochaska and DiClemente (1984).

In this model, individuals are seen to go through five stages when they are attempting any lifestyle change: pre-contemplation, contemplation, preparation, action and maintenance. For example, to quit smoking an individual would go through the stages as follows:

- pre-contemplation: she is not concerned about her smoking and has no intention of stopping;
- contemplation: she starts to vaguely consider giving up, but is not committed to this change and does not think about how it might happen;
- preparation: she intends to quit and starts planning how she might achieve this;
- action: she actually attempts quitting smoking;
- maintenance: she has abstained for six months and tries to prevent a relapse.

A useful aspect of the model is that it is not linear but cyclical: individuals may move back and forward through different stages, and change may begin at any stage. Further, strategies can be employed to identify people at particular stages and to help them move on to other stages. Other stage models have also been proposed, such as the health action process model (Schwarzer, 1992) and goal setting theory (Bagozzi, 1992). However, these models assume that the pattern of stages and processes seen during one type of lifestyle change (e.g. quitting smoking) can be generalised to other kinds of lifestyle change (e.g. substance abuse); but this may not be the case (Rosen, 2000). Further, the value of these kinds of model is in helping people move from one stage to the next in any lifestyle change, yet the kinds of specific strategies necessary and beliefs to encourage this are not yet well identified (Ewart, 1991; Weinstein *et al.*, 1998).

Criticisms of the social cognition approach to changing lifestyles

The social cognition approach to influencing behaviours and lifestyles has been severely criticised. This is partially because, despite the amount of attention and resources devoted to these theories and models, they have not been very successful at either predicting behaviour or changing it. Health education efforts based on these approaches have seen the failure of many people to take heed of healthy lifestyle advice (Davison *et al.*, 1992). Specifically, these models have been criticised for being too simplistic, thus exaggerating the ease with which behaviour can be changed (Richmond, 1998). More complex models have been developed, such as Ewart's contextual theory of individual action (Ewart, 1991) which sets self-regulation and social learning theory within larger social and environmental systems, although these have not been greatly influential in health psychology. Similarly, although social cognition models

aim to identify factors which can be used to change behaviour, they actually tell us nothing about how best to change cognitions (Conner & Norman, 1995). These models also present themselves as value free (but are actually based on a eurocentric view of the individual) and therefore lack culturally appropriate messages.

Ogden (2003b) has recently argued that while social cognition models are pragmatic in terms of guiding research, they are extremely problematic on a conceptual level for three main reasons. First, Ogden argues that negative results with such models are often explained away in terms of methodologies, populations studied and other caveats, and therefore cannot be falsified (and thus tested empirically). Second, Ogden argues that although specific cognitions are distinguished in the models, their operationalisation is similar. For example, perceived behavioural control over snacking has been measured by asking people 'how easy or difficult will it be for you to avoid between-meal intake of sugared snacks and drinks in future?' Behavioural intention is measured by asking people 'how likely or unlikely is it that you will avoid between-meal intake of sugared snacks and drinks in the future?' Ogden points out that the observed high relationship between answers on these questions is unsurprising and would be true by definition. Finally, Ogden also makes the important point that the act of filling in questionnaires about cognitions concerning a particular behaviour may influence (or in some cases create) those cognitions and may also affect the subsequent behaviour. These critiques have been challenged by Ajzen and Fishbein (2004) and the debate continues.

Another major problem identified with social cognition models is their portrayal of a human being as overly rational, like a statistician weighing up various decisions (doing 'cognitive algebra', as Stainton Rogers (1991) calls it). According to these models, if you have the correct knowledge about a behaviour that may have a negative impact (at some distant point) on your health, you would be irrational if you continued engage in this behaviour. However, studies show that people have sensible and rational reasons for engaging in such behaviour, once researchers look further afield to their material and social circumstances. For example, women who are on a low income and are caring for children have accurate knowledge of smoking and its consequences, yet continue to smoke because this provides them with a means of coping, providing physical and emotional distance from the unceasing task of child care (Graham, 1987). Similarly, a study conducted in Wales found that almost all respondents held detailed and accurate knowledge about the risks of unhealthy behaviour for heart disease, yet continued to engage in such behaviours (smoking, eating a high fat diet, not getting any exercise). Their decisions to do so were clearly 'rational' within their wider personal and social context (Davison *et al.*, 1992). Further, such rationality in decision making processes can be questioned in situations

3.2 Choosing to catch HIV and die of AIDS

Tourigny published a study in 1998 which documented how six impoverished African American young people living in Detroit deliberately contracted AIDS so that they were eligible for social services. They viewed AIDS as a terminal illness, but one that took a while to take hold, and which in the meantime entitled them to benefits necessary for their daily lives. A recent editorial (Morse, 2004) highlights how these findings are likely to be generalisable, across cities and across countries. However, because epidemiologists (and others) do not include self-choice as a means of causation of AIDS in surveys, we do not know the extent of such behaviour.

that are loaded with emotion, as is the case for many health behaviours. For example, the process of deciding whether or not to use a condom with someone you have recently met, in the midst of passionate love-making, is not likely to be the same as the process of deciding whether or not you should cut back on the saturated fat in your diet. Our behaviour is embedded in the cultural and moral environment in which we live (Crossley, 2000), and can be seen as rational only within this context. For a tragic example of this point see sidebar 3.2.

Other approaches based on the social cognition approach to changing lifestyles

Attempts to change people's health behaviours have also used other approaches, which are based on social cognition ideas and assumptions. One such approach is **empowerment**, which is 'a process of helping people to assert control over the factors which affect their health' (Airhihenbuwa, 1994, p. 345). Empowerment strategies can be focused on individuals, groups or communities. Self-empowerment is the process of empowering individuals and groups to increase control over their internal (attitudes, knowledge, perceptions, skills) and external (physical and social environments) worlds. This is achieved through various strategies, such as assertiveness and skills training, problem-solving, participatory learning and client-centred counselling (Marks *et al.*, 2000). Self-empowerment has often been used in health education with young adults, to increase assertiveness and resist peer pressure, especially in areas such as sexual health and HIV prevention. Empowerment strategies are also effective in increasing an individual's self-efficacy, which as we have seen is important in forming intentions about health behaviours, as well as behaving in particular ways (Abraham & Sheeran, 1994).

