Chapter 3

Lay Understandings of Health: A Qualitative Study

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Introduction

The North Eastern Health Board (NEHB) region covers the counties of Louth, Meath, Cavan and Monaghan. This area covers a total of 6,498 square kilometres and has a population of 300,183. Geographically, the region extends from the Fermanagh and Armagh borders in the north to the north Dublin boundary in the south. Census data for 1996 (the most recent census data available) puts the population of Co Louth at 92,166, the second largest in the region after Co Meath at 109,732. In terms of population density however, Louth demonstrates the highest population density of 110 persons per square kilometre, with two thirds of this population living in urban areas. In terms of material deprivation 60.7 per cent of the population live in what are classified as deprived district electoral divisions.[1] In addition, within the NEHB counties Co. Louth had the highest proportion of persons living in local authority housing (10.7 per cent) and the highest proportion of persons receiving medical cards (47.2 per cent) which are issued subject to a means test, and entitle the bearer to free medical care.

In terms of mortality, County Louth has continually shown a worse mortality profile in relation to respiratory diseases, cancers (especially lung cancers), and accidents to other areas nationally (NEHB, 2000). North Eastern Health Board figures show that more men from Co. Louth died of lung cancer between 1991 and 1995 than anywhere else in the State. Another study examining deaths in the Republic from 1971 to 1991 found that 'Louth is the worst for lung cancer and is very close to the top for most forms of cancer' (*Irish Times*, 10/9/97).

Residents in Louth have repeatedly expressed concerns that radiation-induced cancers and congenital abnormalities may be attributable to the proximity of the Sellafield Nuclear Plant in the UK (Keogh, 2000). Sellafield is an important issue

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[1] A total of five census-based indicators, widely believed to be a determinant of material disadvantage, form the SARU deprivation index. These include (1) Unemployment, (2). Low social class. (3) No car, (4) Rented Accommodation [5]. Overcrowding. Using mathematical models, a deprivation score was calculated for each of the district electoral divisions (DEDs). A DED with a score of 1 is least deprived, whilst a score of 5 is most deprived. DEDs with a score of 4 or 5 are classified as deprived.

at the national level in Ireland. All the main political parties now support calls for its closure. The issue also has resonance at the popular level, as evidenced by the recent *Shut Sellafield* postcard campaign, which involved the delivery of over 1.3 million postcards, signed by Irish citizens, demanding the closure of the Sellafield nuclear plant (26th April 2002) to Tony Blair, Prince Charles and British Nuclear Fuel's chief executive. Since 11th September 2002 concerns about the safety of Sellafield have been augmented by fear of a terrorist attack on the plant.

It is a central local issue in County Louth. Members of the *Cooley Environmental and Health Group* have been very critical of attempts to minimise the Sellafield effect. The Director of the Cancer Registry in Ireland has come under particular criticism for attributing high cancer levels in Louth to smoking ('Director of Cancer Registry blames Lifestyle of Louth People for Cancer Deaths', *An Phoblacht*, 11/3/99). A number of local groups have been involved in campaigns against the nuclear reprocessing plant.   Four local residents in conjunction with the Irish government took legal action in the British courts aimed at closing the BNFL-operated THORP reprocessing plant at Sellafield (*Irish Times,* 01/02/02). There have also been numerous calls for research into the Sellafield effect (see for example *The Irish Times*, 10/9/97; *The Irish Times*, 16/10/97). In this context it might be expected that popular wisdom might link the high mortality rates in Louth to the proximity of Louth to Sellafield (see also Balshem, 1991: 154).

In order to address these issues, an extensive multi-dimensional study was undertaken of which this study forms a part.   The Louth Project explored correlations between mortality profiles and socio-economic variables, incidents of radiation-linked cancers and congenital anomalies, and key lifestyle components in the region. The aim of the qualitative study was to understand commonly held beliefs about health and how these impacted on lifestyle practices across different age groups and genders located in the lower to middle income groups in Co Louth. In this respect it was a response to an identified need for qualitative work to explore findings from quantitative work on lifestyle and health-related issues previously identified (Friel and Kellegher, 1999).

Previous studies of lay health beliefs have demonstrated that it is essential to recognise that lay people have their own valid interpretation of what being healthy means (see for example McCluskey, 1997). These beliefs are not just diluted versions of medical knowledge, but rather are rooted in social and historical contexts.   The same biological phenomena can be interpreted differently in different times and places for social and cultural reasons, and these variations in interpretation can lead to different responses and actions.   In other words, definitions of health, and accepted ways of producing, maintaining and restoring health are socially constructed. Using this framework, the present study strives to look beyond individual lifestyle choices by focusing on the social meaning attached to these choices.

