

The importance of lay theorising for health promotion research and practice

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SUMMARY

The paper argues that, in the present state of the art, there is a need for a much more flexible approach to theory building in health promotion. The development of the field has been paralleled by an appreciation of the importance of the social and cultural context in understanding health and health behaviour. This argues both for a shift in methods and a shift in the theoretical and

philosophical approaches underpinning these methods. Principally, the need to bring back culture, and the failures of existing theory to tap into the richness, complexity and diversity of human experience, argue for a theorising which will reveal lay structures of thought underpinning everyday health-relevant behaviour.

Key words: health behaviour; health promotion; lay theorizing

INTRODUCTION

When we talk about theory in health promotion, whose theory do we mean? Three important points must be borne in mind when considering the place of theory in any endeavour. Firstly, a theory is also a product of its historical times and, as such, reflects either implicitly or explicitly a particular view of society and how it functions (Caplan, 1993). Secondly, knowledge is power; and the rationalisation of items of knowledge into a logical and potentially verifiable structure, known as a theory or model, is even more powerful. Thirdly, although a particular theory, or way of explaining and looking at the world, may achieve dominance at any moment in time, alternative and potentially competing explanations will also be current (Kuhn, 1970). In the process of developing theory in health promotion it is therefore important always to reflect on the purpose this is intended to serve, and whose reality the theory purports to represent.

The main reason for the development of theory in health promotion is usually claimed to be the provision of a solid base for better informed

practice. Theories, it is held, provide explanations which are abstracted and generalised from empirical reality and, as such, facilitate a more logical and rational approach to practice. Thus, it can be argued, health promotion practice is both strengthened and justified by the development of theory. It has also been suggested, that 'a main aim of theory is to reveal order in seeming chaos' (Research Unit in Health and Behavioural Change (RUHBC), 1989, p. 13). Theory in health promotion may therefore provide the basis for a clear, ordered, or rational approach to practice. However, since practice itself may be informed by implicit theories or assumptions, then the type of theory developed or considered useful may change in different contexts and over time. A further important point, however, is that, practice considerations aside, the quest for a sound theoretical base to health promotion has also paralleled its quest for 'scientific' and professional legitimacy. As Tones (1990, p. 6) has pointed out:

a key requirement of professionalism is the possession of a sound body of theory, in addition to practice skills,

together with the code of conduct associated with the autonomy granted to professions. Theory and an awareness of one's value position contribute to efficient practice.

LAY THEORISING AND HEALTH PROMOTION

Against this background it is suggested in this paper that there is a need for a more flexible approach to theory building in health promotion. Principally, the need to bring back culture and the failures of existing theory to tap into the richness, complexity and diversity of human experience, argue for a theorising which will reveal those lay structures of thought and behaviour which are integral parts of everyday health-relevant behaviour.

It is also important to acknowledge and question the power of the biomedically based positivistic models of inquiry and theory building in health promotion. For example, much social research has tended to begin with a biomedically defined health issue and has then explored respondents' attitudes or behaviours relevant to this. Arguably, the adoption of such a hypothesis-testing approach has constrained the health promotion agenda by shaping the available body of knowledge about lay concepts of health and illness. A questioning of the derivation of the existing theoretical base in health promotion could begin the process of attributing greater validation to lay theorising as an essential feature in the development of culturally relevant theory and practice.

It seems therefore that, rather than focusing efforts on the development of grand, or even middle-range theory, it may be useful to pause and to reflect on the current limitations of theory building in health promotion; and also to address the building bricks before trying to build the house. In particular it is relevant to note that, although those involved in the health sciences and health promotion regularly point to the importance of the social and cultural context in understanding health-relevant behaviour, it is only slowly that a body of knowledge is being developed about Western society which can accurately inform theory development in these areas. This is despite knowledge from medical anthropology that one of the first places to start in understanding health in less developed countries lies in the local social and cultural structures and their

associated meanings (Chrisman and Kleinman, 1983).

As Dean (1989, p. 151) has pointed out:

Behaviouristic approaches to health promotion implicitly, if not explicitly, separate individuals from the social, physical and economic environments in which they live. Many health information programmes operate as though personal behaviour is a simple matter of informed choice rather than of complex processes including opportunities for choosing healthy ways of living combined with personal strengths and resources for making health enhancing choices.