Another approach has been to counsel people to change their health-related behaviour. The women's health movement in particular has employed counselling strategies. In this way information and advice can be provided, individually or in group settings, in a context that encourages sharing and recognises the collective nature of women's health issues (Daykin & Naidoo, 1995).

How effective are individualist approaches to changing lifestyles?

An eminent US health psychologist has argued that ‘primary prevention almost always requires behavior change, therefore, successful primary prevention efforts must use behavioral theories and behavioral interventions’ (Kaplan, 2000, p. 382). However, behavioural interventions to date have not been greatly successful. Despite decades of work attempting to change behaviours which are harmful to health, the impact of providing knowledge and attempting to change attitudes is disappointing (Frankel *et al.*, 1991). Analysis of survey data has shown that there is rarely a relationship between changes in knowledge and subsequent changes in behaviour (Yoder, 1997).

The theories and models developed within the individualist approach appear insufficient to provide in-depth understandings of behaviours related to health. One review of intervention studies on physical activity concluded that the ability of theory to predict outcomes in this field was very limited (Baranowski *et al.*, 1998). Further, while theories focus on initiating change, few address the issue of maintaining changes in lifestyle. A review examining evidence on maintaining changes in physical activity levels following intervention found little data on this topic (Marcus *et al.*, 2000), leading one commentator to highlight this as a priority for future research (Dubbert, 2002).

Ironically, government campaigns to educate the public about health issues can actually shift perceptions in the opposite direction to that desired (Frankel *et al.*, 1991). Being told what to do and how to live one’s life can lead people to react against the advice. (Jokes are made about healthy living, such as asking ‘what’s your poison?’ in relation to the type of alcohol a person wants.) This can be understood partially by examining the theory of psychological reactance (Brehm, 1966), which proposes that individuals see themselves as free to act in realistic ways, either now or in the future. Any threat to this freedom to act, according to reactance theory, generates a motivational state aimed at recapturing the freedom(s) affected. Further, this can affect the value and attractiveness of the threatened freedom, so that, for example, banning smoking can have the reverse effect: it becomes more attractive in and of itself. Also, the stricter the threat to freedom (you MUST change your diet for your own good), the greater the likelihood that it will produce the opposite effect (Fogarty, 1997). Such reactance against health education advice has been found in Danish men’s accounts of health behaviour (see Meiller *et al.*, 1996).

Individualist approaches make a number of assumptions about individuals and their behaviours. Four such assumptions (and their counter-arguments) are outlined in table 3.2. Some of these assumptions about individuals and individual behaviour can help to explain their lack of success in changing lifestyles.

Table 3.2 Some assumptions of individualist approaches to health promotion

Assumption	Counter-argument
Individuals have choice and control over their lifestyles	Focusing solely on individuals and their behaviour does not take into account the material disadvantages of people's lives (Nettleton & Bunton, 1995), which severely limit choices about lifestyles
The individual is an independent consumer who can make straightforward choices between various forms of behaviour	Some groups in society (e.g. women, those on low incomes) often do not fit the stereotype of an independent consumer. Strategies may place responsibility for health on women, without taking into account their lack of power to effect change (Daykin & Naidoo, 1995). Women are assumed to be responsible for the health of family members, and to encourage healthy lifestyles (e.g. Lyons & Willott, 1999; Norcross <i>et al.</i> , 1996)
Behaviours can be examined separately	Although much of the research from these approaches discusses lifestyles, in reality they almost always examine behaviours separately. However, behaviours go together to make up lifestyles. Qualitative studies show that people talk about behaviours that influence their health as interconnected and making up a complex whole, where there is some kind of homeostatis that will balance out 'good' and 'bad' behaviours (Backett <i>et al.</i> , 1994). For example, 'I will eat this piece of pecan pie for dessert only if I go for a run tomorrow'
Individuals do not think in a sophisticated way about their lifestyles and health	People not only consider health behaviours together, but also consider them in relation to the health-promoting benefits of enjoying living life. For example, as one young female recently noted: I think the guilt that people associate with not drinking, not smoking, not eating the wrong things, is actually worse in very many cases than actually committing the sins . . . you're probably getting more benefit from getting enjoyment out of life and your friends than you would if you abstained from everything (from Lawton, 2002)

Implications of the individualist approach

There are several problematic implications of the individualist approach to changing lifestyles. First, its heavy emphasis on cognitive and perceptual factors has meant that many other relevant factors have been little studied and even less theorised. For example, relatively little work has coherently theorised sociodemographic factors (such as age, SES, education), social factors (such as the values of the culture or particular SES group, social norms, social

influence) or environmental factors (such as pollution, crowding), all of which are central to individual lifestyles (Winett, 1995).

Second, the individualist approach also implicates people who do become ill as 'responsible' for that illness. If a disease can be prevented by the lifestyle a person lives, then it follows that people who do become ill from that disease are at least partially responsible for their situation (Davison & Davey Smith, 1995). However, some researchers have questioned the scientific basis of attributing some proportion of disease to lifestyle factors. These critiques point out that a focus on individual lifestyle in health promotion overemphasises the role of the individual, and oversimplifies disease causation (Davison & Davey Smith, 1995). For example, not everyone who is at risk of heart disease will die from heart disease. We have all heard of someone who has smoked cigarettes and drunk alcohol all their lives, and yet lived to the grand old age of 94. Health promotion attempts derived from **epidemiology** are based on population statistics (and estimated population risk), and can lead to 'a situation in which many individuals change their lives to no personal end' (Davison *et al.*, 1991, p. 14), because they would not have succumbed to the particular disease anyway. This is known as the 'prevention paradox', in which a prevention programme may provide a lot of benefit to the population, but not much benefit to any specific individual involved (Rose, 1985).

A discipline of study which examines and documents the frequency, distribution and causes of disease in a population.

