Health Promotion Education

Between Moral Imperative, Heartfelt Desire and Free Choice

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Health promotion education: between moral imperative, heartfelt desire and free choice. Paper presented at the 6th Nordic Health Promotion Research Conference, Göteborg, Sweden, August 20.-22. 2009

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Abstract
The paper discusses the implications of health promotion in education. It is based on my PhD thesis (Lehn-Christiansen in prep). The thesis explores how professional health promotion skills are conceived in a specific educational setting; namely the Danish social and health education programme. Here, health promotion is formally conceived as a qualification aimed at citizens and patients - and not at the students themselves. However, as the paper will demonstrate, conceptions of student's and citizen's health, health habits and health concerns merge within the educational framework. Through empirical findings, based on 20 qualitative interviews and participatory observation studies from four schools, I show that there are widespread ideas, among teachers as well as students that professional health promotion workers should ideally act as health promotion role models. This claim leads to a series of educational and morally anchored dilemmas and challenges. Inspired by Foucault and others who have developed this line of thinking (eg. Signild Vallgårde) health promotion is viewed as a heartfelt self-technology that requires the subject to take on the ideology and practices prescribed by health promotion in order to conduct themselves and others to better health. But where there is power and attempted government, there is also resistance. The paper will investigate and discuss the resistance strategies that teachers and students take up when they (from different perspectives) engage in the educational practices of shaping and becoming professional health promotion workers.

Scope of paper

In this paper I will focus on three arguments that follow my analysis of health promotion within the Danish social and health education programme. I will show how health promotion is thought of as something that needs to be located inside the future health promoting workers, as a heart-felt desire. This perception has a number of consequences. In this paper I will point to some of the complexities that it raises:

1. Health promotion installs a 'style of thought' that operates with a dichotomy of normal/pathologic. Hence, the student's health behaviour and bodily appearances become a problem.

2. Health promotion and moral gets intertwined. As a consequence moral judging becomes legitimate as well as non-legitimate at the same time.
3. Problems of health and bad health condition are individualised. They are viewed as a question of choice. Hence, focus on conditions for choosing and inequality in health disappear. This has consequences not just for the students, but also for the citizens, the receivers of health promotion.

The paper will be devoted to elaborating these points.
But before engaging in the unfolding of these points, I will spend a few words on the thesis that makes the framework for this paper.

Framework (Thesis)

Due to the tight time schedule, I have chosen not to give accounts of my meta-theoretical standpoints, other to say that my research is inspired by post-structural, discourse analytic ways of thinking. The aim of my analysis is to explore the nexus between governmentality and subjectivity.

The thesis is based on a multi-ranged empirical production. I base my work on interviews with students, teachers and school managers as well as observations of class room activities. I do semi-structured interviews of individuals and groups, focusing on health promotion issues inside and outside the curriculum. I try to grasp as well as explore how 'health' and 'health promotion' are conceptualized within the educational setting as well as in the lives of the students. In this paper, I will use elements from group interviews with both teachers, students and managers, and I will make use of my field observations as well.

Empirical field: The Danish social and health education programme (SSH)

The Danish social and health education programme is basically a two step education: Step one is a one year and two month basic education as "Social and Health Service Helper" (SSH) and a second step is the one and a half year long education leading to the title of "Social and Health Service Assistant" (SSA). My research focuses solely on the basic level. I will refer to the students as SSH-student and to the SSH-education.

The SSH-students alternate between vocational college and practical training place. In total the SSH-education entails 24 weeks of 'college' periods and 31 weeks of work practice periods.

SSH is particularly aimed at care and assistance within the primary social and health care sector, while the SSA is aimed at care and assistance within both the primary and the secondary sector.

Approximately 10% of the students are male, so the vast majority of students are women. The average age for students finishing SSH is in somewhere in the early thirties, and the age spread is very wide compared to most other education and training programmes in Denmark (Nabe-Nielsen m.fl 2005: 9). Roughly speaking there are two age groups, one from 17-25 and one from 40-50. Approximately 10% of the students have ethnic minority background.