One way of understanding these 'complex processes' is by investigating their meanings for the people involved. In medical sociology the main approaches have been through the development of grounded theory and ethnography. Here the focus shifts to illuminating the body of lay concepts, practices and meanings which constitute lay theorising about health and health-relevant behaviour. However, the identification and incorporation of such a body of lay theorising into health promotion has been proceeding only slowly, despite the regular acknowledgement of its importance by practitioners and policy makers alike. For example, the Regional Office for Health Education, WHO Europe, stated some years ago that:

More emphasis should be laid on qualitative methods of observation, namely, those that allow lay people to define a problem and its solution from their own viewpoint. (WHO Europe, 1986, p. 121).

Furthermore it is also important to acknowledge that, whilst it is valuable in its own right for health promotion to work with lay concepts of health, illness and disease, the incorporation of 'lay theorising' requires much more than that. Lay theorising involves the location of such concepts, and others perhaps not directly related to health matters, within broader culturally meaningful systems. Thus, for example, food choice and eating behaviour *may* be better understood by examining how these relate to lay theories about the physical or emotional effects of food. However, a more complex understanding of these behaviours is achieved when they are located within, for instance, lay theories about the compatibility or incompatibility of food items; culturally approved or disapproved foods; the social prestige inherent in certain food items; and rules and rituals associated with commensality.

Re-casting the task at hand as not only theorising but also addressing the power and relevance of lay

theorising may also imply a narrowing of the gap between theory and empirically based reality. This is especially relevant for health promotion where practice and the *application* of theory is surely a paramount *raison d'être* (Kelly, 1989). As was mentioned in the opening sentence, the development of theory, and its possession and promulgation by an albeit well-motivated health promotion elite also begs the question of 'whose theory?'. Unless such a question is addressed the process of formal theory development itself may fail to ground research for health promotion within the rubric of empowerment, participation and the negotiated agenda for action espoused by many practitioners (WHO Europe, 1986).

This potential for distancing of theory from lived experience and knowledge is always present in any discipline. For example, Bulmer (1989) addressed such an issue in discussing the divorce of theory and method in recent British sociology. His arguments for an interplay between concepts, theory and data in the course of empirical inquiry have informed this present case for the importance at present of 'theorising' and particularly 'lay theorising', as opposed to 'developing theory' in health promotion. As Bulmer (1989, p. 399) stated:

The Kantian adage that perception without conception is blind, conception without perception is empty, is very much to the point.

Furthermore, one of the main conundrums for health promotion, and one fuelled by the long association of health education with social psychology theory, is the regular lack of fit between knowledge, attitudes and practices. In the following section it is suggested that findings about lay theorising can illuminate the cognitive meanings, settings, and socio-cultural contexts and processes which influence behaviours relevant to health and illness. Taken as a whole, these findings illustrate that, whilst lay theorising can be both independent of and interlinked with the dominant biomedical paradigm, its parameters and referents are based in wider social and cultural systems. It is incumbent on those addressing the task of theory development in health promotion to understand, acknowledge and learn from these lay systems.

LAY THEORISING ABOUT HEALTH AND DISEASE

One of the major challenges for health promotion, which is inherent in any definition of its endeavours, is to move towards an articulation of the processes that underpin health rather than illness. In my own research in Scotland, I have drawn on the qualitative traditions in medical sociology and anthropology, and have collaborated on meta-analyses with researchers working in the areas of lay understanding of health and health behaviour. Other findings reported in this paper also support that overall aim. However, some insightful research focusing on disease prevention and detection provides some of the most pertinent examples of lay analysis of the meanings of health and illness, and illustrates how lay concepts may be critically different from those of health professionals. For example, the concept of risk perhaps overrides the distinction between health and illness; and, indeed, much preventive medicine has encouraged this, which perhaps has led to risk superseding other possible categorisations.

