

**AN EXPLORATION OF THE IDEOLOGY OF HEALTH PROMOTION AND
CRITICAL IMPLICATIONS FOR PUBLIC HEALTH**

by

Alina R. Bodea Crisan

MD, University of Medicine “Carol Davila”, Romania, 1988

MPH, University of Pittsburgh, 2003

Submitted to the Graduate Faculty of
Graduate School of Public Health in partial fulfillment
of the requirements for the degree of
Doctor of Public Health

University of Pittsburgh

2013

UNIVERSITY OF PITTSBURGH
GRADUATE SCHOOL OF PUBLIC HEALTH

This dissertation was presented

by

Alina R. Bodea Crisan

It was defended on

July 19, 2013

and approved by

Dissertation Advisor:

Steven Albert, PhD, MSPH, MA, Professor and Chair
Department of Behavioral and Community Health Sciences
Graduate School of Public Health
University of Pittsburgh

Patricia I. Documet, MD, DrPH, Assistant Professor
Department of Behavioral and Community Health Sciences
Graduate School of Public Health
University of Pittsburgh

John H. Marx, MA, PhD, Professor Emeritus
Department of Sociology
Kenneth P. Dietrich School of Arts and Sciences
University of Pittsburgh

Martha Ann Terry, BA, MA, PhD, Assistant Professor
Department of Behavioral and Community Health Sciences
Graduate School of Public Health
University of Pittsburgh

Kenneth S. Thompson, MD
University of Pittsburgh Medical Center

Copyright © by Alina R. Bodea Crisan

2013

Steven M. Albert, PhD, MSPH, MA

**AN EXPLORATION OF THE IDEOLOGY OF HEALTH PROMOTION AND
CRITICAL IMPLICATIONS FOR PUBLIC HEALTH**

Alina R. Bodea Crisan, DrPH

University of Pittsburgh, 2013

ABSTRACT

This dissertation analyzes the ideological, conceptual, and moral foundations of health promotion discourse. It highlights their implications for the field of public health and for broader socio-cultural contexts.

Using a critical interpretive qualitative approach, the study employs semi-structured interviews to understand how conceptions of health promotion are articulated by a group of professional health coaches. Additionally, written and visual health communication and social marketing materials from the Centers for Disease Control and Prevention are examined through qualitative discourse analysis.

Findings from both sets of data are convergent and support the claim that, currently, the pursuit of health is mainly justified with reference to an individualistic, rationalistic and moralizing doctrine that continues to be pervasive. This translates into professional recommendations which stress individual responsibility for achieving health through discrete behavioral and lifestyle changes.

It is argued that the dominant approach in health promotion discourse fails to integrate a coherent understanding of the structural determinants of health and does not take into account the complexity of the production of health, nor the rich phenomenology of health in daily life. The present dominant status of individualistic conceptions of health contributes to the spread of a reductive understanding of health among the citizenry.

The study points to critical public health implications, including the urgent need for integrating social determinants in the pervasive professional ideology of health. As the health promotion workforce - such as health coaches - is expected to grow at a fast pace in the near future, it is imperative that a more comprehensive conception of health production be incorporated into the training of health promotion and of health professionals, generally. Additionally, efforts should be made so that the social determinants of health become integrated into public debate, public policy agendas, and health communication.

This analysis favored depth over scope. The main limitation of the study is the small number of interviews with health coaches from a single organization. Additional empirical studies are needed to include other health promotion and health care groups as well as lay participants, and to integrate a comparative perspective into the analysis.

TABLE OF CONTENTS

1.0	INTRODUCTION.....	1
2.0	HEALTH AND ITS PURSUIT UP CLOSE: THE ANATOMY OF A PROFESSIONAL NARRATIVE OF HEALTH. A QUALITATIVE STUDY OF THE WAYS IN WHICH HEALTH IS SIGNIFIED BY A GROUP OF HEALTH COACHES ...	4
2.1	INTRODUCTION	5
2.2	HEALTH COACHES AS HEALTH PROMOTERS WITHIN ORGANIZED HEALTHCARE	6
2.2.1	General considerations about the field of health coaching	6
2.2.2	Health coaching approaches and the effectiveness of health coaching interventions	10
2.2.3	Health coaches: work content and occupational status	13
2.2.4	Health coaching as health promotion	16
2.2.5	Conclusion: Health coaching as health promoters in the context of organized health care	18
2.3	STUDY METHODOLOGY	20
2.3.1	General methodological notes.....	20
2.3.2	Interview.....	21
2.3.3	Participants and data collection process	22

2.3.4	Research Integrity	23
2.3.5	From structure of data to structure of findings.....	24
2.4	FINDINGS.....	27
2.4.1	General description of findings	27
2.4.1.1	Health as a notion with many faces and shapes, open to multiple interpretations.....	27
2.4.1.2	A professional narrative of health: a powerful core, a fluctuating periphery	29
2.4.1.3	Health coaches' role in promoting health, and their embodying the new health consciousness	29
2.4.1.4	Fragments of critique.....	31
2.4.2	Main finding and argument. The anatomy of a professional narrative: its core, its margins, and its contradictions	32
2.4.3	The heart of a professional narrative: the doctrine of health as planning for and achieving (moralized self-made) health. Substantiations.....	34
2.4.3.1	An exemplary account	34
2.4.3.2	Key aspects of the narrative of health in further detail.....	39
2.4.3.3	Conclusions on the core of the narrative of moralized self-made health.....	53
2.4.4	The periphery of the narrative: modulations and counter-narrative elements.....	55
2.4.4.1	Exemplary accounts.....	56

2.4.4.2	Challenges to the tenets of individual choice-control-responsibility (internal challenges to the narrative).....	63
2.4.4.3	Fragments of socio-cultural and professional critique offered by the participants (external challenges to the narrative).....	69
2.4.5	Concluding observations about the professional narrative of health	78
3.0	FRAMING HEALTH IN CDC HEALTH PROMOTION DISCOURSE FOR THE GENERAL PUBLIC. A QUALITATIVE VISUAL AND WRITTEN DISCOURSE ANALYSIS	82
3.1	INTRODUCTION	82
3.2	METHODOLOGY	87
3.2.1	Methodological approach.....	87
3.2.2	Forming two sets of data	90
3.2.2.1	Data set 1: Print Public Display Advertisements from Health Promotion and Disease Prevention Campaigns	93
3.2.2.2	Data set 2: Health promotion/communication materials at CDC.gov readily accessible for the general public on a specific, randomly-selected day	101
3.3	FINDINGS.....	102
3.3.1	Content, form, and the codification of health in public display ads	102
3.3.1.1	Screen for Life Portfolio	105
3.3.1.2	The Inside Knowledge Portfolio	114
3.3.1.3	The Act Against AIDS Portfolio	116
3.3.1.4	Other Campaign Portfolios	119

3.3.2	Health communication for the general public in main CDC on-line pages	133
3.3.3	An additional exploration of main pages at CDC.gov: the representation of supra-individual determinants of health	151
4.0	DISCUSSION AND CONCLUSIONS	168
4.1	RESEARCH LIMITATIONS.....	185
4.2	DIRECTIONS FOR FUTURE RESEARCH.....	188
4.3	PRACTICAL IMPLICATIONS	189
	APPENDIX A: GUIDE INTERVIEW HEALTH COACHES.....	191
	APPENDIX B: SEQUENTIAL LIST OF DESCRIPTIVE THEMES INTERVIEWS HEALTH COACHES	194
	APPENDIX C: CDC PUBLIC DISPLAYS ADS	200
	BIBLIOGRAPHY	230

LIST OF TABLES

Table 1. CDC Health Communication and Social Marketing Campaigns Included in the Study (Source: CDC.gov)	98
Table 2. Texts in Selected Public Display Advertisements (Source CDC.gov)	122

LIST OF FIGURES

Figure 1. Gateway to Health Communication and Social Marketing Practice, CDC.gov.....	96
Figure 2. Are You the Picture of Health? (2005), CDC.gov	105
Figure 3. Are You the Picture of Health? (2007) Tall, CDC.gov	105
Figure 4. This is personal, black and white, CDC.gov	109
Figure 5. This is personal, color, CDC.gov	109
Figure 6. Screening for Life, "Busy People" ad, CDC.gov	110
Figure 7. "No Excuses", Tall 3 People, CDC.gov	112
Figure 8. "No Excuses", Wide 4 People, CDC.gov	112
Figure 9. Screening saves lives, 2009, CDC.gov.....	113
Figure 10. Be Brave. Ask Questions, CDC.gov	115
Figure 11. Here's what happened, CDC.gov.....	115
Figure 12. Kiss Transit Ad, CDC.gov.....	116
Figure 13. Hug Transit Ad, CDC.gov.....	117
Figure 14. Billboard, CDC.gov.....	117
Figure 15. Show your love, Caucasian female, CDC.gov	119
Figure 16. Show your love, African American female, CDC.gov.....	120
Figure 17. Budget for Health Feature, CDC.gov	134

Figure 18. CDC Features, May 3rd, 2013, CDC.gov	135
Figure 19. Arthritis Feature page, May 3rd, 2013, CDC.gov	137
Figure 20. Arthritis Month Feature, May 3, 2013, CDC.gov	137
Figure 21. Detail from the Arthritis Month Feature page, May 3, 2013, CDC.gov	139
Figure 22. Top Image CDC Feature "On a Budget?", May 3, 2013, CDC.gov.....	141
Figure 23. Asthma Awareness Month CDC Feature, May 3, 2013, CDC.gov.....	143
Figure 24. Asthma Awareness and other items on the page of the National Center for Environmental Health, May 3, 2013, CDC.gov.....	145
Figure 25. Walk This Way! CDC Feature, May 3, 2013, CDC.gov.....	146
Figure 26. Blood Pressure Control, CDC Feature, May 3, 2013, CDC.gov.....	147
Figure 27. Staying Healthy, May 3, 2013, CDC.gov.....	152
Figure 28. Healthy Community Program, May 4, 2013, CDC.gov	153
Figure 29. About Healthy Places, May 22, 2013, CDC.gov.....	157
Figure 30. Family Health, CDC.gov.....	158
Figure 31. Family Health page, CDC.gov	161
Figure 32. Healthy Communities, Family Health page, CDC.gov	162
Figure 33. 2013 Safe and Healthy Communities Calendar, Family Health, CDC.gov	164

1.0 INTRODUCTION

An important existential and technical category, health is presently the *raison d'être* of a vast societal project aimed at its control and enhancement. This project is so prominent in late modern western societies that some commentators do not hesitate to speak about a “health society” (Kickbusch, 2010). From a socio-cultural perspective, Crawford (2006) defined the contemporary “cynosure of health” as the situation where promoting and achieving health becomes a paramount concern in society (Crawford, 2006). According to Crawford’s analysis, for the past several decades in the United States (U.S.), the dominant practice and understanding has been that of pursuing and achieving health as an individualized, rationalized, and moralized project centered on the individual who is assumed to be solely responsible for his/her health (idem).