Third, this approach can unintentionally be discriminatory, amplifying inequality. Resources, including education and information, may not be equally available or accessible to all people, exacerbating social inequalities. Similarly, the ways in which messages and information are delivered may not be sensitive to different values, expectations and so on, thereby also exacerbating inequalities (Parish, 1995). Fourth, the individualist approach can have unintended consequences for particular groups of people in society. Well-meaning messages may cause inadvertent harm. For example, in trying to convince people not to drink and drive, a poster campaign ran a picture of a wheelchair and the slogan 'Last summer, 1,057 teenagers go so drunk they couldn't stand up. Ever. Don't drink and drive.' Wang (1992) reports that people who are in a wheelchair found such posters devaluing, as they communicated the strong idea that disability was bad, and reinforced the stigma associated with disability. Some of these concerns are highlighted in table 3.3.

It has also been argued that the individualist approach to influencing lifestyles inappropriately targets individuals, rather than tackling important social and economic influences on health (Parish, 1995). According to many sociologists, the individualist approach has been favoured over the more collective model for a variety of reasons: it is favoured by politicians because it is easy, by bureaucrats because it fits the managerialist agenda, by medicine because it furthers medical dominance and by allied health professionals such as health psychologists because this is their starting point (Richmond, 1998).

Table 3.3 Some ethical issues in health promotion strategies

Ethical issue	Description	Example
<i>Individualist approaches to health promotion</i>		
Persuasion	Persuasive strategies may arouse anxieties or fears, be manipulative, impinge on individual rights	Frightening people with terrifying images of people with throat cancer in a media campaign
Targeting	Strategies reach different segments of the population; may widen the gap between those with and without; may be culturally relevant to certain cultural groups and not others	Targeting people in lower socioeconomic groups to change their diet, despite not being able to afford to, while the affluent take heed of the message
Labelling	Inadvertent harm caused by labelling or stigmatising individuals	HIV prevention campaigns using fear appeals which depict people with HIV negatively
Culpability	Inadvertent harm caused by unfairly placing the responsibility and blame on individuals or groups	Individuals with high blood pressure blame themselves for the disease (even though family history is as predictive as behaviour)
Privileging	Influences power in that some individuals are more likely to benefit than others	Labelling a certain level of blood cholesterol as a medical condition means money is provided for its detection and treatment
<i>Structuralist-collective approaches to health promotion</i>		
Coercion	Promotes restrictive policies or regulations to achieve public health goals, impinging on an individual's right to freedom to choose	Regulations on food production in the food industry to reduce saturated fat intake
Harm reduction	Behaviours are supported that are not socially approved	Availability of clean and disposable injection needles to heroin addicts
Depriving	The less privileged are denied pleasures they can afford	Taxing cigarettes so highly denies people in disadvantaged situations their main form of perceived control and relaxation
Exploitation	Individuals may be exploited to achieve health promotion goals	Using a local community organisation to gain voluntary services that should be provided through public funds

Table 3.3 (cont.)*Both approaches to health promotion*

Control	May function as a means of social or organisational control	Organisations can require information about employees' outside activities, based on concern for their health
Distraction	The focus on good health distracts people from important social issues	Emphasising diet as crucially important takes attention away from government policies about pollution and environmental waste
Promises	Promises are made that may not be accurate or beneficial	People who live healthy lifestyles can still die from heart disease, despite health information implying that they will not
Health as a value	Promotes a moralism that might not be compatible with other values	Promoting health emphasises individualism at the expense of values such as connectedness and caring

Adapted from Guttman (1997).

Influencing lifestyles: structural-collective approaches

The focus in structural-collective approaches is less on improving individuals' health knowledge and more on improving social and environmental conditions. From this perspective, focusing on 'lifestyle' in health promotion is fundamentally misconceived, because focusing on individuals to change their behaviour does nothing to correct the structural causes of ill health (Waitzkin, 1983). The structural-collective approach employs both small-scale, local interventions as well as broader, legislative ones. Health-related legislation has been successful in many areas. Richmond (1998) points out that legislation in Australia has outlawed industrial pollution, fireworks, flammable nightwear, cigarette advertising, smoking in public places, and has required compulsory car seat belts, water fluoridation and the labelling of poisons. Such legislation has come about through debate within government and political parties, but also through pressure groups, environmental groups and people working outside the conventional political system (Richmond, 1998).

Changing legislation and political practices to improve health are often considered to be outside the realm of health psychology; however, health psychologists have contributed to (and have much to offer) structuralist interventions at the local level. Community psychologists, and community health psychologists, have been particularly important in developing and implementing approaches based on notions around community empowerment and collective action.

Community empowerment

The notion of community empowerment is an attempt to counter the individualism and authoritarianism that emanates from individualist approaches to changing lifestyles. In this approach, groups of people are encouraged to identify what are the most important health issues for them, to take control of their destinies and have support to bring about change (Nettleton & Bunton, 1995). The aim is to facilitate group and community choices about the way people live. This is achieved by supplementing knowledge acquisition with value clarification and community organising skills, usually by non-traditional means (Airhihenbuwa, 1994). For example, providing communities with packets of oral rehydration salts to combat diarrhea may be effective initially, but in the longer term may create dependency. A more effective solution would be to empower people by showing them how to prepare their own rehydration mixture, using salt, sugar and water and local implements (Airhihenbuwa, 1994).

The focus within this approach is collaborative, between members of communities and service providers. It opposes the use of 'experts handing down advice about individuals' adjustment to social realities' (Borg, 2002, p. 346). Instead, it explicitly recognises that groups within a society hold different levels of power, and also that this power influences individuals' lifestyles and health, as well as their ability to change both. A recent example of community empowerment comes from a low-income housing project in south central Los Angeles in the USA, described in research in focus box 3.2.

The community empowerment approach demands that health psychologists examine systems of health care, and how appropriate these are for the needs of individuals and also the contexts of the communities in which those individuals live (Albee & Gullotta, 1997). This approach sets individual well-being within a wider social and political context, and as such can be seen as multilevel. It focuses on strengthening existing resources to encourage the participatory decision making of community members (Borg, 2002). A key feature of community empowerment is that it is bottom up rather than top down.

However, the effectiveness of community empowerment has been questioned. For example, 'how much "power" do community groups really have? What kinds of changes can they realistically bring about to improve their health? To what extent do such groups become absorbed into the political structures of health care?' (Nettleton & Bunton, 1995, p. 45). It seems that community empowerment can be successful and effective, if it is fully participatory.