Study regulations

Study regulations frame 'health promotion' as part of the overall objectives for the education. In addition, 'health promotion' is part of the curriculum for the teaching of health. Health promotion is formally conceived as a qualification aimed at citizens and patients - and not at the students themselves. Hence, 'health promotion' is not listed as part of the 'personal competencies', but so is 'the ability to take care of your self'. (Study Regulations dated April 16, 2008: 2).

Role models?

My empirical data show that conceptions of student and citizen's health, health habits and health concerns merge within the educational framework. They show that there are widespread ideas, especially among teachers, but also among students, that professional health promotion workers should ideally act as role models. A couple of teachers express it this way in an interview:

> Tom: "(..) I believe in the power of the example, right. It's one of the most important pedagogical tools, and if they do not appear particularly healthy, then/
>
> Sine: So when I ask this question [if health promotion is part of the education, SLC] then you hear it as if I ask if health promotion is aimed at the students in this education?

> Tom: No, what I'm thinking is that they are going to act as professionals, but I think that the two things are connected with each other. It is hard to promote something that you do not understand.
>
> Christina: Yes, or that they themselves...
>
> Tom: Or that are a part of themselves. It needs to be a part of your self. (Christina, Tina, Mikael: 33)

Another teacher puts it a bit differently:

> "Sine: why is it important to work with their [the student's, SLC] personal health in this education?
>
> Marianne : (...) It probably has to do with my own education [as a nurse, SLC]. (...) the main teaching tool is the role model function, and therefore it is my opinion that you can not sell the health message, unless you signal that you believe in it. Fundamentally, regardless of what you sell, you should look like you mean it ... and it may be the physical body, but it can also be mimic, (...) To me it is important that there is consistency between what you say and what you look like. Otherwise you will not get the citizens to listen. You can not gain their confidence (...) and I say it directly to them several times in class They will not get anywhere if they do not look as if they believe in it... " (Marianne: 18)

Even though 'knowledge' is thought of as a very important aspect of motivation-work with in this empirical field, the idea seems to be that health promotion work is more than knowing about health. Health promotion knowledge becomes less efficient or even unreliable if it is communicated by persons, who do not live – or at least *look* like she is living - in accordance with this knowledge. A student puts it this way:

> "Well, I think I would see it from the viewpoint of the citizen. I know it [health] has not got anything to do with size, but a citizen would eventually have less faith in health advise coming from an over-weight person than from someone, who is not over-weight" (Sarah:20)

In that respect, health promotion is different from other subjects the students need to learn. It is about, who they should be. Therefore, the role model phenomena can be conceived as a subject position (Davies & Harre 1990) that is offered within the

institutional framework. A subject position, which can be taken up, adapted or rejected as part of a professional and personal subjectification process (Foucault 1982, Lehn-Christiansen & Holen in press). I shall refer to this specific subject position as the 'role-model'-position.

A way to understand the emergence of this kind of subject position is to view health promotion as a self-technology. The concept of self-technology is developed by Michel Foucault (1988) and since the nineties the concept has been taken up and further developed by a number of researchers within welfare state (e.g. Dean 2004) and health promotion research (e.g. Vallgårde 2003. 2009; Otto 1998).

By using the concept of self-technology, health promotion is framed as something which has to do with power. Not power in a negative sense, power in this perspective is conceived as a productive force, something that works through freedom and brings about the conditions through which we can come into being as subjects[1]. The ambition within health promotion is to make people change their way of living in order to become healthier, to make them want to do something they would otherwise not have done (or vice versa) and that implies power. Foucault writes about "the conduct of conduct" (Foucault 1982). Using this phrase he formulated that power (in this perspective) is about governing people so that they govern themselves in accordance with the expectations imbedded in the society and its welfare policy. Hence, this kind of power is about shaping people by trying to give them certain desires, e.g. the desire to stop smoking or loose weight (Vallgårde 2009: 107). Disciplinary means of power can still be located both within societal health promotion (e.g. the extending smoking prohibition) and within this particular empirical field (e.g. compulsory exercise), but the tendency is that external forms of power are replaced by expectations of inner control (Petersen & Lupton 1996).