Participants and Methods

Given the aims and objectives of this study, the use of focus groups was deemed to be the most appropriate strategy for data collection. Focus groups can be defined as the explicit use of group interaction to produce data and insights that would be less accessible without the interaction found in a group (Stewart, 1990). Nineteen focus groups involving 131 lower and middle income participants were undertaken between December 1999 and February 2000. The majority of respondents were recruited using the General Medical Services database [GMS], which consists of all those eligible for medical cards in the county. Letters of invitation plus a consent form and FREEPOST envelope were sent out to 760 people. Previous experience of conducting qualitative health research in the region led us to over-recruit substantially, thus we invited five times the number of participants required for each group. This is in comparison to the focus group literature where it is suggested that you over-recruit by 25 per cent (Krueger, 1988). Young males were found to be the most difficult group to recruit. Our sample consisted of all those who returned the consent form and can be described as a self-selected sample. In addition two Traveller groups were recruited with the help of a primary health care worker.

In keeping with the principles of maximum variation sampling, groups were stratified on the basis of age, gender and geography so as to explore diversity. There were ten female and nine male groups; twelve were drawn from urban settings and seven from rural. Four of the rural groups took place in the Cooley peninsula where the Sellafield effect was expected to be the strongest. All focus groups were held in venues that were local, neutral and convenient. A payment of £20 was given to participants to cover expenses.

Discussions were guided by means of a topic guide, which was specifically designed so as to minimize the potential for participants repeating 'approved' messages about health. This guide was later tested by means of a pilot study, which affirmed that the original design was acceptable, in that it allowed participants to discuss their beliefs about health 'actively and easily' (see Morgan, 1998: 23). All focus group discussions lasted 1-1½ hours and were taped with the participants' permission, and later transcribed verbatim.

Each facilitator wrote detailed memos immediately after the focus group took place, which were then emailed to the other researcher. In the memos, themes and topics were noted, and interpretative work was begun. Data were analysed using NUD*IST 4. This package proved particularly useful for coding, and retrieving coded data. Emerging themes were identified from the transcripts and memos. The researchers used these to develop a coding scheme. This scheme was data driven and largely inductive in nature. Subsequent coding was done by each researcher independently, with regular checking of material in order to ensure inter-coder reliability. New codes were created right up until the end of the coding process. Following Catterall and MacLaran (1997), transcripts were coded on screen for content and off-screen for process. This was to avoid missing contradictions in participants' comments, changes in participant's views etc. In

addition, NUD*IST's text search facility allowed the researchers to check hunches and do retrospective coding.

Overview of Findings

A number of key findings emerged from this study, each of which will be presented in turn. Lay definitions of health challenge the notion of health as a unitary concept. Instead, health emerges as complex, multidimensional and dynamic, and respondents were found to have developed a subjective and experiential understanding of health. In the next section we present an overview of this new model for understanding health.

Secondly, the evidence of this study suggests that the 'self-responsible' lessons of health promotion appear to have been widely accepted, as reflected in the absence of a fatalist orientation in lay understandings of health. However, it is important to note that self-control does not occur in a vacuum but is a response to external triggers. This has implications for health promotion initiatives, as we shall see. In addition, it was found that the lay understanding of cancer linked it to environmental factors primarily, while heart disease was related to lifestyle factors.

Finally, it was found that the probability model of risk may prove to be a limited tool in evaluating lay risk as it fails to recognise that both risk and risk assessment are cultural phenomena, intricately bound up in subjective value systems. From this study it is apparent that people accept risks either because they enjoy them or because they believe intuitively or calculatively that, on balance, the expected benefits outweigh the possible costs. Dismissing lay risk assessments as erroneous or unscientific hinders understanding. In addition, an over-concentration on a probability risk model excludes this lay perspective and thus prevents a true understanding of 'risky' behaviour.

Health: Towards a New Model of Understanding.

While there is a tendency among health professionals to view health as a unitary concept, lay respondents in contrast hold complex and sophisticated theories of health. From a lay perspective, health emerges as multidimensional, dynamic and relative, a point also noted in the only previous published Irish study of lay health beliefs (McCluskey, 1989). Here, health was defined along four major orientations.

- Performance orientation: the ability to work and carry out normal roles and tasks.
- Fitness orientation: experience of being active and physically fit.
- Feeling-state orientation: a general feeling of well being.
- Symptom-free orientation: the absence of symptoms or illness.