Collective action

The collective action approach focuses on the close relationship between individuals and the socioeconomic and environmental contexts in which they live. These contexts are seen as the primary causes of ill health, and are therefore

Research in focus

3.2 The Avalon Gardens Men's Association

Borg, Jr., M. (2002). The Avalon Gardens Men's Association: a community health psychology case study. *Journal of Health Psychology*, 7, 345–57.

Following the riots in Los Angeles in 1992, city officials attempted a community empowerment approach to address the community crisis and promote health. This was contracted to the Community Health Realization Institute (CHRI), which aimed to address chronic issues such as endemic health problems, racism, poverty, violence, drug and alcohol abuse, as well as acute problems such as rioting, looting, arson and interracial violence, over a four-year intervention.

The community

Avalon Gardens consists of 161 housing units and 419 residents in south central Los Angeles. It is made up of African American (82 per cent), Latino (17 per cent) and Caucasian (1 per cent) inhabitants. It was a 'distressed community', with high levels of violence, burglaries, poverty and poor health.

The approach

The primary goal of the team was to 'address how the influence of current models of health policy, public health and health care administration had traditionally served to exclude and disempower communities of colour.' Specific initiatives for change were those identified by residents of the community, in a series of workshops run by the CHRI within the community. These were focused initially on the question: 'what is a safe and healthy community?' Empowerment was defined by members of the community.

The men's group

As a result of the participatory intervention, a group of African American and Latino men began meeting regularly, with the community practitioners, to discuss what they could do about the serious health risks faced by members of their community. They called themselves the Avalon Garden's Men's Association. The essential feature of this group was that it was voluntary and initiated by its members.

The weekly meetings

The men discussed the community: its hostile nature, the violence resulting from rival gangs, the 'war zone' they lived within and how these

issues had to be addressed before any other health issues could be dealt with. As one member stated: 'It's hard to think about the danger of smoking or eating greasy foods when you're fearing for your life.' They also discussed the stereotypes of men in the community, such as being apathetic and lazy, and talked about how these characteristics function to lessen the danger of standing out and being targeted by gang members and the police.

Collaborations

To address health promotion issues such as drug and alcohol abuse, smoking, HIV/AIDS prevention and diet, the Men's Association began to hold meetings with medical and social service agency providers. This encouraged relationships between residents of the community and health professionals. Members of the men's association also began working closely with a local community-based health care clinic, Unihealth, to foster improved access to health care for community members. Officers from the Los Angeles Police Department were also invited to discuss a partnership with the community which resulted ultimately in a 'community police' initiative.

Outcomes

The residents of Avalon Gardens evaluated their own community at different points over the intervention period. The process of self-assessment allowed people to create their own goals and alliances, and then evaluate their own efforts, leading to the identification of new needs, goals and projects. The intervention produced significant reductions in some behaviours:

Behaviour	Reduced by (%)	Behaviour	Increased by (%)
Reported incidence of violence	43	Health screening	32
Drug- and alcohol-related incidents	38	HIV/AIDS testing	27
Family violence and child abuse	40		
Overall crime rate	35		
Teenage pregnancy	25		
Unemployment	30		

Reflection

Community empowerment is not about measurable goals and objectives, it is about a participatory process. Evaluation of such an approach needs to examine whether people critically engage with the process and evaluate the causes of health problems, and then take community action

(de la Cancela *et al.*, 1998). This case study highlights how it is possible for communities to make a difference to their everyday lives, to identify problems and open doors to services and agencies that previously had been inaccessible. It also highlights the importance of social context for any health initiative: if the community in which you live is a dangerous place, who cares whether or not you smoke cigarettes? However, the study also occurred within a distinct political context, and many of the ethical issues raised in table 3.3 are relevant here. For example, how much did this work act as a means of social control? Were inaccurate promises made? Does the focus on health as the primary moral issue distract people from other important social issues?

the target for change. Individuals work together to change social and environmental contexts, rather than changing themselves (Marks *et al.*, 2000). One example of a collective action approach is Raeburn and Rootman's (1998) People-Centred Health Promotion, which is based on the mnemonic PEOPLE:

People-centredness: this approach begins with subjective, everyday experience, and assumes the greatest wisdom is held by ordinary people (rather than experts).

Empowerment is the fundamental philosophical principle of the approach. It involves control over life affairs at the personal, group and community level. **Organisational and community development** grounds people in their collectivity, and advocates change in organisational processes to contribute to community development.

Participation involving as many people as possible, recognising diversity and encouraging representativeness will provide more impact and strength in health promotion processes.

Life quality: good health within overall quality of life, where quality of life has a positive orientation and definition, and includes spirituality.

Evaluation is an intrinsic aspect of the approach, where the focus is on the participants involved. Five issues are seen as particularly important are outcome evaluation, process evaluation, cybernetics and self-criticism, accountability and ownership, and the power of data.

There are similar problems with the collective action approach as with other community approaches to health promotion. They may come into conflict with those who have the power in society, such as industry, employers and governments (Marks *et al.*, 2000). There is also the danger that the people who are involved in the initiatives become removed from the grassroots concerns of those they set out to represent (Marks *et al.*, 2000).

How effective are structural-collective approaches to changing lifestyles?

State-level controls have been successful at reducing harmful health behaviour. For example, legislation regarding the wearing of seatbelts has meant that for most people putting on a seatbelt when they get in a car is now second nature. A recent review of tobacco controls in five US states has shown that legislation and efforts to reduce cigarette smoking are effective and produce dramatic declines in smoking in both young people and adults (Siegel, 2002).

Community empowerment approaches have been extremely successful in highlighting the importance of the social and developmental dimensions of health-related behaviour. This is particularly so in the field of HIV prevention, in which empowerment approaches have been effectively used at the individual level with single women in the USA (e.g. Hobfoll *et al.*, 2002), at the local level with the gay community in Australia (e.g. Kinder, 2002) and at the national level with the mining industry in southern Africa (e.g. Campbell & Williams, 1999).

However, structural-collective approaches can also be problematic. It is often very difficult to obtain funding for community development initiatives, as they do not provide easily quantifiable outcome data. Thus they become marginalised and survive only by piecemeal resourcing (Daykin & Naidoo, 1995). The concept of community itself is also extremely problematic. People who live in the same geographical region, or who have the same sexual preference, or age, or social class, are not necessarily homogeneous groups (Marks *et al.*, 2000).