The self-technological perspective on health promotion can also be deployed to make sense of the role-model-position that is offered to the students within the SSH-education; health promotion is not something that can be reduced to a professional competence, it needs to be a part of who you are. Something that you believe in and desire. To work as a health promoting professional implies working along the lines of

[1] This does not mean that the use of 'productive' necessarily denotes a positive production. Hence, power in this sense can be both productive *and* repressing (Lupton 1995: 132).

this self-technology. To motivate the citizens to take up the desire for health and make their own. Or as a teacher puts it: "To work health promoting is to work with raising consciousness". (Christina, Tina, Tom: 12). An important aspect of this work is to – to some extend - embody the imperatives of health promotion. At least one should not look like the dis-embodiment of health promotion imperatives.

Who are in need of health promotion?

One reason the role model-position causes problems is that the students are thought of as subjects, who themselves are in need of health promotion work, as persons incapable of taking care of their own health. One teacher puts it this way:

> "(..) we have incredibly many student who smoke, right. (...) it is students, who might be giving advice to people, who are developing COL or something, talking about changing habits or behaviour while being heavy smokers themselves. So they need to separate those different realities from each other and find out where they are at" (Lene:1)

Another one says:

> "We teach the good example. We teach them about healthy eating and afterwards we meet them in the canteen and what did they buy for lunch? A coke, some chocolate and a bag of crisps. And then you think: What was it that we just talked about in class? Does it not make any sense to you? (Christina, Tina, Tom: 10)

And a third teacher tells this story:

> I'm thinking about a student we had, she was very big, I think she was 150 kilos or something like that, and in the beginning when she was here she had elastic in her pants, and once in a while when she was walking, she was hitching up those pants, right. She didn't look too good, really. (Sonja: 18)

These examples could be supplemented by many more. They point towards a reception that the students attending the SSH-education are in a health condition, which is not so good. As individuals they do not commit themselves to health promotion, it is neither part of their behaviour nor of their inner self. It is not clear if 'it makes any sense to them' as teacher Tina says. My empirical data contain quite a few stories about female

students, who are so big that they need two chairs or students who are so heavy that they cannot walk[2].

This issue of the students' health can be addressed either from a 'reality-stating' or a 'reality-reflective' perspective. The reality-stating perspective will approach phenomena as something, which is 'out there' and therefore can be investigated and described, while the reality-reflexive perspective will focus on the complexities, ambivalent and polyphonic ways in which a phenomena can be understood (Staunæs & Søndergaard 2005: 51-53).

Reality-stating questions could be; what is the actual health condition of the SSH-students? Are they capable of managing their own health? My research is not designed to answer that kind of questions and only little research has been made determining the health condition of this particular group. One could claim that the students primarily belong to exactly those low-positioned social groups that suffer from higher morbidity, ill-health and weakening. That is most likely very true. Also it is without a doubt that the work as a home carer is out wearing both physically and mentally (Andersen & Frost 2005) and that this is causing a large number of accidents at work and sick notes[3] (Hansen 2005). The only concrete study of the health condition of recently SSH and SSA-qualified I have found state that: "The recently qualified SSHs and SSAs compare to the rest of the female wage earners in Denmark when it comes to over-weight, physical activity, alcohol consumption and about doing something for one's own health. There are still more smokers and more who eat less fruit and vegetables than women at the labour market in general" (Nabe-Nielsen et al 2005: 19, my translation, SLC). I do not know if the teachers know these conclusions, but assuming that they did, I will still argue that their worries have other sources as well.

Seen from a reality-reflexive perspective the issue can be raised differently. Instead of asking if the students have health problems or not, the focus is on how health and health promotion as social phenomena are talked and acted into existence. From this perspective the question could be if it is the discourse[4] of health promotion and the

[2] As stated in the introduction, male students are a minority in this education. Nevertheless, it is striking that my empirical production does not entail a single story or mentioning of male students' health or their bodies. Lupton notes: "The male body is far less visible in cultural representations, greater attention is devoted to women's health issues than men's health (…) " (Lupton 1995: 141).