In a different paper (see comprehensive exam paper), based on the review of several lines of socio-cultural critique, I argued that public health and its sub-field of health promotion participate directly in the recent formation of the “health society.” I noted that despite this important involvement public health and, in particular, the specialties of health promotion and education appear largely oblivious to their broader ideological affiliation and socio-cultural impact.

In light of the considerations above, I proposed that efforts of self-scrutiny as well as systematic critiques of the general conception of health advanced and disseminated by

professional health promotion are needed. This position is consonant with that expressed by prominent professionals and scholars in the field of health promotion who offered a series of conceptual explorations in health promotion theory and stated that there is an acute need for “critical assessment of the roots, discourses, and practices of the field” (Potvin and Balbo, 2010, p.7).

Examining health promotion discourse is a critical endeavor currently underrepresented in the public health literature. Such effort would contribute significantly to a better understanding of the conceptual and ideological underpinnings of the field and to discerning important implications.

An important way to examine fundamental professional aspects of the expertise of health promotion, as well as its larger social, cultural and ideological impacts, is to focus on the specific “language of health” in health promotion professional discourse. This language is a recognizable form of specific expert-framed claims and assumptions about health and its production as well as about prescriptive regimens for its achievement. To this end, I conducted: a) an in-depth qualitative study of the ways in which health is signified in a group of professional health coaches, and b) a qualitative exploration of official health promotion communication products published by the Centers for Disease Control and Prevention (CDC).

Several critical terms in the paper need to be clarified. First, I make use of the notion of ideology. Eagleton (1991) offered a list of semantics for the term currently in use, including: processes of production of meanings, signs and values in social life; a body of ideas characteristic of a social group or class; forms of thought motivated by special interest; the conjecture of discourse and power; or the process whereby social life is converted to a natural

reality. It is within the range of these multiple and at times mutually inclusive or superimposing meanings that I am using the term of ideology.

Additionally, my investigation is concerned with a professional ideology of health in health promotion. By this I understand a complex structure of related notions, ideas, meanings, factual and normative claims, and values shared among a professional group.

I also use the term discourse. As already suggested by the list of meanings referenced above, ideology and discourse are related notions connected to the issue of power. I use here the definition advanced by James Paul Gee (1999) who sees discourses as “the integration of language with ways of thinking, acting, interacting, valuing (...) that privilege certain symbol systems and ways of knowing over others” (Gee, 1999, p. 12). According to Gee, discourses and the cultural models of meaning that they employ are

deeply implicated in “politics.” By “politics” I mean anything and anyplace (talk, texts, media, action, interaction, institution) where “social goods” are at stake, things like power, status, or valued knowledge, positions or possessions (idem, p. 70).

Finally, according to Heinen and Sommer (2009) and to Richardson (2000), narrative inquiry today characterizes a vast array of disciplinary and interdisciplinary areas. Richardson (2000) reviews four common approaches to the definition of narrative; those relevant for my use are designated as causal and minimal. The causal definition “insists that some causal connection, however oblique, between the events is essential,” while the minimal definition, “the most capacious, Genette’s, suggests that any statement of an action or event is ipso facto a narrative, since it implies a transformation or transition from an earlier to a later state” (Richardson, 2000, p. 169).

2.0 HEALTH AND ITS PURSUIT UP CLOSE: THE ANATOMY OF A PROFESSIONAL NARRATIVE OF HEALTH. A QUALITATIVE STUDY OF THE WAYS IN WHICH HEALTH IS SIGNIFIED BY A GROUP OF HEALTH COACHES

- How do people know they are healthy? How do we know we are healthy?

- (laughing) I think it's our perception, a lot of it it's our perception, speaking for myself, because I cannot speak for other people because as I said, it's perception or what they think, but I think I know that I'm healthy if I, you know, eat properly, exercise, you know, practice stress management, you know, limit alcohol, drugs, you know, no drugs, go and get my exams, and keep those kind of relationships going so... but for other people, I'm not, I'm not sure (laughs), I think it's a lot of perception for a lot of people (interview with G, health coach).

- How do people know they are healthy? How does one know one is healthy?

- Uau! It's a good question! I don't know..ah..., ah... Actually, yes. You know when people know how healthy they are? When they no longer have it... when they become sick, and that's, that's the sad truth. People know how good it was when they no longer have it. But it's not something that I think the majority of society makes a conscious effort to maintain.

- Right... so it becomes valuable when it's no longer there... so only at that point, are you saying, one gets to know one was healthy before?

- No, I'm saying that that tends to be my experience of it.

-Do you feel healthy? I mean...

-Yes! (energized)

- Do you consider yourself healthy?

- Yes!

- Why is this?

- Because I had a good night's sleep, because... because I woke up feeling rested... other ways that I feel healthy is that life has a flow to it. I have energy to handle the demands that are brought on me. So that's, to me, that is what health is. It's a sense of lightness, it's a sense of energy, it's..., it's a sense of peace..., you know, when I say that I mean more mentally. I'm intrigued by all of this. Are we going to see the end result of the things you are studying? I would like to, to see what the different perspectives are (interview with L, health coach).

2.1 INTRODUCTION

One way to examine how notions of health and pursuing health are signified in the field of health promotion, that is, how they present themselves in coherent, stable recognizable forms and meaning structures - is to analyze how health promotion professionals understand health, its genesis and pursuit. Questions like: what are the dominant professional discourse(s) and explanatory frameworks about health and its achievement that professional health promoters currently espouse? how are these frameworks constructed and what functions do they carry? and what is the relationship between the professional understanding of pursuing health and general ideas of a good life? are the fundamental interests that guided my inquiry.

Practically, to investigate how notions of health are construed by a group of health promotion professionals, I focused on a growing occupational category: health coaches in health care organizations. I conducted an in-depth qualitative study aimed at answering what are the key meanings and explanatory strategies that health coaches use in construing the content and significances of the professional conception of health.

In the next sections I justify why professional health coaches can be regarded as a category of health promoters, describe the methodology of the study, and, finally, present and discuss its most prominent findings.

2.2 HEALTH COACHES AS HEALTH PROMOTERS WITHIN ORGANIZED HEALTHCARE

What is health coaching? What do health coaches do? Who are they, and what is the connection between health promotion and health coaching? In order to answer these questions, I conducted a literature review regarding the field of health coaching.

2.2.1 General considerations about the field of health coaching

Health coaching is described in the health literature as a relatively new, very promising, and rapidly growing type of behavioral intervention generally aimed at improving health care outcomes, promoting health and wellness, and containing health care costs (Butterworth, Linden, McClay, & Leo, 2006; Huffman, 2007, 2009; O'Connor, Stacey & Legare, 2008).

From a broader societal perspective, the emergence of health coaching appears to be linked to the rising acceptability of coaching for a widening array of personal and business activities since the early nineties (Palmer, Tubbs, & Whybrow, 2003). Sociologist Arlie Hochschild (2012) commented recently on the conversion of more and more aspects of private life into objects of the market, a process illustrated in part by the rapid expansion and

diversification of coaching and consulting services that sell expertise or products for myriad activities, including personal care, health, and wellness.

The general popularity of health coaching is illustrated by a cursory Google search. More than 75 million results were instantaneously listed for a search using the term “health coaching” on May 8, 2012. A review of several pages of entries revealed a plethora of companies and on-line businesses offering health coaching services, training in health coaching, or training and products such as software for opening a health coaching business.

In the health literature, many sources including both health journals and health industry publications note a growth in health coaching services incorporated into health promotion and health management programs in a variety of organizational settings and for a variety of populations. For instance, health coaching continues to expand within managed health care plans where it was initially developed (Berry, 2008; Butterworth, Linden & McCay, 2007). Szabo (2007) noted that in the context of health plans coaches are generally trained health professionals, such as nurses or dieticians who work one-on-one with members, usually in call centers. An example is a Pittsburgh health plan where, in 2007, “nearly 100 nurses made and received more than 24,000 calls a month to patients” (Szabo, 2007, p 2).

Another major vehicle for the current expansion of health coaching is represented by occupational and employer wellness initiatives (Buttenworth, Linden, McClay, & Leo, 2006; Merrill, Aldana & Bowden, 2010; Thomson Healthcare Company, 2011; Schoeff, 2006).

According to a 2010 survey by a non-profit association of large U.S. employers, 56 percent of employers were providing health coaching services as part of their renewed health strategies, a trend estimated to increase (Health coaches: increasing employee wellbeing, 2010). According to the same report, it is the sluggish economy “forcing many large U.S. employers to

take more aggressive measures to control rising health care costs and motivate workers to take charge of improving their own health” (idem, p.12). In this context, health coaching appears to be a “mainstay” of wellness initiatives generally aimed at “keeping employees healthy” by addressing health risks such as tobacco use, physical inactivity, and obesity (Pallarito, 2008) or, as a health systems manager for a large company put it, “give the employees information on how to get healthy, stay healthy, and how to live a full and healthy life if diagnosed with a health condition”¹ (Thomson Healthcare Company, 2011).

In addition to health coaching being used by health care plans and employers’ programs, a variety of health care providers, such as hospitals, health care centers, physician offices, and home-care organizations have also incorporated health coaching interventions into their practices for a variety of purposes, conditions, and populations. For instance, health coaching has been employed for patients with chronic conditions in the context of primary health care offices, particularly as part of teamlet and hospital-to-home models of care, where it is considered to serve the functions of providing self-management support, bridging the gap between clinician and patient, helping patients navigate the health care system, offering emotional support and serving as a continuity figure (Bennett, Coleman, Parry, Bodenheimer, & Chen, 2010, p.25; Bodenheimer and Laing, 2007; Margolius et al, 2012). According to a health news report,

¹ A recent example of the rising prominence of employer wellness programs emphasizing health promotion is offered by the announcement of the “Clinton Health Matters Initiative,” “the most ambitious effort yet” of the William J. Clinton’s Foundation (Begley, 2012). The initiative, aimed toward “closing the gap in health based on income, race and education” and addressing preventable disease is based precisely on engaging large “corporate partners” such as Verizon, GE, NBC, and Tenet Healthcare Corp. in providing wellness programs in their workplaces and communities. According to Clinton, “big employers with a coherent culture of wellness can make a massive difference by reducing preventable disease” (idem, 2012).

physician office-based health coaching is seen as critical to making health care more patient-centered (Health coaches, 2011).

Hospital and medical practices in search of excellence are also including health coaching interventions among their services with the purpose of engaging patients and coordinating care (Wetzel, 2011). Some hospitals offer health coaching interventions for particular conditions such as overweight and obesity in children (Healthy 100 Kids, 2011).

Medicare used and tested health coaching via “The Medicare Health Support Pilot Program,” a large randomized three year study intervention of eight commercial programs offering call-based nurse coaching for congestive heart failure and diabetes (McCaul & Cromwell, 2011).