Further, even though many global, national and local health promotion strategies claim that they are employing principles of community involvement and participation, according to Kelly and Charlton (1995) they are in reality technicist, scientific and expert driven. This means that 'communities remain marginalized and invisible – other than in the rhetoric' (p. 81). These researchers also make the point that such strategies reify social systems, constructing them as acting on people in a deterministic way (e.g. unemployment causes ill health). Thus from this approach, too, the individual is not viewed as a thinking and acting human being but becomes an outcome.

Feminist critiques of structural-collective approaches have challenged the way in which women are often constructed as carers in social policy, thereby naturalising gender inequalities. Further, social policies that aim to promote health may end up penalising the most vulnerable (as is the case with women smokers on low incomes when tobacco taxation is increased) (Daykin & Naidoo, 1995).

There are problems with all attempts to alter lifestyles and improve health. Ethical issues are raised by both individualist and structural-collective attempts

to influence health. Some of these ethical concerns have been outlined by Guttman (1997) and are summarised in table 3.3. More generally, the critiques we have noted in both the individualist and structural-collective approaches highlight the importance of context. The next section examines individual lifestyle within its social and cultural context.

Influencing lifestyles: the individual in context

In most Western countries, attempts to improve health have been made through trying to get people to change their lifestyles. The theories and models employed by mainstream health psychology focus quite narrowly on cognitive processes and individual behaviour (Crossley, 2000). However, social and cultural issues are very important in the types of behaviour that people engage in (Backett *et al.*, 1994). For example, what would it mean to a 19-year-old in her first year at university to give up drinking alcohol? Would this mean she would become socially isolated, as the new friends she had made continued to go out drinking on Thursday and Friday nights? What if a man who is contemplating giving up smoking has a group of friends and work colleagues who also smoke? Is it more important to smoke and risk one's health than to end up being socially isolated and lonely? Here we consider some of the important contextual factors involved in individual health-related behaviour.

Individuals through the lifecourse

Behaviours are related to social and structural contexts. One important aspect of behavioural context is the individual's position in the lifecourse (Backett & Davison, 1992). Some behaviours are more acceptable and appropriate at different stages. For example, burning the candle at both ends is viewed as life enhancing or career promoting in young adults, but as stressful and damaging to health in older adults (Backett & Davison, 1992). People view a healthy or unhealthy lifestyle differently depending on their stage of life, as research from the UK (Backett & Davison, 1992, 1995) has shown:

Children: young people's bodies are viewed as resilient and able to withstand many 'unhealthy' behaviours (Backett *et al.*, 1994).

Young single adults: the body is viewed as in peak condition, able to deal with toxins and unhealthy living. Healthy lifestyle is achieved by balancing unhealthy (smoking, drinking, eating junk food) with healthy behaviours (exercising regularly, not being stressed, having a young body). Concern about lifestyle and its implications for illness is viewed as boring and middle aged.

Parents of dependent children: new parents change their lifestyles dramatically and change the values they place on their health. This can be paradoxical, in that they may live in unhealthy ways (lack of sleep, overwork) to meet their young children's needs (Backett *et al.*, 1994). At the same time, new parents often report living in healthier ways and thinking more about their health, mortality and their bodies, because 'you couldn't afford to be ill' (Backett & Davison, 1995, p. 636).

Middle age: health behaviours are assessed in terms of current health status.

Experience of illness is important in deciding about healthy lifestyles.

Older adults: ideas about healthy behaviour are strongly grounded in personal experiences.

Thus views and motivations about healthy lifestyles need to be located within the lifecourse context. Individuals view what is appropriate and feasible behaviour within the life stage they are at, and it is within this context that engaging in unhealthy behaviour can be viewed as reasonable and rational (Backett & Davison, 1995).

Experience

Lawton (2002) has recently shown that the embodied experience of ill health influences the ways in which adults perceive their future and the possibility of further ill health. In her qualitative study with people living in England, Lawton found that people's motivation to change their lifestyles and behaviour was directly related to how conscious they were of their future morbidity and death. This, in turn, was related to their position in the lifecourse, as well as their experience of ill health. Older participants were more health conscious than younger participants, and were also more likely to perceive their futures as containing ill health and death as certainties. However, Lawton reports two further important findings here:

- the experience of embodied ill health, irrespective of lifecourse position and age, related strongly to perceptions of vulnerability to future morbidity and mortality;
- participants who reported changing their lifestyles for long-term health reasons had done so because they had suffered ill health. Thus their motivation to change was reactive, rather than proactive.

Health was taken for granted by young participants, and in middle- and older-aged participants who had not had health problems. As a 55-year-old male respondent noted: 'Up to forty you don't give a bugger. Do you, you know? You don't really think about it at all.' This study highlights that the people who are likely to change their lifestyles for health reasons are those who are already experiencing embodied ill health.

Experience of previous health promotion strategies may also influence individuals' behaviour. For example, contradictory messages can lead to people ignoring any health advice. Contradictory health messages have been most apparent in relation to diet, where advice about what to eat changes (for example we are now told to turn the classic 'food pyramid' on its head). As participants in studies have noted:

- 'As a child I was always brought up, well you should drink milk and you should eat eggs and you should eat butter otherwise you're not going to be healthy. Well today you're not supposed to do none of them are you? So really who is right?' (from Backett *et al.*, 1994, p. 278).
- 'If you listened to everything they said, you wouldn't eat anything' (from Frankel *et al.*, 1991).

Material disadvantage

The rhetoric of health promotion focused at individuals is that if you know the health risks of a particular form of behaviour, then you have some choice and some power in your life. Yet this vastly exaggerates the options for the poor and economically vulnerable. Individuals in the middle classes may well have some control over their lives, and therefore some capacity to care for their own bodies, but such messages often simply create anxiety for those with fewer material resources (Richmond, 1998).