3 This gives very good arguments for concerns about working environment

[4] I include language as well as all kinds of materialities in the concept of discourse.

student's particular position within this discourse (as future health promotion workers) that shape the teacher's perception this particular way? The argument would be that health promotion shapes the reality in such a way that a certain "style of thought" has become possible and taken shape. Nikolas Rose puts it like this[5]: "a style of thought is not just about a certain form of explanation, about what *it is* to explain, it is also about what *there is* to explain. That is to say, it shapes and establishes the very object of explanation, the set of problems, issues, phenomena that an explanation is attempting to account for" (Rose 2007: 12). My argument would be that these students are seen as having particularly bad health due to the logics and imperatives embedded in the style of thought within health promotion. This also implies that the judging-position does not 'belong' to the teachers, it embedded in the style of thought, and therefore teachers are also potentially exposed to judgements of their ability to display a healthy-looking body. I have not found any examples of students evaluating teaches, but co-teachers and the school management seem to have access to that position. A school vice director express like this:

> "We have actually been discussing it when hiring teachers. How heavy or how fat can a person be when working at a social and health education school? We've been discussing that. And it's not easy to discuss, but how much can we talk about health and everything, and – can a person like that be taken seriously? It's very, very difficult". (Eva Sørensen, Vice president SSH, Greve)

So teachers might not get hired if they are too fat. My data also include stories about students, who get thrown out of the education if citizens make too many complaints about over-weight related issues.

According to Foucault one of the important aspects of modern medicine was the establishment of pathology. The birth of pathology established dichotomies between normality/pathology, health/disease and normal/deviant as well as interlinked these conceptual pairs (Raffnsøe et al.2008: 141-143). Fat bodies and actions like buying lunch in the school's canteen can be estimated according to these divisions. 'A coke, some chocolate and a bag of crisps' clearly fall on the wrong side of the slash.
Thus, a heavy body, cigarettes, coke and crisps can be seen as indicators or even symbols of bad health behaviour made visible due to the health promotion style of thought. The

[5] With reference to Ludwik Fleck.

threadbare saying that 'you are what you eat' becomes a renewed truth here, it's not only the body that is seen as equivalent to the unhealthy habits, it is the self, the inner being that is seen as unhealthy, pathologic and deviant.

My point is not that it is wrong to see over-weight smoking or drinking coke as indicators of bad health. My point is that the stories about junk-food and over-weight students are told at the expense of stories about healthy-eating or normal-weighing students. They are pretty much relegated from the stories – they are out of the field of vision. One could argue that that's only to be expected. Why use energy on those who are doing fine? I see the point, but I am worried that at least some of the students are constructed as weak-willed problem persons and therefore marginalised in the professional field. Maybe an alternative, not very attractive subject position for those students will be that of the "pre-patient" (Rose 2007: 20). A position, which become all too present when one school compare student's fitness ratings with those of cancer patients just out of chemo therapy, to demonstrate the need for compulsory physical training within the education[6].

I am not arguing that the teachers from this particular education are the only ones who notice what people next to them in the canteen queue have on their lunch tray. But I do find it remarkable that these stories about unhealthy and obese students are so massively present in the oral discourse, in the stories about the students. The point here is not to blame the teachers for having an incorrect or negative perception of the students. On the contrary I experienced the teachers as truly engaged, carrying and concerned. The point is that it is the encounter between a specific style of thought imbedded in health promotion, the educational setting *and* the teachers carrying engagement that constitute the students as subjects, who are not capable of taking care of their own health and therefore not capable of fitting the subject position of the role-model.

Health promotion or missionary work?

The quotation about the student, who bought the wrong, unhealthy food items in the canteen, can also direct the attention towards another aspect that makes the heartfelt-

6 Status rapport from the project "Healthy SSHs", The Danish social and health education programme in West Sealand.

version of health promotion complex and somewhat difficult to handle in this particular educational setting. Deborah Lupton writes[7]:

> "Judgement of others and self-blame were themes that recurred (...), reflecting the a general moralization of health achievement (...) Fatness thus stood as a tangible sign of lack of control, impulsiveness, self-indulgence, while the thin body was a statement to the power of self-discipline, 'an exemplar of mastery of mind over body and virtuous self-denial" (Lupton 1995: 139) .

My findings are on a par with these observations. When interviewing students and teachers, I never insisted morality to be a theme. Nevertheless, in most interviews it became a theme. Health promotion seems to be caught up in a bubble of morality, judgements and self-blame. Not surprisingly, neither the teachers nor the students like to think of themselves and their professional role as someone, who passes judgements onto others. But working with health promotion seems to constitute this as a position one cannot easily steer clear of[8].