While all these orientations were also found in this study, other nuances also emerged.

For some respondents, definitions of health were bound up with visiting or avoiding the doctor. Some respondents felt that health is 'about not going to the doctor for starters'; for older people the converse was in fact true. For these respondents their health was something that could only be determined by a visit to the doctor.

> I think if you go to the doctor and you get a clear answer from him that there's nothing wrong, well then you can say you're healthy, but if you don't go to the doctor then you don't know you are healthy.

Here we see respondents drawing on what Tucker (1997) terms the biomedical 'folk' model where health is equated with medicine, and dependent on doctors and drugs. Health was also defined as the absence of illness in many groups. However many of those with illnesses still claim health, so a contradiction can be identified here. This might be how health is defined in general terms, but when respondents spoke about their own health a more subjective definition of health was seen to emerge. Respondents saw health as a subjective and experiential phenomenon.

Health as Relative: '… Everyone is Totally Different'

When participants shifted from objective definitions to more subjective definitions of health, the notion of health as a relative concept emerged. Standards of health are not static but are influenced by stages in the lifecycle, life events, and respondents' own health history. For many, health was a matter of degree rather than an absolute. 'I would not say that I'm not healthy, I'm healthy to a degree' or as another respondent put it 'I'm healthy with a question mark'. This finding is similar to the notion of less than perfect health introduced by Twaddle and Hessler (1977), who argue that there is a range of less than perfect health within which a person is still considered healthy.

The idea of health as a relative concept, while most important in the older groups, was not exclusive to them. A number of different nuances emerged in this regard. Firstly there was the connection made between health status and age. As one respondent put it 'one certainty is the older you get the less healthy you get'. Illness was seen as inevitable as you got older. However, there was also resistance to this equation of ill health and old age, in the sense that aging can affect people differently; 'you can have people of 80 and they are healthy and you can have people of 50 and they are old long before their times.'

Many respondents equated youth with health. There was a feeling that you could do things when you were younger, e.g. smoking and drinking, without damaging your health. It was as if the younger body had a reserve of youth that acted as a barrier to ill health. For younger people, health involved thresholds prior to which health was taken for granted; 'When you hit 50 then you start thinking about it [health]'. One respondent suggests the reason health is taken for granted

until a certain age threshold is because it is not threatened. In other words it is illness that concentrates the mind on health. For others it was not illness per se, but rather the fact that as you get older you become aware of your own mortality; 'It's only now [at 40] that you start thinking I have to be healthy, I want to live a good life and live a bit longer'.

Health was also seen as relative to respondents own health history. For some respondents in older groups, health problems were seen as normal. Many argued they were healthy despite having various illnesses and conditions; 'Even though I have me arthritis and that I don't feel down with it because I have lived with it now'. It is as if older participants often expected health problems because of their age and therefore discounted them because of this expectation. This ties in with Fry (2000) who argues that 'older people report surprisingly high levels of well-being' and that well being ratings do not decline according to age.

Respondents were also willing to accept that you can be 'sick but healthy'. However they did make the distinction between 'conditions' and other illnesses. Conditions such as arthritis and diabetes are chronic illnesses that can be managed and so allow you to claim health. Other illnesses disallow you from claiming health, e.g. cancer. Cancer even if it was 'under control' was almost always seen as anathema to health.

Health as Minimal and Maximal Standard: A Paradox

Another lay model for understanding health is the idea of minimal standard, which refers to the notion that you are healthy when you meet or exceed a self-imposed minimal standard -.as one respondent put it 'the normal things in life if you are able to do them then you are healthy'. While the notion of a minimal standard was more prevalent among older respondents, in the younger groups the emphasis was on health as a maximum standard or as an ideal type.

> /: Someone who is [healthy is] pretty active, yeah [(ok)], looks after their body, knows what they're eating (right)], eats the right food [(right)]…
> /: Unlike us, probably [all laugh].

Related to this is the notion of aspirational health, with young people mainly wishing to do better in relation to their health.

A difference can be identified between older and younger groups in relation to lay definitions. Older groups seemed to want to claim good health, or fairly good health even in the face of illnesses. Younger people and some middle aged people in contrast seemed reluctant to claim health despite the absence of illness. Our hypothesis is that older respondents have developed a personal definition of health over the years as a result of illness. Their definitions of what it is to be healthy are more complex and tend to focus on the minutiae or the everyday. In contrast younger participants have internalised the healthist discourse of health promotion, which leads them to view health in absolutist terms thus rendering it elusive.