Further, people who have little choice in their lives as a result of material disadvantage see immediate comforts and pleasures as much more important than what might happen to them later in life (Ritchie *et al.*, 1994). For example, smoking increases with relative disadvantage, so that it is higher among people in lower socioeconomic groups. Efforts to convince people to stop smoking have been most successful with white women in privileged positions. However, it has been argued that explaining the differences in health outcomes between ethnic minorities and the rest of the population in terms of SES reduces health disparities to class and completely ignores (and undermines) the effects of cultural expressions and cultural values (Airhihenbuwa, 1994).

Culture

Much evidence demonstrates that culture is a central feature in health behaviours, perceptions of health behaviours and decisions to alter health behaviours. However, many of the theories and models employed to understand and intervene in health behaviour come from Western cultures, which are characterised by a view of the self as a production of the individual and a view of culture as a man-made part of the environment (Triandis, 1994).

Airhihenbuwa and Obregon (2000, p. 10) have argued that models and theories of health behaviour conceptualise culture as a 'barrier' because of the Western view of culture:

Controlling one's environment is a central theme in Western conceptions of culture – a conception that eschews other cultural realities such as harmonizing with nature or adapting to one's environment or both. If controlling the environment is the *raison d'être* of cultures, then the inability to control one's environment suggests retrogression, a barrier to be overcome. Hence 'cultural barriers' (never cultural strength) become a common expression in this discourse.

Models and theories such as the theory of planned behaviour, self-efficacy and health locus of control were developed in an individualistic Western culture and are therefore relevant, meaningful and appropriate here. However, we should not expect these models to be effective in explaining behaviour in other social contexts, where there are different commonsense knowledges of the world (Yoder, 1997). For example, in more collectively oriented societies such as those in Asia, Africa, and Latin America and the Caribbean, family and

community are more central to health and well-being than is the individual, and people are less likely to describe themselves in internal terms from the standpoint of 'I'. This means that measuring notions such as health locus of control does not make much sense in such societies. Even in cultures where Western beliefs are dominant, they will not function for some minority groups in which decisions are made in groups, where individual decisions (the key to health behaviour models) go against the grain (Airhihenbuwa & Obregon, 2000). Similarly, the importance of religion and religious beliefs is largely ignored in these models, yet may be primary in affecting people's decisions about health behaviours in non-Western cultures (see sidebar 3.3). These issues can help explain the ineffectiveness of HIV/AIDS prevention strategies based upon social cognitive approaches in Africa, Asia, Latin America and the Caribbean.

3.3 'Born again' young Nigerians and their views on HIV/AIDS

HIV/AIDS has been increasing dramatically in Nigeria in recent years, and it is expected that by 2010 18–26 per cent of the adult population will be infected (Smith, 2004). Many young adults in Nigeria are taking up evangelical and Pentecostal Christianity, and call themselves 'born again' Christians. From this religious perspective they make sense of HIV/AIDS, assess their risk and negotiate their sexual relationships. Connections between religion, morality and sexuality are complex, with young adult migrants responding in different ways to HIV/AIDS:

- Religious views mean that some young people do not have sex, not just to protect themselves against HIV/AIDS, but also as an ethical choice which may combat the immorality seen to have led to the epidemic.
- Religious views mean that some young people justify certain sexual relationships as more moral than others (e.g. with a girlfriend/boyfriend) and therefore as not putting them at risk and not requiring condom use. Indeed, condom use implies their partner's infidelity.
- Religious views mean that young people rationalise, hide or deny their sexual relationships which would be judged as immoral.

Knowledge of different cultural values is important for the effectiveness of lifestyle interventions, although it is also important to consider the process of communicating health issues. For example, several African countries have an oral tradition in both producing and attaining knowledge. This is not just about speaking or singing, it is also about listening: people are used to learning by hearing. This is why person-to-person home visits have been much more successful in changing particular behaviours in these countries than traditional mass media campaigns (Airhihenbuwa, 1994).

Unfortunately, health promotion efforts in much of Africa have been developed and applied on the basis of Western traditions and values, which may account for why they have not been greatly successful. Health communication campaigns have assumed that if individuals do not gain the 'correct' health information from the campaigns, then they need to learn skills so that they will be able to acquire the correct information (meaning in effect that literacy programmes are necessary for the target population). This places 'all the responsibilities for program failure on the inaction or indifference of people in the target communities' (Airhihenbuwa, 1994, p. 348). This is a classic example of the actor-observer effect, whereby the people observing (health professionals and promoters) attribute the cause of (a lack of change in) behaviour to the actors (targets of health promotion strategies) (MacLachlan, 1997).

In summary, the role of culture is often overlooked in models and theories about health behaviours. Culture is central to the ways in which we live, our values, knowledges and subjectivities. Rather than assuming the global relevance of theories and models developed in social and health psychology, it may be more beneficial and effective for field experience in different cultures and contexts to shape appropriate frameworks (Airhihenbuwa & Obregon, 2000). It is worth remembering here that different contexts and cultures will present opportunities for new and different frameworks, strategies and interventions (MacLachlan, 1997).

Globalisation

Hippert (2002) has recently argued that **globalisation** and the world economy have a major impact on poor health, especially in women. Multinational corporations in Mexico, Malaysia, the Philippines, India and Indonesia have had a serious negative impact on women's health. These corporations do not always provide safe and healthy working environments for their mainly women employees (who have been exposed to toxic chemicals, must endure long work days of over fourteen hours without overtime pay, with no bathroom breaks, with harassment and brutality). However, poverty is the most significant health issue these women face, with the corporations often paying less than the host country's minimum wage requirement (LaBotz, 1993). As Hippert points out, 'these problems could be solved by working against the global economy that keeps developing countries in their place, working for the international

accountability of multinational corporations, and working to elevate women's status within local societies and the international community' (p. 866).

To influence people's lifestyles we need to understand not only an individual's ideas and beliefs, but also social structures, how people comprehend these structures, and how these impinge on their lives. As noted by Kelly and Charlton (1995), 'a dynamic and reciprocal analysis of the individual set into context ought to be at the heart of health promotion' (p. 90). Health is related to lifestyle, and lifestyle is set within a personal, social, political, cultural, economic and global context.

Consequences of health promotion efforts to change lifestyles

Researchers have argued that the concept of 'health' has become a key cultural motif in the construction of identity in contemporary societies. According to Radley, health and being healthy are linked to values and morals because they are inseparable from what people believe is good or correct or responsible (Radley, 1994). Crawford makes the case more strongly in arguing that 'the pursuit of health is actually the pursuit of moral personhood' (Crawford, 1994).