The work of Davison *et al.* (1991) into heart disease has revealed the cultural complexity of lay theorising of the risk of heart disease. Based on ethnographic research in South Wales Davison *et al.* argued that in popular British culture there exists a lay epidemiology of coronary heart disease which has considerable relevance for current health promotion messages. This lay theorising involves linking regularities from personal observation or report and, from this and other knowledge, generating explanatory hypotheses which serve to challenge or support suspected aetiological processes. This is a collective, social activity drawing on many data sources, including official scientific data. Central to lay epidemiology, however, is the notion of candidacy: 'an overall profile, or image of the kind of person who tends to suffer from heart trouble'. As Davison *et al.* (1991, p. 6) explained, candidacy:

is a mechanism that helps individuals to assess personal risks, obtain reassuring affirmation of predictability, identify the limits of that predictability (thus mapping unpredictability) devise appropriate strategies of personal behaviour and to go some way towards explaining events which, by their very nature, are deeply distressing. In the cultural edifice which our society has erected to make sense of coronary disease and death, 'candidacy' is a central pillar.

This work on lay epidemiology and candidacy reveals how lay theorising is structured and based on everyday discourse about health and illness. Whilst there may be overlap between lay and scientific epidemiologies, Davison *et al.* (1991, p. 18) stressed that: 'ideas of luck, fate and inexplicable random distribution continue to play an important part in modern British explanatory culture'. Indeed such ideas can be seen as providing a counterbalance to the concept of candidacy, accounting for its inadequacies. Understanding such explanatory theorising is obviously important in the development of culturally relevant health promotion activity.

Further elucidation of lay theorising about the links between health and illness comes from Gifford's (1986) work in the USA on 'The Meaning of Lumps'. Here she used a situation of acute uncertainty at a different point in the aetiological chain, i.e. following the detection of a benign breast lump, to reveal the qualitatively different conceptualisation of its meaning and associated risk within epidemiology, clinical medicine and lay experience. She summarised her findings as follows:

For the epidemiologist, risk is an objective, scientific concept which describes relationships within large populations. However, for women, risk is an experienced condition of non-health. (Gifford, 1986, p. 238)

Gifford further explained that from her empirical work it was evident that medical practitioners saw risk as a situation of clinical uncertainty, a sign of possible future disease. This risk then became a physical reality which should be medically manipulated and controlled. Once women experience risk in this way it becomes for them a symptom of future or current illness and further medicalisation may ensue. As Gifford concluded: 'This process might be thought of as the medicalisation of risk, and it results in a greater clinical control over uncertainty by substituting an uncertain disease future with a certain state of ill-health.'

LAY THEORISING ABOUT SETTINGS AND RELATIONSHIPS

This work on lay epidemiology and the lay construction of risk begins to map out some features of the culturally based conceptual structures surrounding health and disease. Lay theorising

about health also addresses how these conceptualisations are bounded by social settings and the relationships they contain.

In an important paper examining the role of social relationships in the conceptual organisation of health relevant knowledge, Morgan and Spanish (1985), like Davison *et al.*, demonstrated what they termed 'the common existence of a health belief schema for heart attacks'. However, they also began to address the social processes which shape and form this body of lay theorising. Using data from focus groups about 'who has heart attacks, and why?', they concluded that:

For heart attacks and other health problems, vicarious experiences provide a person with far more knowledge than he or she would usually obtain through direct experience. Interactions within social networks are also important influences on the interpretation of this knowledge. (Morgan and Spanish, 1985, p. 420)

Their observations of focus group interactions revealed how individuals shared and compared their differing knowledge and experiences of who has heart attacks. Individuals also put forward their views about risks and causes, which met with agreement and disagreement. Drawing on these observations it may be assumed that, in real life settings, similar social exchanges take place which constitute, develop and reaffirm the body of lay theorising about heart attacks.

This analysis of lay theorising shows how health-relevant issues and behaviours are articulated and validated as part of ongoing social processes. Moreover, the understanding of what constitutes a health-relevant concern in a particular social setting becomes a topic for investigation in its own right, rather than an assumed motivator for behaviour (Backett and Curtice, 1991). Thus, for example, in a study of health in the setting of the family group, behaviours relevant to health were seen to be legitimated and accounted for in accordance with other wider social relationships and obligations (Backett, 1992). In this study, the health beliefs and behaviours of the adults and children were studied as part of their daily lives at home, work, school and play over a 2-year period. During the fieldwork it was evident that the salience of health concerns to individuals vacillated depending, for example, on the immediate social context and the constraints or choices it entailed. For instance, the attempts of respondents to increase their physical fitness, or to make sure their children ate 'a good diet' were often accorded a lower priority than were fulfilling

other family obligations or achieving harmonious relationships at home. Indeed, the latter were sometimes described by respondents as being 'healthier' concerns.