Health as Moral Imperative

In recent years, there has been an ideological shift in medical discourse from curative to preventative medicine, resulting in increasing stress being laid on the role of the individual in maintaining his/her health. One consequence of this shift is that moral judgements overlay the attainment of health (Crawford, 1984). Health is understood as a moral imperative. People 'admire' others who look after themselves. Respondents were found to be harsh about those who do unhealthy things, in particular smoking; 'They are neglecting their health that is a fact'. Non-smokers were found to be more likely to minimise the effort required to give up smoking, and to be judgmental about those who cannot give up. Excess drinking was also mentioned by respondents, but was not judged as harshly as smoking. Some respondents also made moral judgements about those who were overweight; 'I think overweight is terrible … it is a terrible burden on people, you could be much more active'.

Our respondents felt the need to apologise or to justify aspects of their lives that they thought unhealthy (see also Backett, 1992: 261). The regular appearance of terms such as 'should' and 'blame' in the transcripts are reflective of this. There was a form of self-flagellation evident in young women's talk about their health behaviour. Terms like 'I'm a disaster' and 'I'm terrible' were used in relation to diet. Note here that it is not the diet that is judged to be terrible, but the self. One respondent described herself as 'the most UNHEALTHIEST PERSON EVER', another said 'I'm very bad'.

The findings of this study indicate that not only was healthiness defined on moralistic grounds, which involved judgements about 'good' and 'bad' behaviours, but it also seemed to slip over into judgements about 'good' and bad' individuals. These judgements were applied both to the self and to others and reinforces the notion of lay health moralities.

Gender and Health

Gender also emerged as an important factor in relation to lay health understanding (see also Saltonstall, 1993). Women were more likely to talk about weight than men were and were more likely to define health in relation to appearance. Men tended to only speak about weight in relation to themselves if they were overweight. Discourse surrounding 'dieting', 'trying to lose weight' or 'feeling guilty' because of over indulgence in 'bad food' were mainly confined to female groups. In contrast, men spoke about eating 'well' or 'properly'. Also self-flagellation was a gendered phenomenon as we have already seen.

Another difference that emerged was in relation to exercise. Young men in particular spoke about exercise as a means to achieving fitness, stressing the physical benefits of exercise; 'I go to the gym to be fit'. In contrast women stressed the mental and social benefits and saw exercise more as a means of weight control than as a means of keeping fit; 'I love going to the gym, it's getting out as

well and you know I feel better and I feel slimmer and I feel that I must be losing weight'.

These differences can be seen as reflecting men and women's different relationships to food and the body. These relationships in turn reflect gender norms, which equate sliminess and health in women. These findings challenge the medical notion of there being one body differentiated only by biology. It might be suggested that health promotion initiatives in the future be cognisant of this gendered body.

Re-Assessing Fatalism in Health

Respondents in this study were found to have developed a complex understanding of who or what was responsible for health. Health is understood as involving an interplay between external forces and the self. There was no group where the emphasis leaned exclusively in one direction or the other. There was little evidence of a fatalistic orientation and there was a belief across the groups that 'you have a responsibility for your own health'. There was a feeling that in order to achieve health 'it is up to you to look after yourself'. In their talk about health these working-class respondents are making claims to 'moral equality even in the face of clear economic inequality' (Blaxter, 1997: 754).

The evidence of this study indicates that health promotion messages about food, exercise and smoking are generally accepted even if they do not lead to changes in health behaviour. There was a belief in the power of self to control events, and in particular a belief in the potential power of self if you do everything you 'should'. Bordo (1992) has identified a discourse about the body that insists 'on the possibility of creative self-fashioning'. This discourse of possibility means that although 'being healthy' involves a strict exercise regime and diet, it is taken for granted that we should discipline our bodies in this way as the results will be worth it. A belief in the possibility of creative self-fashioning was found across the groups.

> /:There is loads of things you can do [in relation to your health] if you want to do it.
> /: Put your mind to it like.
> /: Will power isn't it.

Despite this belief, very few respondents reported disciplining themselves in this way and the role of the self also involves people choosing unhealthy behaviours.

However, it was found that in those instances where respondents reported embarking on a strategy of self-control, it was typically exercised as a result of external forces. In this instance these relate to:
(a) 'The fright', refers to diagnosis and/or experience of what was perceived as a life threatening illness by the participants themselves;

(b) The vicarious fright: in contrast refers to illness and/or death among friends and close relatives (see also Meiller et al.; 1996)

The Fright: 'You wait till you get a problem first and then do something isn'tiIt?'