3.4 New campaign targets bingeing women's vanity

Lee Glendinning, Thursday 26 August 2004, *The Guardian*

It has reached that stage of the night where the fifth glass of white wine is on offer. Drinking it will almost certainly guarantee that the evening enters that otherworldly domain where there is no place for inhibitions. There could be falling out of the cab after having a good chat to the driver all the way home, thinking it is suddenly OK to send that text message saying how you really feel, and grabbing a kebab from that shop on the corner which is never approached in daylight. Yes, one drink too many can damage your love life, and leave you with a few bruises at the end of the evening, but excessive alcohol is also ruining young women's appearance.

This has prompted the Portman group, a body funded by the drinks industry to tackle the social problems linked with alcohol, to market an anti-binge drinking message as a beauty product to try to reach young women, urging them to consider what alcohol

If healthy behaviours represents all that is morally good and righteous, then the flipside is that unhealthy lifestyles represent what is bad, irresponsible and immoral. Because of this association they take on a value of their own. Thus engaging in risk-taking and unhealthy lifestyles can create a whole new kind of subjectivity, one based on risk and a refusal to attend to 'authority'. Health psychology does not take into account relationships between healthy behaviours and moral identities, and by not doing so may actually be 'instrumental in perpetuating and exacerbating the very behaviours it is trying to reduce, manage and control' (Crossley, 2000, p. 42). It is important to remember that an individual's behaviours are integrated into her sense of self and

feelings of belonging to a particular social group (Giddens, 1991).

Further, people now use the language of health promoters and experts to discuss their own experiences and construct their subjectivities. For example, people talk about eating 'five a day' in New Zealand following a health promotion campaign to improve consumption of fruits and vegetables. They discuss whether a glass of orange juice counts as one portion, and engage in social comparison to see who makes the 'five a day' target. Rose (1990) has argued that social institutions and the social sciences produce ways of talking, thinking and being that are fundamental to our subjectivities. These 'technologies of the self' create languages and discourses that shape and create our thoughts and behaviour. Therefore, it has been argued that the efforts of health psychologists and other health promoters may be seen as a form of control, outlining particular social identities that are appropriate in today's culture (Nettleton & Bunton, 1995; see also Giddens, 1991).

Health promotion efforts are also strongly related to consumerism and consumption. Kelly and Charlton (1995) state that 'health is about lifestyle, and lifestyle is about consumption' (p. 88). We live in a consumer culture in which we carve out our identities and subjectivities through purchases and ways of living (see Bordieu, 1984). Our consumption of goods and services contributes to distinct lifestyles (food, cars, clothes, leisure activities).

is doing to their eyes, skin and general smell. They've called it 'masq crème de regret' – a potion to remind women how excess alcohol affects their looks.

Almost inevitable after a big night out are bloodshot eyes, blotchy skin and the smell of alcohol seeping from the pores for much of the following day. But binge drinking can also result in broken capillaries around the nose and cheeks as alcohol dilates blood vessels close to the surface of the skin. Certain drinks dry out the skin, because alcohol blocks the release of the antidiuretic hormone, and causes the kidneys to excrete excess body fluid. And then there are the permanent scars from that odd fall, which didn't hurt at all, at the time.

The mock beauty lotion which is to act as a reminder of these ailments comes in a glass jar with gold labelling and looks just like one of the thousands of other sophisticated beauty products which line department stores. But then, there on the label, is a silver outline of a woman's upper body. Her hands are placed over her eyes, she is leaning over – and throwing up.

It is intended to be a savvy way of driving home an old message which has dulled in the minds of many young women as promotions such as happy hour become more popular.

'We thought this was a nice idea to capture them,' Samantha Jobber of the Portman group explained. 'It looks like any other beauty advertisement until you pick it up and look closer when it lists some of the short term effects of alcohol which a lot of people forget about – which is basically how rough you look the next day.'

The directions for usage of the lotion suggest: 'Put sickening regrets and gruesome skin behind you by allowing your natural moderation to shine through . . .' Pastel coloured posters and postcards advertising the faux cosmetic brand, which look similar to current cosmetic advertisements, will be placed in 250 pubs, clubs and coffee houses around the country next month.

What women will find when they pick up these advertisements is a reminder of the government-recommended daily intake of two to three units. But the question is whether women will be moved to moderate their drinking for the sake of their appearance.

The Portman group says it has tried to appeal to women's vanity, an area of weakness which was likely to have more of an effect than a 'finger wagging' campaign. Ms Jobber said it was important to remind women that the longer they drink each night, although they may feel they look stunning their looks are declining with each glass.

'We decided to target women this year, there's been a lot of press about how much younger women are drinking,' she said. 'Women are having babies later, they have more disposable income to socialise and are more independent. It is acceptable for a woman to be in a pub drinking with the boys now, when it wasn't in the 1950s.'

While drinking habits of men are heavier than women, they have remained steady over the last 20 years, whereas the level at which women are drinking has increased and many will engage in episodic drinking with their male friends. Among women aged 16–24, the proportion drinking more than 35 units a week has more than tripled rising from 3% in 1998 to 10% in 2002.

The Portman Group's chief executive, Jean Coussins, says the pretend beauty lotion has been made to look like something that has been developed by white-coated experts working in a lab, who are trying to hang onto a secret formula.

'In fact, there is no secret', she added. 'Women who want to drink should stick to the government's recommended daily guidelines of three units if they don't want to start running any health risks.'
(Guardian Unlimited © Guardian Newspapers Limited 2004)

Health is constructed as a lifestyle 'choice', and has become part of this consumer culture. In this way, the notion of health is no longer confined to the arena of the hospital or medical professionals, but is now part of our social and commercial lives. There is a blurring between health promotion and commercial literature, so that health can be produced through various products (such as those advertised by fitness, cosmetic and dieting industries) (Nettleton & Bunton, 1995) and marketing techniques (e.g. Maibach *et al.*, 1996). For a good example of this in relation to young women's drinking see sidebar 3.4. Health has become a market commodity: it is fashionable (Kelly & Charlton, 1995). It is trendy to go to the gym, frequent health-food shops, and read about what to eat and not eat in glossy magazines (Nettleton 1997).