Community-based health promotion programs have also used and studied health coaching for preventing disability among the elderly (Leveille, Phelan, Davis, Logerfo, & Logerfo, J., 2004) or for promoting exercise and other healthy behaviors among older adults (Greenberg et al., 2005).

Complementing the recent growth of health coaching in private and public health programs are provisions in the Patient Protection and Affordable Health Care Act (PPACA) that emphasize improving the quality of healthcare, containing healthcare cost, and promoting health and wellness among the U.S. population. The National Health Strategy for Quality Improvement in Health Care (2011), mandated by the PPACA, specifies as a priority patient and family engagement in their health care. In this respect, health coaching activities offered by professional or lay health workers seem particularly suited to respond to the need for coordinating care and engaging individuals in their care within health care systems, especially within delivery models

like accountable health organizations and health homes, both promoted by the PPCA (Martinez, Ro, Villa, Powell & Knickman, 2011; Huffman, 2012).

Another critical component of the health care system emerging from the PPACA is the National Prevention Strategy of 2011 that offers a renewed focus on the promotion of health and wellness across communities and populations. Of note, licensed health professionals with expertise in health coaching were explicitly included, among other professionals representing a total of seven designated areas as part of The Advisory Group for The National Prevention and Health Promotion Council mandated under PPACA Title IV, “Prevention of Chronic Disease and Improving Public Health,” and were responsible for elaborating the aforementioned strategy (The National Prevention and Health Promotion Strategy Report, 2010, p. 12).

Thus, it appears that health coaching interventions are considered to be well suited to respond with versatility to priorities of national strategies for health promotion, prevention of chronic disease, and improving quality of health care, as well as to recent developments in the health care industry.

2.2.2 Health coaching approaches and the effectiveness of health coaching interventions

Paralleling the growth in health coaching services within organized health care, a number of reviews of health coaching methodologies and several studies on the effectiveness of health coaching interventions have been recently published.

In the most general way, the content of health coaching is described as a “structured and supportive partnership between an individual and a coach with the purpose of facilitating optimal wellness through engaging in healthy behaviors and lifestyle changes” (Huffman, 2007, p.271). Other authors referencing Van Ryn and Heaney (1997) describe health coaching as “a service in

which providers facilitate participants in changing lifestyle-related behaviors for improved health and quality of life, or establishing and attaining health promoting goals” (Butterworth, McClay, and Leo, 2006, p.358). Typical modes of interaction between individuals and coaches are one-to-one telephone and face-to-face sessions; group coaching is also noted in relation to some programs.

Studies on the effectiveness of health coaching interventions yield some mixed results. A review by Olsen and Nesbitt (2010) in the *Journal of Health Promotion* examined 15 studies on the effectiveness of coaching interventions published in peer reviewed journals between 1999 and 2008, and found that 40 percent of the studies indicated significant changes in one or more of the behaviors of physical activity, weight management, nutrition, or medication adherence, with features of effective programs including goal-setting, motivational interviewing, and collaboration among healthcare providers. Based on these findings, the authors concluded that health coaching is a behavioral change intervention that “suggests promise,” despite the limited data from methodologically rigorous studies confounded by the lack of standardization of health coaching content. On the other hand, results from the large randomized Medicare pilot study using nurse-based telephone coaching for patients with congestive heart failure and diabetes showed modest improvements of quality of care outcomes and no reduction in cost of care (McCall & Cromwell, 2011).

Recently, a randomized clinical trial using integrative health coaching assessed the effectiveness of this coaching approach on psychosocial factors, behavior change, and glycemic control in patients with type 2 diabetes. Integrative health coaching was defined in this study as a guiding approach focused on patients’ values and sense of worth in creating individualized health-goals. The study found improvements in its measurements and concluded that the

intervention may be applied in diabetes education to improve patient self-efficacy, accountability, and clinical outcomes (Wolever et al., 2010).

A qualitative case study of integrative health coaching consisting of document analysis and interviews with six health coaches in the randomized intervention referenced above (Wolever et al., 2010) concluded that characteristic to integrative coaching is “a process of self-discovery that informs goal setting and builds internal motivation by linking clients' goals to their values and sense of purpose” (p.30). The principles guiding integrative health coaching emphasize the leading role of patient’s personal values, vision of health, and life situation in guiding the coaching partnership; in setting health goals; and in finding meaningful ways to change behaviors, along with a non-judgmental orientation of the coach (Wolever et al., 2010).

Motivational interview-based health coaching is another approach studied in the literature. The motivational interview methodology is advocated as an evidence-based behavioral intervention with proven effectiveness in addressing multiple behaviors, health risks, and illness self-management (Butterworth, Linden & McCay, 2007). Motivational interviewing is defined as a goal-oriented and client centered counseling approach that seeks to address the ambivalence of the participant toward behavioral change. In a non-randomized study, Battenworth and colleagues (2006) studied the effectiveness of motivational interview-based health coaching among employees in an occupational setting and found improvements in both physical and mental health status. More recently, Linden, Butterworth and Prochaska (2010) studied the same intervention among chronically ill participants and found improved self-efficacy, patient activation, lifestyle change score and perceived health as compared to controls.

Health coaching employing motivational interviewing principles and skills is currently a favored evidence-based approach among large health-care organizations. Supporting its

prominence are a solid practice and research base that demonstrated the effectiveness of motivational interviewing in achieving positive behavioral changes (Rollnick, Miller & Butler, 2008). In addition to being effective in treating alcohol and drug addictions, motivational interviewing has been shown to positively influence physical activity, nutrition, weight management, hypertension and cholesterol control, medication adherence, as well as general health and wellbeing in a variety of populations (Linden, Butterworth & Prochaska, 2010; Rubak, Sandbaek, Lauritzen & Christensen, 2005).

In conclusion, despite the few number of rigorous evaluation studies of health coaching and their mixed results to date, health coaching interventions employing either the motivational interviewing or the integrative approach are generally considered to yield positive effects on psycho-social and behavioral measures and on health outcomes.

2.2.3 Health coaches: work content and occupational status

In the literature reviewed, health coaching is seen as either a set of job-specific functions that any healthcare professional can assume or as a more specialized occupational role, usually filled by nurses. According to a health industry publication, health coaching programs within employers' health plans are characterized by large variability, with better programs employing highly trained health professionals and requiring a health education or coaching credential (Pallarito, 2008). Remarking on this situation and reviewing developments in health coaching over the past five years, one of the founders of the National Society for Health Coaches commented that while several years ago health coaching "used to be a title defined internally by an organization according to the role that the organization required, today health coaching has been adopted as a legitimate behavioral, evidence-based intervention, and the role of health coaches has been

elevated, relying on more specialized training, and including validated interventions from behavioral health, such as motivational interviewing” (Huffman, 2012, podcast).

Despite the variability of health coaching services within organized health care and the differing conceptual orientations to coaching, a set of responsibilities appears to be common to the mission of health coaches. One reviewer found that the responsibilities of health coaches in health care organizations are generally “to help people clarify their health goals, and sustain behaviors, lifestyles, and attitudes that are conducive to optimal health; guide people in their personal care and health-maintenance activities; and, assist people in reducing the negative impact made on their lives by chronic conditions such as cardiovascular disease, cancer, and diabetes” (Kevinmd, 2009).

Supporting this general characterization, a job description posted for recruiting professional health coaches in a large health care organization specifies the following as general purpose of the position:

- Primary nurse providing both health coaching and case management services to members across the continuum of health ranging from health promotion to end-of-life
- Uses clinical and motivational interviewing skills to assess members' needs and establish mutually agreeable goals
- Supports members in developing self-management skills and in adopting positive behavior changes
- Identifies and addresses barriers to member's adherence to standards of evidence-based medicine
- Helps members to coordinate care and navigate the healthcare system

- Identifies on-line, telephonic and community-based resources to assist members in achieving their personal health goals
- Handles inbound calls from members seeking assistance with acute symptoms, chronic conditions and/or health information on specific topics
- Proactively incorporates lifestyle improvement and prevention opportunities into member interventions (Retrieved from http://www.candidatecare.com/srcsh/job.guid?reqID=2000012625210&_cache=-384013578216965122&x=51695, April 10, 2012).

It is obvious that central to the objectives of health coaching are health promoting and disease management responsibilities, and that both sets of goals are specified as activities directed at the adoption of healthy behaviors and lifestyles.

Several organizations such as The International Coaching Federation (www.coachfederation.org), Wellcoaches (wellcoaches.com), Duke Integrative Medicine (www.dukeintegrativemedicine.org), the Coaches Training Institute (thecoaches.com), and the National Society for Health Coaches (www.nshcoa.com) are recognized in the health literature for their role in promoting the professionalization of health coaching via training and certification activities, as well as through publications and efforts aimed at the conceptual and organizational advancement of health coaching. While nurses seem to be particularly active in leading the efforts aimed at defining and advancing the health coaching agenda, training and certification in health coaching are generally open to a variety of health professionals (for example, see the list of professionals accepted for training and certification by the National Society for health coaches at <http://www.nshcoa.com/site/certification.php>).

According to Huffman (2012), the health industry will be moving over the next several years toward the standardization of health coaching in terms of definition, education, and training and skill validation” (Huffman, 2012). A similar position in reference to the nurse-coaching role is formulated by Gulino Schaub, Luck and Dossey (2012). Efforts are currently on the way toward defining the role and competencies of the professional nurse coach as demonstrated by a first draft document on this issue edited by a group of professionals (Hess et al., 2012).

2.2.4 Health coaching as health promotion

A common denominator in all the literature reviewed is the description of health coaching as an intervention primarily directed at assisting individuals in addressing and controlling their health risks through the adoption of healthy behaviors and lifestyles. All the elaborations on the topic of health coaching in the literature emphasize the critical link between coaching activities, behavioral determinants of health, and health outcomes. The content of health coaching appears to be health promotion.

In a frequently referenced briefing published in the *International Journal of Health Promotion and Education* in 2003, the authors reviewed several definitions of coaching in psychology, business and sports, and juxtaposed them to a definition of health promotion offered by the Institute of Health Promotion and Education in the United Kingdom (Palmer, Tubbs & Whybrow, 2003). Palmer and colleagues found no divergence between the definition of health promotion and the principles of coaching, and advanced a tentative health coaching definition by linking the two: “health coaching is the practice of health education and health promotion within a coaching context, to enhance the wellbeing of individuals and to facilitate the achievement of

their health-related goals (Palmer, Tubbs and Whybrow, 2003, p.92). This definition captures well the characterization of health coaching in the health literature, and clearly places health coaching in the domain of health promotion and education².