There was evidence of an unwillingness to take responsibility for own health until you were pushed to do so; changes in diet, weight loss and smoking were all stimulated 'by the fright'.   This phenomenon was mainly confined to middle aged and older groups, probably because younger people have not yet really experienced 'the fright'. The evidence of this study would therefore suggest that youth denies young people the 'fright' as a precipitating factor to positive changes in health behaviour.   The feeling of invulnerability associated with youth inoculates the young from interpreting a negative experience as a fright.

Some people were found to respond badly to being told by others what to do, but will respond to the fright.

> You wait till you get a problem first and then do something isn't it? Like the way if you feel great like you're keep the way you are you know what I mean [(yeah, yeah)]

> [If] The doctor came up to you and told you you've to give up the fags, well fuck you I'm not giving up fags you know what I mean [(yeah)], it depends if you get a bad fright or bury someone then you will go off them you know what I mean like [(yeah)]… They work better on frights don't they.

The vicarious fright: 'I got a fright when my husband died'

The vicarious fright emerged as another strong theme. While this was not confined to any one age or gender group, it was more common in older and middle age groups.   Heart disease emerged as an integral part of the 'vicarious fright'.   For some respondents the 'vicarious fright' was a more effective cue to positive health behaviour than advice given by the doctor. Unlike the fright, the 'vicarious fright' has a preventative health component to it. The vicarious fright causes people to take stock before they become seriously ill. However, it must be noted that is not clear whether the change in health behaviour is transitory or long term.

> I got a fright when my husband died, and I wouldn't do the things I did when he was alive, I wouldn't do them now … I'd be afraid I'd get sick. That frightened the life out of me … I don't smoke, I don't even drink since he died … I go to the doctors more often.

> I met him [my neighbour] in the waiting room, he smoked a pipe, he was that failed that I didn't know him, he was dead in a fortnight. I had had a chat about this at home then … and I said Gabby [wife] do you know I was sitting on death row there today and I said it [apologised for using swear word] I said well fuck it, I said it's going to be me or the fags … and I just cut them out and that was it.

The results of the study suggest that some of the most important cues to action revolve around social networks and the experience of illness either directly or vicariously, rather than as a result of health promoting initiatives. This is not to say that health promotion education is lost on individuals but rather it is activated only when it is perceived as relevant (Meiller et al.; 1996). The findings suggest that negative changes or a crisis in a person's life can open up possibilities for positive health-related changes. There is a tradition in health education of focussing directly on changing health habits but, as the study suggests, changes in health habits maybe a consequence of changes in a person's life which are social rather than health specific. Health educators in the future might be better advised to put some energy into detecting and harnessing life changes, which act as 'cues' to action rather than just focusing on measuring health outcomes.

Health as Release: The Value of Immediate Enjoyment

While a shift towards individualism has increased the notion of health as a form of self-control, paradoxically it has also created the notion that 'life is for living' and that pleasure should also form part of modern lifestyles. It is apparent from the transcripts that the respondents find themselves astride two opposing mandates, one calling for 'self-control', the other for 'release'. Both mandates are internalised in varying degrees and are variously applied depending on the person and the social context. While some respondents admitted that their health behaviour is governed more by 'release' than 'self-control', most admit that striving for balance is the best option. Health involves a continued struggle between indulgence and denial.

Release, as one respondent put it, 'is about doing what you feel like doing, not what you know you should do'. Release is the antithesis of a regime of self-discipline, denial and self-monitoring. The argument running through the discourse on release is that letting go can make you happy and therefore it can only be good for your health. Release involves enjoyment and allowing yourself the things that you love. Respondents pointed to the pleasure of release; 'I would take cream every day, I'd eat a pound of sweets a day … I would also take the fat on a rasher, and fat on a chop, I would love it … I just love it'.

While there were a number of participants who advocated a constant state of release, for the majority health behaviour involves tension between control and release. The evidence of this study suggests that self-control is something that occurs sporadically, and often as a response to a trigger. However 'bad habits' have a tendency to reoccur and self-control is something that is transient for many. Self-control is often followed by release. Respondents fluctuated between declaring the importance of controls while at the same time expressing a longing to be free of discipline. Release is best seen as a spectrum rather than an absolute, where respondents shift from not caring at one end of the scale to giving into pleasure on occasion at the other end.