A somewhat similar socially based lay theorising of health emerged from the study of children's beliefs and behaviours, which was part of the project on health in family groups (Backett and Alexander, 1991). These young children expressed many physiologically based ideas about health such as: 'eating fruit and vegetables is good for you' and 'you should take exercise and be active'. However, when the qualitative techniques allowed the children to explain in more detail how they saw these various factors as being good for health, much more broadly based concepts emerged. For instance, eating the 'wrong' foods, which were chiefly identified by the children as those having too much fat, sugar or salt, was seen as resulting in a fat, lazy or inactive body. This in turn would result in exclusion from full participation in peer group games or activities, or being relegated to an inferior or boring position, such as keeping score. Thus, it was usually the social rather than the physiological consequences of these poor health outcomes, and how these consequences acquired meaning in particular social settings, which were seen as of major concern by the children.

LAY THEORISING ABOUT THE SOCIO-CULTURAL CONSTRUCTS UNDERPINNING HEALTH-RELEVANT BEHAVIOUR

Examining lay theorising can therefore provide insights into the socially based meanings and motives underpinning health-relevant behaviour in particular settings, as well as eliciting respondent-based definitions of health. Analysis of lay theorising also illuminates the role of socio-cultural factors in the construction of health-relevant behaviour. For example, studies have shown that the way people develop ideas about age, ageing and the lifecourse can have implications for how they then behave with regard to health and illness.

Williams' (1981) careful analysis of the lay logic of his elderly respondents' conceptions of old age demonstrated the importance for health promotion of acknowledging the coherence of lay theorising. Williams explained the advantage to health professionals of understanding 'the nature

of common systems of thinking about illness' as follows. He said:

to understand something of the situational determinants of an ill old person's actions is not enough, for this leads only to attempts to manage or control him. Even when such attempts are successful, they may inflict an inner injury or dividing behaviour from the mental premises which are the source of self determination. By contrast, perhaps the most potent influence on co-operation is the recognition of the other person's premises, and the demonstration that a course of behaviour flows from them. (Williams, 1981, p. 185)

Williams' work also showed that the analysis of lay theorising may reveal how individuals interpret and relate to socio-cultural constructs such as 'old age'. Similarly, based on a meta-analysis of two qualitative studies in Scotland and Wales, Backett and Davison (1992) have shown how lay theorising of the lifecourse generally has implications for health relevant behaviour, and therefore for health promotion. Their data illuminated how, in popular culture, being at different stages of life implied having different priorities about behaviour relevant to health.

In lay theorising, reference to the stage of life was an important way of explaining what was felt to be 'reasonable' behaviour with regard to health. In line with other studies (Blaxter, 1990) not only was there a complex interweaving of healthy and unhealthy behaviours at each stage of life, but this was also combined with changing assessments of whether such behaviours were good or bad for health. In lay theorising the *same* behaviour might therefore be assessed differently depending on the person's age or position in the lifecourse. Thus, lay evaluations of a particular health-relevant behaviour were carried out in the context of its perceived cultural reasonableness in terms of age, demographic position and personal biography of the individual involved.

CONCLUSION

For theory to be both empowering and useful for practice, it must be based on people's own experiences, and cultural and social circumstances. Research has demonstrated that there exists a sophisticated and coherent body of lay theorising of health and illness which reflects the complex web of such experience in a population. Culture, social structure, familial and social relationships all interact in the process of developing such explanatory frameworks.

This paper has argued for the acknowledgement and validation of lay theorising as an essential prerequisite both for relevant theory-building and effective practice in health promotion. Such a development would not only be in keeping with the ethics of the discipline but would also, in the long term, be a pragmatic investment in ensuring effective and sustainable health promotion activity within communities and settings.

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