The conceptualization of health coaching as health education and health promotion is in fact embedded in the discussions of health coaching in all the literature reviewed. To exemplify, Butterworth and colleagues state: “health coaching is a relatively new behavioral intervention that has gained popularity in health promotion, public health, and disease management because of the ability to address multiple behaviors, health risks, and self-management of illness in a cost-effective manner (Butterworth et al., 2006, p.1). Additionally, supporting the close affinity between health coaching and health promotion are articles published in important specialized journals, such as *the American Journal of Health Promotion*.

Health coaching is not currently indexed as an occupational category by the U.S. Department of Labor, yet in a recent description of work content for a health educator provided by the Occupational Index Outlook of the Department of Labor, the following attributes are specified:

Health educators teach people about behaviors that promote wellness. They develop programs and materials to encourage people to make healthy decisions. Health educators work in a variety of settings, including hospitals, non-profit organizations, government, doctors’ offices, private business, and colleges (U.S. Department of Labor, <http://www.bls.gov/ooh/Community-and-Social-Service/Health-educators.htm>)

According to the same source, this occupation is expected to grow at more than a double rate as compared to most occupations (*idem*).

² Palmer returned in 2004 with a practice note that explicitly regarded health coaching as an emerging field of health education (Palmer, 2004).

Despite significant differences between the character of health education described above and the general philosophy of coaching, there is a remarkable overlap in the sphere and setting of activities between health coaches and health educators (and possibly other occupation categories, such as community health workers), specifically in their sharing the central mission of “encouraging people to make healthy decisions.” In view of these conceptual and occupational aspects, it appears that health coaching is an occupation fundamentally related to health education and health promotion.

2.2.5 Conclusion: Health coaching as health promoters in the context of organized health care

The key findings of this review of health coaching can be summarized as follows:

- Professional health coaching is an emerging occupation with growing relevance due to recent trends in health policy and health care industry.
- While research on health coaching interventions and their effectiveness is in a beginning phase, the practice of health coaching is rapidly growing in organized health care organizations and through employer health plans.
- Within organized health care, health coaching encompasses both health promoting and disease prevention and management activities. Larger health organizations operate health coaching departments, with services provided by nurses or other specially trained health professionals.
- Professional health coaches are a growing contingent of health professionals working directly with a wide range of clients on health promotion and disease prevention activities. In the context of large organized health care organizations,

health coaches are health professionals with nursing or other professional health backgrounds specially trained to assume coaching responsibilities. Motivational interview-based health coaching is favored by many health care organizations as an evidence-based intervention.

- It is expected that the competencies, skills, training and certification of health coaches will acquire a standardized character in the next several years.
- Health coaches can be regarded as a new and growing type of professional health promoters or as an occupational category fulfilling a health promoting role. Though likely to be frequently trained in settings other than schools of public health and to operate with a conceptual apparatus that may not be similar to that of graduates of doctoral programs in health promotion and public health, health coaches are, nevertheless, health professionals engaged in the first line of health promotion practice.

Thus, it seems justified in the context of this study to inquire how notions of health and pursuing health are construed by professional health coaches who: a) share a common organizational home; b) have major work responsibilities aimed at promoting wellness, healthy behaviors and healthy lifestyles among clients; and c) have diverse health professional backgrounds and received similar coaching training including widely accepted motivational interviewing techniques.

2.3 STUDY METHODOLOGY

2.3.1 General methodological notes

Before detailing the methodology of this study component it may be helpful to restate its focus: how do health coaches, considered here practicing health promoters, construe notions of health and of its pursuit? What are the ways in which they describe “health”? How do they understand the sources and the production of health, and what are their views on the ways health is to be secured? How do they see the relation between pursuing health and having a enjoying a good life?

My methodological approach is aligned with qualitative (Wolcott, 1994; 2004) and critical-interpretive traditions (Scheper-Hughes & Lock, 1987; Wodak & Meyer, 2009), and shares the essential characteristics of all qualitative work (Mason, 2002). I hold the position that interpretation is a dialogical process (Bakhtin, 1981; Holquist, 2002) between a series of socially and ideologically situated human interactions such as the ones encapsulated in the text of this group of interviews. Additionally, another bakhtinian concept, that of heteroglossia (Morris, 2009) is also suggestive for the specific manner in which I approached the interviews. I regarded the accounts offered by health coaches as an expression of multiple intersecting discursive threads, some likely more technical and “official” and others more idiosyncratic and private. A related assumption in interpreting the interviews was that individual accounts can offer insights about personal views, but also about conceptions shared by a professional group.

2.3.2 Interview

In order to address the research questions, I opted for an individual face-to-face interview with semi-structured format supported by questions in an interview guide (see Appendix A. Guide Interview Health Coaches). The interview included two visual elicitation materials: a CDC health advertisement promoting colorectal cancer screening, and an advertisement image for health coaching services. At the end of the interview, I asked the participants to complete a brief questionnaire, including a few questions to collect demographic data and questions about recommended measures for healthy ageing; this component was not included in my current analysis.

The interview guide consisted of main and prompting questions framed at the level of generality of daily life. It was my deliberate choice not to specify categories of health such as physical, mental or social health, nor to ask directly about the distinction between individual and supra-individual sources of health. I asked only one direct question, what is community health? Proceeding this way, I intended to get closer to the semantic area of the term “health” as most commonly understood by participants. Additionally, in the conversations with health coaches, I allowed room for elaborations about the distinction between private and professional private and professional roles, notions and experiences of health. I anticipated that the participants would traverse spontaneously in their answers both professional and private dimensions of reflection about health; indeed, this happened.

The interview guide was designed as a backbone for the interview sessions. It was meant to orient the discussion with the participants and allowed idiosyncratic developments during the actual interviews. I piloted the interview guide several times and also submitted it for advice to committee members and qualitative researchers in the department. The piloting exercise was

helpful in assuring that the questions made sense to prospective participants and that its density and flow were appropriate for stimulating participation over the approximate interview duration of one to one and a half hours.

2.3.3 Participants and data collection process

Participants in this study were health coaches working for a large health care organization. A series of facilitating contacts allowed me to establish the necessary communication with the hierarchical level responsible for the approval of conducting the study within the particular organization. Upon receiving IRB approval, I presented the home organization of health coaches a brief study description as well as a copy of the interview guide - this per the specific request of the organization. Once the home organization granted approval for conducting the research, I received valuable help from the coordinator for the department of health coaching who facilitated my indirect communication with prospective participants and also scheduling the interviews. I sent an e-mail invitation for health coaches to join in an individual interview about general ideas of health and aspects of pursuing health. This invitation was presented by the coordinator in an internal meeting with health coaches.

My research design aimed at ten to twelve participants, yet only six of the department's health coaches, including the coordinator, signed up for the interview. The interviews themselves were held at the organization's location, in a closed space adjoining the department of health coaching. Each interview lasted about an hour and was audio taped. All the interviews were conducted the same day per the request of the organization.

The participants in the study were experienced professionals who met my questions with energy, interest and involvement. That the health coaches participating in the conversation were

genuinely interested and at times intrigued by the questions posed to them and also by their own answers, is visible at several points in the interviews. This is exemplified at the end of the second quote prefacing this text. Additionally, during the interview breaks, two health coaches from the department came to say that had they anticipated that the discussion would be about such interesting things, they would have enrolled to participate. I interpreted these statements as reactions indicating both the relevance of the issues discussed for the participants and the ability of the researcher to offer a stimulating substance and tone of discussion. All the participants were women and, at the time of the interview they had been working in the department of health coaching for several years. With only one exception, the participants had degrees and previous work experience in nursing (three of them), and degrees in nutrition or physical education (two of the participants). Each interview piece retains the participant's idiosyncratic mode of expression.

In regards to managing the data, I downloaded and saved the interviews in audio format on my computer, made back-up copies and also sent copies of the audio files to be saved on a departmental server. Subsequently, I listened and transcribed verbatim the audio material.

2.3.4 Research Integrity

To ensure the integrity of the research, all the methodological specifications - study aim, research questions, data collection instruments, participants, venues for data collection, methods for analysis - were submitted for approval to the IRB Office at the University of Pittsburgh. I submitted and received approval for an exempted study involving individual interviews with health coaches.

2.3.5 From structure of data to structure of findings

My analytical work followed closely the data. It advanced through iterative layers of reading, thinking, and writing which allowed me first to understand globally the contents of the interviews, and then to orient my analysis along emerging descriptive patterns and analytical themes. The crystallization of an analytical structure that would eventually support a key argument was a slow process. It required dwelling long enough on multiple ideas so that a relevant structure for an argument solidly rooted in the data acquired satisfactory shape.

Specific analytical procedures employed included repeated readings of each interview considered as distinct piece with a unique voice. Additionally, early on in the analytical process I wrote a descriptive summary of the contents of the entire group of interviews. This was a helpful working document in that it offered a succinct view of the major thematic areas in the elaborations of participants.

During the transcription process I wrote notes about aspects that caught my attention. Then, re-reading each interview I wrote labels on the side of the text, such as “personal experience,” “control,” “contradiction,” “hard” or “compliant.” Subsequently, I reduced the text of each interview by eliminating unessential fragments and I wrote descriptive and analytical summaries for each piece. On the reduced texts I could follow better the sequencing and associations of ideas in the elaborations of participants. I again placed labels, this time on the side of the compressed versions and then listed one after the other each interview’s list of labels or themes in their order of occurrence. Having a head to head list of themes in each interview was a critical step guide in advancing my analysis about the pattern, contents, and structuring of the conception of health identified in the interviews (see Appendix B. Sequential List of Descriptive Themes Interviews Health Coaches).

At another point in time, for each important theme such as “health as change” or “health as pressure,” I selected and grouped relevant quotes from the interviews. This procedure was difficult to perform because of the intricacy of themes and close interdependence of notions discussed in the text. However, it helped to substantiate with quotes my list of themes. This procedure also helped ascertain conceptual and language continuities in participants’ elaborations.

After a repeated reading and of the entire group of interviews, themes of a higher order emerged. Thus, at a descriptive and horizontal reading, the contents of the interviews appeared structured largely into three areas: a) meanings, definitions, and dimensions of the notion of health; b) considerations about the production of health; and c) considerations about societal concerns for health and about the contribution of the media to the health consciousness in society. Each of these clusters had associated lists of “labels” or “themes.” (A description of these three areas is included in the Findings chapter.)

Times of manuscript writing were interspersed with times of re-reading the interviews. In this long process of dwelling on the interviews and on my own written text, of disintegrating and reintegrating aspects encountered in the accounts of participants, of taking distance and then reconnecting closely with the texts (that in the meanwhile I had come to appreciate as a unified body of data), I experienced analytical hunches and tentative ideas, some elusive and some persistent. For instance, early on I realized that important contradictions or counter-takes are present in the elaborations of the participants. I also noticed that the labels that I had created inductively on the side of the interviews text echoed concepts used by Crawford (2006) in his theoretical analysis of the societal pursuit of health. The participants were indeed substantiating with their own expressions the theses advanced by Crawford (*idem*).