Shifting between self-control and a form of controlled release is legitimated by social events. Many mentioned events in their lives where they felt release was

sanctioned or well-earned and thus involved little guilt. Examples of these included holidays, when women in particular spoke of enjoying food that they normally denied themselves; 'If I was away too I'd say to heck with it and don't worry about the fat end of it, I would always have the fry for breakfast'. However this is not a permanent state of release and once the holiday is over it is back to a regime of control.

Respondents also used release as a means of coping with or rewarding themselves for getting through a hard day, either at work, or in the home. Life events such as pregnancy worked as a catalyst for release for some women, while for others it had the opposite effect. In the course of the discussions, respondents also made reference to stages in the life cycle where they believed release was more acceptable (see also Backett and Davision, 1995). Release in young people, even if it occurred on a regular basis was deemed less of a health hazard because it was counter-balanced by high levels of activity, and the reserve of youth. On the other hand there were some older people who felt that old age in itself sanctioned a shift towards release.

The evidence of this study would suggest that health promotion strategies need to pay more attention to lived experience rather than emphasising ideals. The health promotion agenda is permeated with 'should language' or the language of control. Rather than encouraging people to adopt more constraint, this language can have the opposite effect, that of release.

> Most people are doing it [giving way to release] saying no I don't believe that. No I don't believe the so-called experts, it is a kind of rebellious thing, I suppose it is more it is put up to people it is bad for you and well for young people it makes it more attractive [referring in particular to smoking].

The Role of External Factors: Lay Understandings of Cancer

Although there was acceptance of the role played by the self in relation to health there was also talk about external factors. Respondents saw the environment as the most important external factor affecting their health and brought up a range of environmental issues in the focus group discussions. The exception here was in the traveller men's group where there was emphasis on the role of the self. This is of interest given that this group has the worst morbidity and mortality rates of any group in Irish society. This poor health status is largely attributed to external factors, for example poverty, and poor sanitation and living conditions. This echoes Blaxter (1997: 748) who found that external causes of health and illness, such as 'housing, the environment, personal poverty or prosperity' tended not to be mentioned by working class respondents although, objectively speaking, these factors were most significant in relation to their health.

The findings of this study indicate that respondents linked cancers in particular to the environment, while heart disease was deemed a lifestyle issue. Popular wisdom linked the high rate of cancer in Louth to the proximity of Louth to

Sellafield; 'Co Louth has the highest population [with cancer] because of Sellafield', 'Louth is pretty, pretty awful' (see also Balshem, 1991).

A fear of Sellafield was evident, and a number of respondents believed that cancer, and specifically cancer in young people was caused by Sellafield. One young respondent stated:

> It [Sellafield] has to be doing something because so many young people are dying around the place, so there has to be something somewhere, so that has to be one of the problems.

There was a desire for an explanation for cancer, and a feeling that cancer in the young particularly needs to be explained. The evidence of this study would suggest that Sellafield is blamed for unexplained instances of illness in Co. Louth.

In general, respondents did not feel in control of the environment. It was seen as something outside of their control. This was particularly true of Sellafield. As one respondent put it 'Sellafield is there, but what can you do about it wear a gas mask? you can't really do anything about it'. The role played by individuals in relation to the environment was not acknowledged. There was a feeling that 'you can do nothing about that [the environment] really'. This is in keeping with the findings of a recent survey on environmental attitudes in Ireland, where only 23 per cent of working class respondents believed that individuals had responsibility for the environment (Department of the Environment and Local Government, 2000: 10). This is despite the fact that while health risks in the nineteenth century were associated with the natural environment, current environmental risks can be described as man made. Nettleton and Bunton (1995) argue that health promotion ignores the importance of the environment for health. The evidence of this study would suggest that the environment is an important issue in relation to lay health beliefs in Co. Louth and that health promotion initiatives in the region should pay attention to this.

There was no evidence of respondents changing their own behaviours because of these environmental problems or risks (see also Department of the Environment and Local Government, 2000: 6). In relation to health, this means that there is no evidence to suggest that environmental awareness led to risk avoidance. Instead, there was a link between environmental awareness and feelings of uncertainty in relation to respondents' own health.

> I just imagine we could be living, you know, a healthy enough life and if it's, I suppose, the atmosphere or Sellafield or something else could get to you, you know [(yeah)]. You're trying to live healthy and as I said you know something else could get you, you know.

However this is not to suggest that respondents were fatalistic as a result. Rather, Sellafield was seen as one of a number of factors contributing to ill health in the area; specifically, ill health in others.