"I'm not a priest and I do not think they should be either" teacher Tom says (Christina, Tina & Tom: 19) when I ask him if he works with the student's health as part of his teaching. Teacher Marianne puts it this way: "Its not like I think one should be self-righteous, I'm not in favour of that at all" (Marianne & Lisa: 19). A student talks about like this:

> "Anja: (...) One can become a freak if one's too healthy
>
> Sine: How's that?
>
> Anja: If you have an attitude saying that you should live like this and this and this. You cannot load that onto others, that they need to do like that too. People have their free will to choose what they want and don't want. (...) Deep down inside we all know what's healthy and what's not, right. And in fact we do know what we need and what we don't need in everyday life, right?" (Anja: 26-27)

7 With reference to R. Crawford (1984) :" A cultural account of 'health': control, release and the social body. In Mckinlay, J.B. (ed.): *Issues in the Political Economy of Health Care.* New York: Tavistock.
8 Similar conclusions can be found in Mik-Meyer's study of health promotion within organizations. Managers generally do not feel comfortable having to work with personal health issues such as weight. Mik-meyer points to the idea that over-weight persons are positioned within a 'care discourse' that constitutes the over-weight person as someone, who has a problem that goes beyond the weight problem. (Mik-Meyer 2008:174)

The figure of the priest, the missionary, the health freak, who makes judgements over the behaviour of others, is many times present in my material and so are talking about 'self-righteousness. Both teachers and students use these words in a negative sense. They are used to mark actions and characteristics that should be avoided when working with health promotion, but also more generally. It points to the idea that one can actually be 'too healthy' and that there are limits to the intensity one can use when pushing the project on to others. Thus, it can be seen as ways of marking the constitutive boundaries for the health promotion project.

Pedagogically it makes good sense not to try too hard to make people change. But, it is as if the manoeuvre space for the professional health promotion worker becomes very limited. The idea that professional health promoters actually know about health and therefore posses a position from which is makes sense to have a professional opinion about the health promotion, seem to collide with another discourse, which is also very much present in my material. That is the discourse of the free choice.

A free choice?

'People have their free will to choose what they want and don't want' Anja says pointing to the widespread idea health is something to be chosen by the individual subject (Glasdam 2009, Petersen & Lupton 1996, Dean 2004). My data clearly show that this choice is not to be messed with, it should not be questioned, it is something to respect. The individual's free choice is what get's in the way of professional health promotion work. The free-will-rhetoric makes it possible to talk about alcoholism or addiction to junk-food as something one has chosen. And it makes it almost impossible to act upon. But the free-will-rhetoric can also be seen as the argument that sets the professional health promotion worker free form her moral yoke. When the individual becomes administer and controller of risk (Middelthon 2009: 235), there's basically only few things you can do as a health promoter: you can inform and you can motivate through the use of information. But as Anja says: 'Deep down inside, we all know what's healthy and what's not.'

Conclusion: Health promotion education: between heartfelt desire, moral imperative, and free choice

In this paper I have pointed to some of the aspects of health promotion that makes it complex and difficult to handle within a particular educational setting.

On the one hand you need to live, act and look in accordance to the claims of health promotion in order to motivate others to healthy living. On the other hand, the commitment can be too heartfelt. You must not overdo it, then you are considered to be a freak and you must not preach the message. But how should one then act? What is the difference between preaching and motivating? How are the students (and the teachers) to balance these blurry boundaries and conflicting demands?

Instead of giving answers, I have focused on drawing lines of complexity and raising questions, which are relevant for the education of health promotion as a professional skill.

I have pointed to health promotion as 1) a self-technological phenomena that 2) is linked to morality and 3), is framed by the discourse of the free choice of the individual. I have pointed to some of the implications of this construction, not just for the students, but also for the citizens, who are in fact the objective for health promotion work.

My worry is that health promotion as a heartfelt technology and the rhetoric of the free choice will continue to deepen the individualization of health problems and bad health conditions. I fear that the interconnection to morality will extend the marginalization of subjects, who suffer from so-called 'life-style' sequela. Hence, focus on the conditions for choosing and on inequality in health will continuously disappear. And even though the authority given to the SSH-profession is rigid and the possibilities for social change properly are limited, it does have societal implications, how the professionals understand what health and health promotion is all about.

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