As already described, during my iterations through many analytical layers I could discern idiosyncratic modulations in participants' elaborations, but also consistent commonalities and emerging patterns in the ways health and its pursuit were interpreted by the participants and in the way their accounts were structured at a level going beyond the sequencing introduced by my questions. Different aspects of my analysis fell into place when a crystallization occurred, whereby diverse observations and ideas, the patterns connecting these, and "layers of triangulated effort" suddenly "formed a coherent and (...) cogent picture of what [was] happening" in the data (Fetterman, 2009, p.110). This crystallization was the notion of a professional narrative of health being embedded in the interviews. This notion brought together the idea of a cohesive system of professional meanings of health in the interviews and also the idea of it being an ideological creation rather than the direct mirroring of a set of scientific truths, both important for my interpretation of the data. Treated as narrative, the conception and discourse of health in the text of the interviews appeared easier to understand and analyze.

A related crystallization helped me to clarify my main argument about the anatomy and the dialectic of this narrative. Namely, I noticed that there were defining conceptual elements around which the narrative of health was organized, such as the issue of sources of health, location of health, and the understanding given to pursuing health. These aspects were in fact critical tenets of the conception shared among this group of participants.

Based on the analytical effort described above, I could identify that along the horizontal themes describing the specific contents of the interviews, there was also a key transversal theme underpinning the body of data. This was the theme of a narrative of health and of its pursuit construed by participants throughout their elaborations. Thus, the main analytical argument to be

made in my study was that, in the accounts of health coaches, a common signifying structure or a central narrative with distinctive features is expressed and shared by the participants.

Finding a compositional structure for communicating this argument was part of the writing process integral to qualitative analysis. The manuscript evolved through multiple rewritings and repeated transformations of text to the current form.

There were difficulties in advancing the analytical process. In the first phases of work, a persistent level of uncertainty about the direction of the argument was taxing. Because of the complexity of research questions and the rich elaborations from participants, a long time was needed for the argument to emerge. These difficulties contributed to a learning experience formative for the researcher conducting this study.

2.4 FINDINGS

2.4.1 General description of findings

Before presenting in detail the central finding of the study, I will offer a synopsis of the general findings of my analysis of the data.

2.4.1.1 Health as a notion with many faces and shapes, open to multiple interpretations

The interviews did not focus specifically on the definition of health, yet they illustrate that the participants operate with a flexible, multidimensional and loose concept of health, rather than with a standardized definition. For instance, the operational concept manifest in the interviews

blends various professional terms and categories, such as sources and domains of health: mental, physical, or social, along with personal significances: a sense of daily balance and satisfaction, or a sense of life meaningfulness.

An additional line of complexity is apparent in relation to the subjective-objective distinction and tension in defining health. Most participants emphasized the role of personal perception and subjectivity in defining health and assessing the attributes of being healthy. Yet according to another set of elaborations in the interviews, health is an objective standard or an objective line against which people's personal health is plotted; the position on the line diagnoses one's health as very good, very bad or anywhere in between. Interestingly, this view coexists with the position expressed by all the participants that only one's subjectivity can give the accurate measure of one's health. Both the experience and the definition of health are generally considered the domain of legitimate personal interpretations: "ask anyone [what health is] and you'll get a different answer." From such a vantage point, it is difficult if not impossible for the professional health promoter to assume a universal definition of health: "I cannot speak about other people's health, because, as I said, it's perception; I can speak about my own health."

Adding lexical evidence about the malleability of the notion of health, there are examples when "health" as category and noun is equivalent with "healthy" as quality or attribute: "health or healthy for me means that (...);" "health or healthy is (...)." Another important observation is that speaking of health in the interviews frequently comes to speaking about measures for achieving health. Health is equated in some instances with behavior and lifestyle change or with personal choice and responsibility, while in other instances it is equated with the sources of health, e.g., good nutrition, balanced mental and physical status and dynamics, physical exercise, or a life of meaning. Generally, in the interviews health and pursuing health are treated

coextensively, in the sense that when talking about one of these notions participants usually address the other one as well.

2.4.1.2 A professional narrative of health: a powerful core, a fluctuating periphery

Despite the definitional variability, flexibility, and complexity of the notion of health in the interviews, there is a solid overarching structure of meaning that unifies the participants' interpretations of health. This signifying pattern underpins interrelated formulations and interpretations and amounts to a shared conception with a stable form. This conception offers an explanatory framework for understanding health and its production; because of its logical coherence and consistent expression, I name it a professional narrative of health. This finding centers my key argument in this study and will be detailed in the next section.

2.4.1.3 Health coaches' role in promoting health, and their embodying the new health consciousness

The participants elaborated on their role in the project of health promotion configured in the professional narrative that they espouse. Specifically, this role was defined as support or a partnership aimed at helping individuals discover and articulate their health goals. Health coaches were seen as instrumental in offering clients the tools - information, personal health journals, charts and the follow-up support and reinforcements needed for administering their health. Managing one's health was seen similarly to a linear logic model in project management with a specific measurable baseline and discrete documentable inputs and outputs. In most elaborations, health coaches appeared as a sort of external aide or administrator to the individual pursuing health; they provided essential dialogue in the process of selecting information and

resources, in setting individual goals, and in articulating management health plans for the achievement of specific health goals.

At the same time, this group of well trained professionals appeared to be embodying the narrative and regimens of health that they advocate to their clients, thus actively embracing the new health consciousness in society (Crawford, 2006). This did not deter the participants from also formulating ambivalent or critical positions about the new health consciousness in society.

a. Fragments of critique

As noted above, while the participants appeared to generally embrace and promote the dominant narrative of health as a rationalized, individualized and moralized project - what could be tentatively called a narrative of self-made health - they also expressed qualifying considerations about the limitations of this conception, and also about practical difficulties in implementing its requisites. Furthermore, they articulated bold criticisms of the form of the pervasive health consciousness in society. Most of the participants elaborated vigorously on the massive and frequently negative contribution of the media - through entertainment, commercial or specialized health venues - in patterning this new health consciousness, which they regarded both with deference and appreciation, but also with distancing and irony. In a few instances health coaches suggested continuities between the general view of health in society and the media on one side, and their professional role, on another side, yet most of the time their professional conception of health promotion was not connected to the larger societal contexts for pursuing health.

The issue of a main explanatory and normative framework for understanding health, and its structuring into a stable narrative underlies all the observations above. These observations are incorporated into my detailed analytical and interpretive account of the narrative of health

presented here as the central finding of my study. (At the same time, the observations under points a, b and d can serve as basis for other self-standing arguments.)

I dedicated this study component to the in-depth analysis of the professional narrative of health in the interviews for two reasons: it encompasses much of their contents, and it contributes directly to the important and necessary discussion of the dominant ways in which health is understood in the professional and public sphere.

The following sections are thus dedicated to presenting and analyzing the professional narrative of health characteristic of this group of interviews.

2.4.1.4 Fragments of critique

As noted above, while the participants appeared to generally embrace and promote the dominant narrative of health as a rationalized, individualized and moralized project - what could be tentatively called a narrative of self-made health - they also expressed qualifying considerations about the limitations of this conception, and also about practical difficulties in implementing its requisites. Furthermore, they articulated bold criticisms of the form of the pervasive health consciousness in society. Most of the participants elaborated vigorously on the massive and frequently negative contribution of the media - through entertainment, commercial or specialized health venues - in patterning this new health consciousness, which they regarded both with deference and appreciation, but also with distancing and irony. In a few instances health coaches suggested continuities between the general view of health in society and the media on one side, and their professional role, on another side, yet most of the time their professional conception of health promotion was not connected to the larger societal contexts for pursuing health.

The issue of a main explanatory and normative framework for understanding health, and its structuring into a stable narrative underlies all the observations above. These observations are

incorporated into my detailed analytical and interpretive account of the narrative of health presented here as the central finding of my study. (At the same time, the observations under points a, b and d can serve as basis for other self-standing arguments.)

I dedicated this study component to the in-depth analysis of the professional narrative of health in the interviews for two reasons: it encompasses much of their contents, and it contributes directly to the important and necessary discussion of the dominant ways in which health is understood in the professional and public sphere.

The following sections are thus dedicated to presenting and analyzing the professional narrative of health characteristic of this group of interviews.

2.4.2 Main finding and argument. The anatomy of a professional narrative: its core, its margins, and its contradictions

I proposed that the interviews are underpinned by a traversing key or super-theme: that of a professional narrative of health, which brings together key meanings and explanatory strategies employed by participants in construing the contents of a conception of health. The health coaches in the study appeared to operate collectively with and within this key professional narrative of health that represents health as rationally controlled and self-produced individually - what one participant named “achieving self-health.”

My analysis shows that the professional narrative visible in the interviews has a double structure: a consistent and dominant core and a fluctuating weaker periphery. The highly consistent core represents the first line of elaboration in the accounts and overpowers secondary layers of discussion. At the core of the narrative, health is construed similarly to Crawford’s

description (2006), as an individualized, narrowly rationalized, and moralized project of achieving health through personal choice, behavioral change and control, and individual responsibility. Congruent to this conception, the dominant model of health causation in the narrative is one strongly individualized and centered on individual controls of lifestyle factors. In a system of equivalences with the determinants of health, it could be said that the core narrative is one mirroring the behavioral production of health at the level of individuals.

At the periphery of the narrative, elaborations differing from the ones at the core point toward the supra-individual/social production of health, as well as to the limits and challenges of applying the prescription of health advocated by the propositions of the core. These elaborations on the periphery qualify, complicate and subvert the tenets at the core, and add an important set of contradictions to the narrative. I propose that these contradictions can be regarded as tensions between ideologically hybrid strains of discourse.

Paradoxically while contradicting their main assertions, the participants constantly reaffirm the core tenets of the narrative. Based on these observations, I argue that it is the core that gives the narrative its identity and explanatory and normative power, while the periphery remains fluctuating, secondary, and disconnected from the tenets of the core.

In the next sections I describe in detail the dominant core of the narrative and then its periphery by substantiating my observations with quotes or paraphrasing fragments in the interviews.

2.4.3 The heart of a professional narrative: the doctrine of health as planning for and achieving (moralized self-made) health. Substantiations

2.4.3.1 An exemplary account

Soon after the beginning of one of the interviews, a thread of elaborations by the participant gave expression to the major tenets, defining tone and formulation of the key narrative of health shared by this group of professional health promoters:

- You have mentioned the wellness continuum. What is understood by this?

- By me? By me, personally? Well, the wellness continuum in the way I think of it is a line (laughs) and I like to see myself kind of either in the middle or on the good end (...) and I hope to have people that I work with that are in the middle or on the good end, not on the bad end; if they are in the wrong end or bad end, however you want to think of it, I hope to be able to help them understand that even that they are there, they can move themselves forward, because my personal opinion on healthcare, (...) my concept of healthcare is that we are responsible for our own healthcare. The individual is 99% responsible and the other 1% are people that we ask for help. The person that you know is your primary care physician, but they don't go home with you, they don't go home with you and help you, they are part of your healthcare as long as you need them or if it's a crisis situation, but again, they don't go home with you. They send you home, and eventually you become responsible for yourself. So, that's the way I operate and that's the way that I encourage the members that I work with to operate: to take control of their own lives, and that's basically how I look at the health continuum, or the wellness continuum: to keep yourself healthy and moving forward to **a good place**.