The findings of this study indicate that respondents linked cancers in particular to the environment, while heart disease was related to lifestyle factors. The

evidence of this study illustrates that the lay understanding of cancer led to a fear of cancer, in view of this it might be suggested that cancer education initiatives be considered in the Louth area that would address these fears directly.

Lay Understandings of Risk

According to epidemiologists, health can be promoted and disease prevented if we can identify and control risk factors. Here, the concept of risk is underpinned by the notion of probability. However, others have contested the accuracy of this tool in evaluating risk, primarily because it fails to take into account the notion that risk is a cultural phenomenon, intricately bound up in subjective value systems (Heyman, 1998). In other words lay people have their own rationality on what constitutes health risks for them, and although these may be at odds with scientific wisdom, they are rational and appropriate in the socio-cultural context in which they occur. Lay formulation of risk emerged as an important concept in understanding of lay health beliefs.

The case of smoking

Respondents made the distinction between controllable and uncontrollable risks. Controllable risks refer to lifestyle risks you take yourself, for example smoking. Respondents tended to use their own lay logic to legitimate such risky behaviour.

> I was very much involved in Scuba diving for 25 years and I smoked all the way through. I was still probably one of the better ones in the club and could hold my breath for longer than most. I smoked all the way through that … I reckon the fact that I was active kept any risk very much down.

Examples of this often occurred with smokers who viewed activity as an antidote to smoking, rather than something that was negatively affected by smoking. This rationale is the reverse of expert logic, which often highlights the negative impact smoking has on one's activity levels. For other smokers, living in a rural environment with lower pollution also served (they believed) to reduce the risk of smoking and thus gave them a licence to smoke more; 'If you are smoking say 10 or 20 cigarettes a day and you drive fast and you live in the city or whatever well that is probably worse than smoking in the [country]'. For some women, the risk of excessive weight gain associated with giving up cigarettes was greater than the risk associated with smoking itself, thus smoking was deemed less 'risky'.

Rationalising feelings of well being was another strategy participants adopted to legitimate their return to smoking after a period of abstinence. Here, smokers suggested they felt no better after giving up the cigarettes, in fact some complained that their health deteriorated as a result of the abstinence; 'I smoke too, I was in hospital for three weeks, that was my lungs clearing out, I went straight back on them and now I am as fit as a fiddle since I went back on them'.

The mythical smoker

Respondents also refuted expert calculation of 'risks' associated with certain health behaviours simply because they did not fit in with their own lay observations that 'fat smokers really do live till advanced old age and svelte joggers really do fall down' (Davidson et al, 1992: 683). In several of the focus groups respondents spoke of someone they knew who smoked 'like a trooper' but lived 'till ripe old age'. Smokers used this 'mythical smoker' in order to justify their continued smoking.

> I was reared with my granny and grandfather, he lived until he was seventy nine, he drank everyday and he smoked about 40 cigarettes or more everyday.

> Then I look around me and I see people dying anyway that don't smoke. My father never smoked or drank in his life … and he had the worst death anyone could have of cancer.

Lay formulation of risk is an important concept in our understanding of lay health beliefs. From this study it is apparent that people accept risks either because they enjoy them or because they believe intuitively or calculatively that, on balance, the expected *social* benefits outweigh the possible *medical* costs. Dismissing lay risk assessments as erroneous or unscientific, hinders understanding. In addition, an over concentration on a probability risk model excludes this lay perspective and thus prevents a true understanding of 'risky' behaviour.

Relationship between Lay and Expert Perceptions of Risk

Another related area of interest is the relationship between lay and expert perceptions of risk. Discussions around food in particular highlighted the current tension that exists between lay and expert definitions of risk. Risks mentioned included growth hormones in meat, genetically modified food, antibiotics fed to animals, steroids in food etc. There was a feeling that 'everything' is dangerous and that there are too many risks to be managed in relation to food. Conflicting expert advice serves to undermine lay trust in expert systems, which in turn can result either in consumer apathy or consumer anxiety, both of which can be injurious to health.

> I ignore that kind of thing, there was a bit too much scare mongering, and people got cynical about it. Because every couple of months now the so-called 'experts' are telling you something is bad for you, and what was bad for you a few years ago is now good for you … you sit back and you say to yourself is there a hidden agenda … there is a bit too much scare mongering.