This can partially help to explain why health promotion efforts to change lifestyles are more successful with people who are materially advantaged, but have very limited success in changing the lifestyles of the materially disadvan-

tagged (despite the fact that campaigns often target these groups) (Nettleton & Bunton, 1995). If you have no money to spare, you cannot afford to buy extra virgin olive oil or the fresh vegetables that are now available all year around. If you have no money to spare, then buying a takeaway meal for the family will only be possible if it is deep-fried (and cheap) fish and chips rather than stir-fried Chinese food. On the other hand, many goods and services are consumed precisely because they are not healthy, and they become attractive for this very reason. Taking drugs, smoking cigarettes, drinking alcohol can together portray a 'to hell with it' attitude, which in itself can increase social status because of the meanings surrounding such behaviours. Any health professional trying to influence other people's lifestyles must understand the meanings and values that specific health behaviours are accorded.

Conclusions: what do we need in health psychology?

This chapter has further examined the concept of health, which is currently idealised as a self-governed lifestyle choice (Bunton & Burrows, 1995), and is certainly more than the opposite side of disease. Being healthy now represents a fulfilled life with physical, social and mental well-being (Kelly & Charlton, 1995). Aiming to change people's lifestyles to improve health is not the same as changing lifestyles to prevent disease. Health is not merely a neutral idea relating to the absence of illness, but means much more than this and is a value in itself. As a value, it is important to remember that it may not be given high priority by all individuals. Do all people want to be healthy? As we have seen, behaviour that is labelled unhealthy may not be 'health enhancing', but could well be 'life enhancing' (Backett *et al.*, 1994).

This chapter has argued that contextualising health and health behaviours is essential in any attempt to understand and change lifestyles. The mere fact that we focus on individual lifestyles highlights the Euro-American value of individual freedom (MacLachlan, 1997). Generating effective research and theory to guide health promotion practices will only be possible if it takes into account the complex social and cultural meanings of behaviours. People live in social worlds which are 'packed full of value-laden meanings' (Crossley, 2000, p. 40).

The challenge that health psychologists have is to come to terms with the complex relationship between individuals and the collective. Any attempt to change lifestyles needs to focus on the relationship between individuals and the much wider context in which they live (Spicer & Chamberlain, 1996). Thus social systems and the norms and rules of behaviour are key targets for health psychologists. According to Davison and colleagues (1991), the most 'efficient method of mass behavioral change is to change the norms or rules of behaviour – in short to change culture itself' (p. 15). It would be beneficial to examine how different health promotion perspectives might work together. For example, as well as trying to get individuals to change their behaviour in terms of cutting down on the amount of salt they add to their food, it would also be beneficial to change the food processing laws to reduce the salt content of tinned and frozen food (Jamison, 1995). As Richmond has tentatively suggested, 'there may be some ground for convergence . . . health promotion can involve sensitive and culturally appropriate individualistic methods of lifestyle change, coupled with structural and collective methods aimed at producing wider social change' (p. 172).

What can health psychologists do from here? In terms of influencing lifestyles, the research suggests some strategies for the way ahead:

- Be more honest in the depiction of scientific evidence, probabilities and the random nature of illness (Davison *et al.*, 1992). Remember that

people's perceptions of health issues are much more sophisticated than health professionals realise (Frankel *et al.*, 1991).

- Do not fragment the study of behaviour, but focus on lifestyles from the perspectives of those creating them.
- Treat social and cultural groups differently but with equal respect.
- See communities as cultures in themselves (MacLachlan, 1997).
- Consider the unintentional consequences of trying to influence lifestyles in particular ways.
- Focus on small improvements in the sociocultural fabric of community life (MacLachlan, 1997).
- Always contextualise behaviour and explore the meaning and value it has for the individual.

Finally, it is worth thinking about the goal of all these efforts to change lifestyles. Is it possible to aim for a world in which everyone is free of disease? Much of the work which attempts to change lifestyles for health benefits assumes that health is a natural state. As Kelly and Charlton (1995, p. 85) remind us, at the same time as health has improved for the Western world, and many diseases have been controlled,

humans have been devising the most mind-boggling forms of mass destruction, and industrialization has levied a heavy toll on hazards, pollutions and environmental damage. War remains commonplace and famine is endemic throughout much of the world.

RECOMMENDED READING

- Backett, K. C., & Davison, C. (1995). Lifecourse and lifestyle: the social and cultural location of health behaviours. *Social Science and Medicine*, 40, 629–38. This paper examines the concept of lifestyle and draws on data from two different qualitative studies to examine how people make sense of their health behaviours in their everyday lives. It provides a good account of why health promoters need to work with, rather than against, cultural norms and values.
- Crossley, M. L. (2000). Rethinking psychological approaches to health promotion. In *Rethinking health psychology* (ch. 3, pp. 36–62). Buckingham, UK: Open University Press. This chapter provides a solid overview of some of the problems with mainstream psychological research into health behaviours and health promotion. It places health behaviour in broader personal, moral and cultural contexts and provides excellent examples to demonstrate the points made.
- Raeburn, J., & Rootman, I. (1998). *People-centred health promotion*. Chichester, UK: John Wiley. This book provides an inspiring and practical guide to health promotion. It puts people at the centre of health promotion efforts, examining their quality of life and showing how quality of life and well-being can be improved through empowering communities and self-determination.

- Richmond, K. (1998). Health promotion dilemmas. In J. Germov (ed.), *Second opinion: an introduction to health sociology* (pp. 156–73). Melbourne: Oxford University Press. This chapter provides a clear and concise overview of different approaches to health promotion and views on health behaviours, and the values and problems associated with each. Written from an Australian perspective, the examples are direct and helpful.
- Rutter, D., & Quine, L. (2002). *Changing health behaviour*. Buckingham: Open University Press. This edited book provides a number of chapters outlining specific interventions that have been developed and employed based on social cognition models. A range of different behaviours are examined (e.g. safe sex, smoking, reducing fat intake, vitamin C use, speeding). The [final chapter](#) provides a clear discussion of some of the methodological and practical problems involved in devising theory-based interventions.

EBSCOhost®