- This is very interesting... so you said earlier that you help people achieve their health and then maintain it...

- Hopefully yes, and try to make them understand that they are responsible for maintaining once they've achieved, and help them realize that – and I find that to be very... that was a very challenging concept for some people when I was on the phones (...) and... it was very difficult for some people to take responsibility ... and usually, if I found someone like that, and after I tried all the techniques and all the interview ways that we have learned and I could not move that person, then I realize that that person wasn't going to change. But there are people that you can get, that you work with that you know are willing to change, and those are the people that I like to work because they are willing to take control over their own health...

- Ok... what about the others, why do you think they don't... or are not in a position to...

- I think there were a variety of reasons, I think first it was cultural, I think certain cultures do not promote self-health (laughs) for lack of a better term, I think that it was also educational, I think it was sometimes the demographic of where the people lived or what they were used to, I think it also had to do with work, the type of work that they did, and I **firmly believe** that those were many of the factors that prevented some people from being responsible for their own health, they left it out to somebody else (interview with N).

In this conversational thread several critical statements illustrate the core of a dominant professional narrative of health. Straightforward and implicit tenets apparent in the fragment above indicate that this narrative stands on the ideological premises of health as a rationalized, instrumentalized and moralized responsibility of the individual.

For instance, it can be observed that the obligation/moral imperative of personal responsibility for health surfaces spontaneously from the very onset in this participant's elaboration. Health is represented here as a line or a continuum, and its trajectory is qualified by moral attributes: the ends of the wellness continuum are "good" and "bad," or "wrong". (At a later point in the interview, N. used "dark" and "bright" as qualifiers in her description of the ends of the wellness continuum.) Furthermore, in this exemplary account the individual appears as solely responsible for bringing her/himself on the morally desirable part of the continuum. To accomplish this, one has to approach one's self and body as the object of one's volition and action aimed at achieving and maintaining health. Achieving health means "to keep [oneself] healthy and moving forward to a good place". Incessant effort, awareness, self-scrutiny and responsibility are needed to ensure one is moving in the right health direction. Of note, the image of health appears as an objectified goal placed on a straight line. In this linear representation of health as progress, the only desirable and acceptable change is that of moving forward on the incremental axis of health improvement that appears underpinned by moralized significances. It

is the obligation of the individual not only to achieve health through personal effort - whether using or not the help of professional health promoters, such as health coaches - but also to continue to be responsible for working hard toward maintaining and improving wellness.

The elaboration of the key narrative of health offered by this participant rests on the doctrines of free will, personal choice, and individual control and supports the logic of individual responsibility and the moralization of the pursuit of health. The moralization of pursuing health interlaces several closely related assumptions, such as the tenet of individual responsibility, of individual control, of effort and exertion, and of linear progress in achieving health. Together, these elements configure a core signifying ideological structure: a professional conception of achieving health as personal health. This conception is expressed in the form of a stable narrative, a critical signifying structure that can be called the narrative of self-made health. As illustrated in the excerpt above, the narrative functions both as a professional explanatory framework for the production of individual health and as a normative model of the responsible citizen.

The normative function refers to how this model of signifying health operates as a moral grid in determining social valuations of people; the excerpt exemplifies how achieving health operates a major distinction between individuals in society: there are those who live up to the ideal of taking control over one's health, and people who, for various reasons, do not do so, or are not in a position to do so and leave this control 'out for someone else' to take care of it. Additionally, in another place in this interview, a sense of assumed (middle) class stance is apparent when the participant commented when describing the failure to assume change and take control over one's health typical of lower socio-economic groups: "I would not do this, but I'm in a different class stratum."

Another significant element in this fragment is the important place given to one's willingness to change that is expressed by one's stated or demonstrated desire and ability to adopt behavioral modifications and, thereby, to move on, or be "pushed" by professional intervention toward the good end of the continuum. The willingness to change is a very important signifier for the logic of personal responsibility as worthiness. To be willing to change means that one has the motivation and confidence necessary to achieve health and that one can enroll in the process of establishing, pursuing, and achieving health goals for oneself.

Perhaps a culminating statement in the excerpt above is the one that equates achieving one's health through individual effort and responsibility with "taking control over one's life" or over one's destiny as another participant put it. This insight is a powerful validation of Crawford's (2006) assertion that the contemporary pursuit of health carries an important symbolism and is a key expression of an existential project historically characteristic of the American middle class that evolves currently within the demands and constraints of the neo-liberal rule.

Finally, another typical and important aspect in the narrative of health is apparent in this fragment: social and cultural circumstances of the individual appear late into the elaboration. Rather than important determinants of a supra-individual order that are universally at play in producing health - better or worse, these are framed as deterrents to the individual's rational-volitional project of taking control over his health and over his life.

The twin ideological tenets expressed in the quote above, according to which health is an issue of individual rational choice and action, and the individual is solely responsible for the personal achievement of health through proper control and practices of self-care is shared by all

the participants, without exception. According to this line of reasoning, the individual is also responsible for collective health. Collective health is typically seen as the net sum of individual “healths.” One participant talked about people’s resistance to change for health and described areas in the south of the country where hypertension and diabetes affect entire communities; these communities are unhealthy because they are composed of types who find it hard to adopt the doctrine and project of self-made health.

In this group of interviews it is generally the case that the narrative of health equates health with the pursuit and achievement of self-made health, a process centered on the individual’s rational planning for health. This conception proposes that: the individual is solely responsible for his/her health; health is located inside the individual; and is produced and achieved by the individual via rational control of her behaviors and lifestyle - thus of her life. The regimens derived from this conception center on assuming proactive measures: setting health goals and taking rational steps toward actualizing these goals on a linear health improving trajectory, and cultivating a general sense of health awareness. By enacting these recommendations, one qualifies as “making the right choices” health-wise, and also life-wise. As understood here, the process of achieving health is one that can be ordered and controlled by the individual via a sort of contractual arrangement that looks like a simple line connecting limitless resources with limitless room for improvement, provided that one puts his/her mind and heart to it. Health is within one’s choice, and choice for health is within one’s range of choices in life. This is the view of self-made health.

2.4.3.2 Key aspects of the narrative of health in further detail

What are the critical propositions: assumptions, processes and ingredients of the professional model or narrative in the interviews? My analysis contributes distinguishing tenets that are intricate in recurring elaborations.

Health generates intra-individually, inside one's mind. At the sources of health is the rational-moral individual (or one's rational-moral individuality)

An important distinguisher of the narrative of health is that the production of health is understood mainly as an intra-individual process determined by conscious reason and volition.

“I think it just comes within yourself” said E about being healthy, then she continued about achieving her own better health: “I had to put my mind there in order to do it.”

When asked about what are the things that make us healthy, L answered:

The most important things to me are these two: internally, intrinsically, the attitude we hold determines a lot of what we think about ourselves, of what's important to you, health included – that happens inside; so you have to make a conscious effort, put your mind to something that's important, and you'll do anything to follow through on it – you have to do a mental shift, you consciously have to make that mental shift that makes you healthy.

As obvious in these quotes, health originates inside one's consciousness, specifically in one's attitude and determination. A rational mental shift accompanied by conscious effort is needed to make the individual healthy. Another participant stated that health starts with the motivation to be healthy which, in turn, is explained by “the kind of person you are”: “it's personality, for a lot of people it's personality” said G, reflecting on the mechanisms of being healthy. Conversely, people who do not embrace (pursuing) health “have set in their mind that whatever they want to do they're not going to achieve it.” The examples illustrate the observation made earlier about the fact that the participants treat the notion of health as

equivalent with that of pursuing health. Importantly for the point in discussion, the quotes clarify that the origin of health is placed primarily and unequivocally within the individual's mind and intrinsic rational-psychological-moral characteristics.

Several important consequences for the way in which health is construed in the narrative of health derive from this standpoint. One such consequence is the view that health is up to the individual.

Health is up to the individual; it is malleable and can be indefinitely improved under the individual's rational control

Originating inside one's mind, health can be determined and controlled by the individual.

For example:

- You were saying that health is something that comes from inside?

- Yes, yeah, (...) I know for me it's something I've internalized and over the past 2-three years I've changed a lot of stuff in my life to make my health better. (...) (Health) it's just your own opinion, or your own perception of what better health is, 'cause I, I mean I feel I'm in good health, but I could definitely always do something better to achieve better health, that's for sure, can always do that... it's up to me to do that (...). (E)

Another participant said: "you're born with whatever you're born, but you take it from there, is really up to you as to whether you want to try and make it better (...)." (V)

Another example:

- So you've told me that health is something that people have a choice of, and that people can control their health and that people can achieve their health...

- I do believe that, yes.

- Is health something that happens without people being conscious of it, or working toward it, or is health something that only happens as a result of some effort?

- I think it's both, it's both. I think that you know, genetically, has a lot to do with your health (...) but it is important to pay attention to what is going on

in your family around you and what has gone in the past in order to make informed decisions about how **you want** to take care of yourself, then it comes to **you** to be responsible for nurturing yourself in a healthy way. (N)

As the quotes above illustrate, the individual has the power to decide, determine and control her acquisition of health. When factors outside the individual's will and control such as genetic determinants are acknowledged in the production of individual health, a decisive reassertion of individual control eventually recalibrates the equation of health production.

How much control has the individual in determining her health? It is implied in the quotes above that the limit of control is not an issue for this model of health; the individual is seen as having a lot, if not unlimited power in controlling his health, with the condition that he applies himself to the task. Paralleling this view, the object of control, health, is itself construed as malleable and unlimitedly improvable: "I can always improve my health if I put my mind to it," said one participant quoted above. In principle at least, there is no limit to one's health.

Materializing control over one's health: the individual's rational plan for (achieving) health

Another consequence of the view that health originates inside one's mind and can be indefinitely improved by the individual is that in order to be or to become healthy, the individual needs to rationally – that is, deliberately and conscientiously - discover her reasons, motivation, and determination to be healthy. This latter point is closely linked to a pivotal proposition in the narrative of health, namely that health and its achievement are contingent upon the individual formulating and implementing a rational plan for health. Importantly, in this process of achieving health, health becomes the equivalent of having a plan for health.

We have seen so far that, according to the narrative in discussion, health starts inside one's mind and the individual has the power to decide, determine, and control her health. This is

done by the individual assuming a rationalized process whereby (s)he moves through a series of phases/stages/steps toward the deliberate achieving and securing of health. In other words, in order to be healthy one has to establish and implement a rational plan for health.