In late modernity it is the responsibility of each individual to evaluate risks for him/herself, using information obtained from the mass media, and from family and

friends. This reliance on the self in the production of health had led to an increased feeling of the precariousness of health (Beck, 1992). We are seeing perhaps a move away from blind faith in science towards a more questioning and critical attitude among the lay public, where routine scepticism has replaced blind acceptance. This scepticism it must be noted, was not confined to the young or the better educated, but emerged in all groups.

Scepticism about experts allowed respondents to ignore expert advice. This finding has implications for health promotion as a discipline. Health promotion often involves the promotion of expert advice. Given the problems respondents identified in relation to such advice it might be more useful for health promotion initiatives to consider focusing instead at facilitating lay behaviour.

Conclusion

There has been a shift in health promotion recently to recognise socio-structural components of health. This is reflected in the recent call for 'greater… multidisciplinary approaches to address the impact which social, economic and environmental factors have on the physical, mental and social well-being of individuals and communities' (Department of Health and Children, 2000: 21). This chapter can be seen contributing to knowledge in this area. In particular, a focus on lay understandings of health is a welcome corrective to a focus solely on quantitative measures in relation to these socio-structural components.

> If health promotion is to be effective then it needs to be sensitive to the ways in which structure (and behaviour) are experienced in the everyday lifeworlds of individuals; the everyday cultural and social locations of health. (Watson *et al.*, 1996: 163).

The evidence of this study would suggest that lay definitions of health are complex and multidimensional. Health was understood in its social context and a holistic understanding of health was evident in respondents' talk. A qualitative approach was found to capture the complexity of lay health beliefs in a way that a quantitative approach cannot.

There was no unitary understanding of health evident. Instead, health was found to mean different things to different people, and also to mean different things at different times over the lifecycle. Health was understood to be a relative concept. Age differences were central here and definitions of health were found to change over the life-course. A difference can be identified between older and younger groups in relation to lay definitions. Older groups seemed to want to claim good health even in the face of illnesses, while younger people seemed reluctant to claim health despite the absence of illness. It was also found that moral judgements seem to overlay the attainment of health. The evidence of this study would suggest that health promotion strategies need to pay more attention to lived experience rather than emphasising ideals. An emphasis on ideals may have unintended negative consequences and may in fact contribute to inertia.

While there is still some evidence of the hegemony of biomedicine, particularly among older people, there is a growing questioning of its efficacy in the treatment of illness and in the production of health. The findings would suggest a shift away from the biomedical paradigm and a move towards the more holistic paradigm, which stresses the role of the 'self' and lifestyle in the production and maintenance of one's health. There was evidence of a questioning of expertise in general and biomedicine in particular.

Notions of control, release and balance emerged as central components in the discourse surrounding health behaviours. Respondents found themselves astride two opposing mandates, one calling for self-control and the other for release. Health behaviours for the most part were bound up in striving for moderation or balance rather than actually achieving it.

Self-control does not occur in a vacuum but was often found to be the result of external triggers. Negative changes or a crisis in a person's life can open up possibilities for positive health-related changes. There is a tradition in health education of focusing directly on changing health habits but, as the study suggests, changes in health habits maybe a consequence of changes in a person's life which are social rather than health specific. Health educators in the future might be better advised to put some energy into detecting and harnessing life changes, which act as 'cues' to action rather than just focusing on measuring health outcomes.

Health was understood as involving an interplay between external forces and the self. The self has the ability to control some risks, but other risks are determined by forces external to the self. There was no group where the emphasis leaned exclusively in one direction or the other. Following Tucker (1997), this can be termed a holistic rather than reductionist understanding of health. In relation to Sellafield, it was evident that this was a concern of the local community in Dundalk and the Cooley peninsula in particular. Popular wisdom linked the high rate of cancer in Louth to the proximity of Sellafield. However, there was no evidence of fatalism in this respect. Sellafield was seen as one of a number of factors contributing to ill-health in the area and respondents also pointed to the role of the self in the production of both health and ill-health. The evidence of this study illustrates that the lay understanding of cancer led to a fear of cancer. It might be suggested that cancer education initiatives be considered in the Louth area that would address these fears directly.

Lay formulations of risk also emerged as an important concept. Risk is understood not in terms of probability but as a subjective concept rooted in respondents' own experiences. From this study it is apparent that people accept risks either because they enjoy them, or because they believe intuitively or calculatively that, on balance, the expected benefits outweigh the possible costs. Lay people, in other words, have their own rationality on what constitutes health risks for them, which although it may be at odds with 'expert' advice, it is rational and appropriate in the socio-cultural context in which it occurs. An over-concentration on a probability model of risk does not allow for the inclusion of this lay perspective.

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