According to multiple threads in the interviews, the sequencing of phases in the plan of health configures a sort of simplified logic model. This model comprises first establishing one's motivation for health. This means that the individual has to rationally, that is, deliberately and consciously frame one's reason for being healthy: "(...) because you have to have a reason, otherwise, what's the point?" Put differently, without an acknowledged reason there is no point in looking for health, because there is no alternative way of acquiring or maintaining health other than that of rationalized individual plan. Once the motivation for health is established, the individual has to articulate a specific health goal: people "need to hear themselves spelling out what they want to achieve." After spelling out the reasons for being healthy and specific health goal(s), one has to make the right choices toward being healthy. Making the right choices is announced by being willing and ready to assume change. Upon implementing change, one's health goal is attained and then the entire process can be restarted for another established goal. Thus, specific steps call upon each-other in a stable and pre-ordained sequencing that forms the process of achieving one's health.

Health goals are usually described punctually - one's weight, one's cholesterol, one's blood pressure or mobility - and are seen as organized on a linear health improving trajectory. On such a trajectory, achieving health unfolds in smaller or bigger steps according to one's preference and resourcefulness: "some people strive to do everything right, others are ok with small changes," through connecting causes with effects, and by moving from one health and life situation to the next one. This process is generally described as smooth and neatly manageable

by the interested individual. The preference for a logic model representation of health, where its achievement is organized as inputs, steps, and outputs is obvious here. Achieving and maintaining health (gains) is represented as a progress line. As the wellness continuum image already quoted, or as the car maintenance metaphor offered by another participant suggests³, the process of achieving and maintaining health is an orderly one. According to this view, the individual is in charge/control of the line that connects limitless resources for change with a limitless capacity for health improvement provided that one puts his/her mind and heart to the contractual obligation of achieving health. Yet this progress line is mobile, and health gains are not an irreversible process:

I've seen people come so far, and then with like the slightest little thing, they fall right off the wagon and go right back to their old ways... it's... it's a phenomenon, I mean, it's like a tough thing to figure out. (L)

Thus, planning for health has to be a monitored and continuous effort requiring constant self-awareness.

Individual choice, change, control, and responsibility: a cascade of correlate notions in the account of health

As exemplified by the fragment from the interview with N used in the opening of this chapter, in the accounts of health coaches, individual choice, change, control, and responsibility are close correlates in the sense that one calls and connotes the others in a stable association. Frequently, each of these notions carries the significance of the entire process and can equate the project of health and the condition of being healthy. For instance, having a health goal or being

³ I look at health... it's like maintaining your car: you get regular check-ups, you either put good fuel in it or you don't and that will determine how it runs, you take care of the outside of it, so that it doesn't rust and break down, so... that's kind of an analogy that I use about maintaining your health. (L)

willing to make healthy choices signifies that one has a plan for health and thus already deemed healthy, or at least healthier; being willing to change means that one is in control over one's health and thus a responsible person.

Often in the accounts, health is framed interchangeably as motivation to be healthy, as the goal of health, as choice, as change, as control, and as personal responsibility. These interrelated notions function in a system of equivalences that configure the narrative of achieving health as a rationalized, individualized, and moralized enterprise of the responsible adult. As already suggested, in this process **one's health becomes synonym to one's plan for being healthy**. The plan materializes in acknowledging/practicing "good choices": healthy living or healthy lifestyle measures and behaviors such as good nutrition, exercise, weight management, moderation, no tobacco and drugs and preventive medical exams that are deemed to result in achieving and guaranteeing health as a goal-oriented, rational and conscious process that requires effort and consistency.

Change, in particular, is a strong codifier of the entire regimen of self-health. Let me return to a quote already discussed when locating the origin of health inside the mind:

(...) 'cause I mean a lot of people know what's healthy and what's not healthy, or they know good health and they know bad health, but I think it just comes within yourself... I know for me it's something I've internalized and over the past 2-3 years... I've changed a lot of stuff in my life to make my health better (...)

We see here that the realization of what one's health is about is immediately linked to adopting change, to making changes in one's life. In many instances, Health appears as the conversion to a healthy lifestyle.

Throughout the interviews, as in the quotes above, **health is construed as the personal goal of health and as the personal plan for health** – a rationalized and internalized plan toward

achieving, maintaining, and securing health. Thus, the dynamics of achieving health come precisely to having and implementing a personal plan for health. Similarly, the process of enacting individual control over one's health is in fact equivalent with setting and implementing a rational plan for health. As already mentioned, the proposition that health and achieving health are contingent upon the individual formulating and implementing a rational health plan is a pivotal one for the narrative described here, not only due to the fact that it advances an administrative view of health along rationalistic and individualistic tenets, but also because in **the process of achieving health as a rational plan for health – or of “making oneself healthy,” health becomes the equivalent of having a plan for health. Otherwise said, within the narrative of health, pursuing health via a plan functions as a synecdoche of health.** These propositions will acquire more clarity when analyzing the functions of lifestyle measures in the next section.

The substance of the plan for achieving self-health: healthy behaviors or a proactive healthy lifestyle. Functions of healthy lifestyles or behavioral changes and controls in the narrative

The direct object of individual choice and control, and the substance of much of the act of achieving health are represented by enacting healthy behaviors or a proactive healthy lifestyle. Lifestyle is regarded by participants as a major source of health. Good nutrition, exercise, weight management, moderation, no tobacco and drugs, stress management, preventive medical exams and cultivating a general sense of health awareness are unanimously regarded as critical to ensuring good health:

- Where does health come from?
- I think lifestyle it's very big in that; personal habits are very important, for instance sleep, nutrition, physical activity, weight management (...).

At a closer analysis, it becomes apparent that healthy lifestyle measures or healthy behaviors play multiple and overlapping functions in the narrative of health. For exemplification I am using one participant's elaborations. In this account, healthy lifestyles appear first as generators of health:

- What are the things that make people healthy, the things that are the sources of health?

- Ok... first one would be nutrition and good nutrition, meaning having a balanced, you know, of all the food groups, getting enough nutrition, (...) there would be exercise, getting the recommended amounts, say at least thirty minutes five times a week or more, (...) I guess you know, the mental health and trying to do stress management kind of techniques, you know, keep that mental health... not smoking or using tobacco, no drugs, you know, limited alcohol, routine doctor visits and preventative exams, and then, I guess that goes with the mental health, is kind of the social, social health, having those good relationships, I think that makes people, you know... that holistic view of making people healthy. (G)

As presented here, healthy behaviors and their management appear as key sources of health.

Subsequently, the same healthy behaviors, or a proactive healthy behavioral regimen appear as the equivalent of the condition of health or of being healthy.

- How do we know we are healthy?

- (laughs) I think it's our perception, a lot of it it's our perception... (...) ah, I know that, you know, speaking for myself because I cannot speak for other people because as I said it's perception... or what they think, but I think I know that I am healthy if I, you know, eat properly, exercise, you know, practice stress management, you know, limit alcohol, drugs, you know, no drugs, go and get my exams and keep those kind of relationships going. (G)

Here healthy measures are understood as health. Differently said, actions *toward* achieving health are taken as the status of good health. According to this logic, one's health is equated with one's plan for being healthy.

Finally, healthy behaviors are seen a warranty or protection policy for securing one's health: if one really wants to make sure one is healthy, one needs to exert health awareness and

controls along a series of behavioral health promotion and preventive measures like those listed on “Women: Your Checklist to health” (U.S. Department of Health and Social Services). Furthermore, securing one’s health means securing a good life: asked what a good life is for her, G. responded with a list of typical healthy practices that she can share with dear ones.

Thus, healthy behaviors or healthy living measures appear to simultaneously explain the sources of health, the diagnosis/condition of health, and also to guarantee good health. Equating acquiring health, being healthy, and securing one’s health with the adoption of lifestyle controls provides a critical link in the project of pursuing health. As suggested in the quotes above, the logic that lends the important and extensive significance of lifestyle measures within the dominant explanatory narrative of health might derive precisely from their allowing the conflation of means - actions toward being healthy, with ends - being and staying healthy. It could be precisely the flexibility of this logic that makes behavior controls much utilized in the instrumental project of health resting on the assumption that health is up to the individual, and always malleable, controllable, and improvable. Otherwise said, assuming healthy lifestyle measures may take so prominent a place in the narrative of health specifically because these factors offer validity and substance to the claims of individual choice, control, and responsibility over one’s health.

Achieving health is a difficult, hard process

While the process of achieving self-made health is generally presented as a certainty in assertive and optimistic tones and as smoothly organized along the rigors of a simplified logic model, there is, nonetheless, a cautionary attribute of it: the achievement of health prescribed by the professional narrative is (very) hard. The participants unanimously state at different points in

their excursions that achieving health through the regimen of self-made health is difficult, challenging, or really “hard” - pronounced with a strong emphasis. They exemplified this point with their own personal experiences in achieving their health, and also with insights from their professional experience as health promoters.

The issue of hardness in construing the pursuit of health opens several lines of discussion. For instance, it points to a serious limitation of the narrative of health which appears to propose a regimen that is very hard to actualize or embody even by those most dedicated to advocating and enforcing it. In being recognized as hard, the plan of self-made health appears far less accessible than initially configured by the main tenets of the narrative, whose rationalistic clarity, simplicity, and invincibility are thus severely undermined. At the same time, hardness opens largely the way to the moralization of pursuing health as a rationalized and individualized plan.

Instances of Moralization

As already observed, moralization enters the narrative of self-health through all the tenets that underpin the logic of an individual rational plan for health. This plan is articulated along the interrelated notions of choice, change, control, and responsibility over one’s health; all these notions carry moral connotations. Discussing the faces and dynamics of moralization in the narrative presented here could turn into a self-standing study. My present goal is simply to signal important instances of moralization as they appear in the accounts of participants.

The willingness to change as a marker of social valuation and worth

- How does society look at people who do things for their health versus the ones that are reluctant to do so?

- You mean how they look at people who are willing to change as opposed to people who aren’t? I think society is very aware, and I think in our current culture that society is very resentful of the people who are not willing to change because that’s driving up their healthcare dollar and they’re having high care costs, so that I think that society, especially now, with the reform

bill and everything that's coming up, is very aware that they are carrying the burden for the people who aren't willing to change. (...) And I think that especially the way that the middle class of society is affected by it, that the middle class especially is very aware (...). (N)

Obvious here, the willingness to change is the key marker of the responsible subject or citizen assuming/accepting the project of self-health. Resisters to the regimen of self-health are generally resented in society, especially by the middle class who share the view that responsible citizens pay for the poor health of irresponsible citizens: the ones who are indifferent or resist change for health. Their poor health is a result of this resistance and they are deemed guilty to themselves and to society for raising healthcare costs.

In another elaboration, we see again the dynamic of valuation in the particular story of working with a client: this is an older man from the south, living in an area devastated by hurricanes, working a menial job, poor and also diabetic. This man did not want to change; precisely, he did not want to control his blood sugar regularly. He would only take responsibility for taking his medication:

He would say to me: my doctor does that, my doctor knows what it is. He didn't even want to know what the number was; he did take his medicine, he would take his medicine, but he wouldn't take responsibility for nothing else. (N)

Here resisting monitoring blood sugar levels means resisting the plan for a better health and also a lack of personal responsibility. The specific recommendations for diabetes care serve here as an indicator for moral failure, or, more generally, for either failure or success. One of the means by which health is moralized is by virtue of the expert regimen for health serving as a litmus paper that distinguishes between compliers and non-compliers - ok or problematic people. In the example above, failing to adopt the regimen for diabetes control means the moral failure of rejecting personal responsibility for one's health and for one's life.

The distinction between resisters and achievers/compliers to the plan of health configured by the core narrative is present in all the accounts. There are people easy to change, people hard to change, and people who will never change. According to the participants, in practice there is an equal share of resisters and compliers, defined, most of the times, by their attitude to change for health. Indications of the moralized language used in describing the non-achievers of change are obvious in the following quote:

- I do have both sides of the spectrum, I have people who, you know, they really want to... (...) some people are constantly thinking about these things, other people, you know, they don't care, just don't... they just don't want to change.

- Do they tell you why they don't care about these things?

- Ah... no, not a good reason, anyway, I mean, they'd say, you know, it runs in my family, or other people say, you know, my schedule doesn't allow me to exercise, healthy food is expensive, you know, you hear everything, you hear all the excuses in the world, but you know I don't think that they actually dig down and say why they really don't want to... so, you know, just that, that motivation, they just don't want to do it, it's easier to stick to their unhealthy habits. (G)

Other lexical choices are also suggestive for the moral dimension embedded in the narrative: internalizing a plan for health is described as “doing everything right” and “moving forward;” not embracing a plan, is described as being “stuck,” “losing out,” self-defeating oneself in an imaginary powerlessness or “going to the grave” without attempting any change for health.

It is apparent throughout the elaborations of participants that the narrative of achieving health construes the healthy self and the healthy person as one willing to embrace and implement the prescription for health. Generally, it can be observed that the professional narrative of health rests on the vision of the prototypical socially desirable adult: autonomous, well functioning, fit for sustained effort and for overcoming hardship, able to plan for, carry through and achieve individual success. This is the individual centering the model of self-made health.

Perfect or imperfect in health(style) and an example of framing health as moral attribute

- I know I am not as healthy as I should be, and I'm trying, I work in a very healthy place, I had some things that I could not necessarily control that affected my health, and then I had them fixed, and I've tried recently, and I'm very bad, I hate to exercise and I would admit it freely..

- Why are you bad?

- I don't like to exercise, I hate to sweat...

- Why would that make you bad?

- Well, because I know it's... it affected my health. I'm overweight. I don't eat un-healthfully (...) but I'm also self-indulgent, and I know this is not good for me... I know that, I'm a health care professional, so again I'm not perfect, I'm a human being too... (N)

In the quote above, not exercising is deemed bad because "it affected my health, I'm overweight." Conrad (2007) noted that healthicization turns health into the moral. As discussed by Brandt and Rozin (1997), one of the mechanisms of moralization is extending moral qualities to domains previously morally neutral. We see here a clear example of investing health outcomes and, by extension, voluntary actions and behaviors of the individual with moral values based on which the valuation of the entire person is operated: not exercising may not be bad in itself, but becomes so and makes one "bad" because this situation leads to less than good health. Health is morally good; so is what the individual does deliberately toward achieving health. Health is regarded here as a superior moral norm. Thus, in health as in anything else, one can be good or bad. The example above suggests that to be totally successful in self-made health means one has to be perfect; to be only partly successful is an assumed human weakness or imperfection. Nonetheless, trying, striving to do the best toward achieving health appears as a redeeming process. Probably this is why to be willing to change, and not necessarily to change is regarded as important by the participants. Of note, what the quote above suggests is not only that the

narrative of health is predicated on pursuing health as a moral value, but also that it proposes a (morally) normative regimen of the perfect health.

In another example, the health coach ascribes to herself, if mildly, the attribute of “lazy” for not living up fully to the requirement of maximizing her health prescribed by the narrative:

I could definitely always do something better to achieve better health, that’s for sure, can always do that... it’s up to me to do that... (then laughs pointing to a little controversy, implying it’s something hard or unlikely to happen)... it’s up to me to do it (still laughing)... **unfortunately I get kind of lazy with work and with everything...(E)**

In addition to having a full time job, this participant assumes the typical traditional child and house caring roles of many women. Not maximizing one’s health is considered laziness rather than impossibility - the result of work demands in the workplace and at home that occupy most of one’s time and energy.

Hardness and moralization

The already noted difficulty of the task of acquiring health acquires a new meaning when the project of health is invested with the significance of a moral struggle between good and bad. The participants state that health gains are hard to achieve and to maintain, and that people can work hard for a long time, and then relapse in a second and fall back or go back to their old ways. (In this imagery of moving forward and falling back we see again how achieving health is conceptualized as a linear progress toward a desired destination: better or maximal health, the “good end.”) In light of the acknowledged difficulty of both acquiring and maintain health, the regimen of self-made health implies an ethos of hard and incessant effort with an exemplary value. The moral of the “fable” of self-made health may be not only the objective of a perfect/maximal health, but the effort and hard work invested in striving for attaining the

objective. The insignia of assuming the effort of striving for health are precisely the willingness to change and to adopt behavioral healthy measures. This may be the reason for which being willing to change and adopting lifestyle measures appear particularly moralized in the accounts: they carry the critical distinction between good and bad in acquiring health as a moralized process.

Above, I outlined several instances of moralization in the accounts. Moralization is encoded at the core of the narrative of health. While reflected in all the interview accounts, there are obvious variations among the participating health coaches in assuming either an overt and bold moralizing and normative tone, or a more subtle, subdued or tolerant stance.

It is significant that all the health coaches made reference to their own experiences with their health and health achievement, whether talking about control of preventive measures and maintaining a good mental health; weight control and food; bone health; yoga and a holistic lifestyle; exercise and a good sense of life; or doing everything right since a young age: eating properly, exercising, taking preventive exams. Following these personal reflections and their intersection with the doctrine of self-made health, it becomes apparent that at the heart of the professional narrative of health pursuing health as a rational plan acquires the status of a socio-moral performance involving self and others. In performing the function of health, people demonstrate - to themselves and to “society” - their worthiness, and prove that they can live up in a satisfactory way – or at least try to do so -to the powerful commandment of taking responsibility and control over their lives.

2.4.3.3 Conclusions on the core of the narrative of moralized self-made health

So far we have discerned and substantiated a key narrative of health. This narrative is a professional ideological framework. As already mentioned, the framework serves at explaining

the production of health and at prescribing normative regimens for achieving self-made health, and moralizes both the explanation of health and the prescription for it.

The analytical description of key tenets at the core of the narrative allowed me to observe that choosing healthy behaviors as expression of a rationalized plan for health is seen as the equivalent of health. Furthermore, asserting the pursuit of health appeared to function as a metonymy for being healthy and to demonstrate that one is morally aligned to the ideal of social fitness and responsibility. Health coaches embodied the professional doctrine of self-health and the new health consciousness in society. Pursuing health in accordance with the narrative appeared to be a sort of a socio-moral performance. Overall, the professional expertise of health promotion advances a moralized and rationalized project of maximal/perfect health and contributes to construing the healthy person – health conscious and health striving – and the desirable client and citizen.

From a moral-philosophical standpoint, all the components of the model of achieving self-made health: prerequisites, mechanisms, and outcomes rest on the assumptions of individual autonomy and responsibility, free choice, and unlimited self-determination. These assumptions provide the justificatory basis for the moral and practical effectiveness of the project of health in the narrative.

In conclusion to this descriptive analysis, it can be said that according to the professional narrative of health under investigation, achieving health rests on a rationalized, individualized and moralized view of health, confirming in this way Crawford's (2006) conceptual propositions.

In a summarized form, the critical propositions of the core narrative are:

- i.* Health is generated inside the individual, more specifically, within one's reason and volition.

- ii.* Each individual has considerable, if not unlimited rational control over one's health, and exerts the control over being healthy or not.
- iii.* There are no limits to improving one's health and health can always be improved as long as one can establish and assume personalized goals and take appropriate actions in the form of steps that connect the starting point with a desired outcome.
- iv.* Individuals have the responsibility and obligation to assume the active pursuit of health. Each individual is responsible for achieving and securing their health understood as rational plan and moralized action. Achieving health requires effort, discipline, continuous self awareness and scrutiny.
- v.* Achieving and securing health means, in essence, adopting healthy behaviors and maintaining rigorous health promoting routines. Healthy behaviors are seen as an equivalent of health. Asserting the pursuit of health is a synecdoche for being healthy and reinforces the desirable ideal of social fitness and responsibility. Health-wise and life-wise, some people are on the right track - changing and internalizing this model, while others are 'stuck' and resisting change.

2.4.4 The periphery of the narrative: modulations and counter-narrative elements

Although articulating the core tenets is a straightforward process in the interviews, there are side elaborations in all the accounts that cannot be neglected. Taking into consideration these side statements, the dialectic of construing health visible throughout this set of interviews becomes in fact contradictory and complicated. It is common for participants to start by affirming fully the dominant individualized, rationalized and moralized conception of health and then, as the

interviews advance, to substantiate various limitations to this dominant view and to make way to undercutting or opposing considerations. Of special significance is the following observation: statements challenging the tenets of the core narrative of self-made health and critiques directed at important aspects of it that represent counter-narrative elements are always articulated at the periphery of the main elaborations in participants' answers. This is a pattern throughout the interviews: main statements at the core of the narrative of health are accompanied by explicit or implicit counterstatements. However, in the general economy of the accounts these counterstatements remain peripheral instances or counter-narrative elements rather than an articulate counter-narrative or a different narrative of health. However, even though they do not affect the explanatory and interpretive model of health that structures the professional narrative employed by health coaches, it is significant that counter-narrative elements are present and mark important tensions embedded in the narrative.

In order to gain an appreciation of the dialectic of construing the narrative, it is important to further examine the nuances, tensions and contradictions on its periphery.

2.4.4.1 Exemplary accounts

To substantiate the observations above, I present two of the analytical summaries written for each interview as part of the analytical process⁴. The summaries illustrate well the thematic weaving of tenets and counter-tenets common to all the interviews.

⁴ A methodological note: the analytical summaries used extensive paraphrasing and quotes of participants' elaborations. I observed carefully the sequencing of topics in the transcripts and I also made connections between ideas expressed by the same participant throughout the entire body of the interview.

Interview with V

V expressed first the position that health is derived from personal care and from attending to specific health needs. According to her, people can exert control over their health and have the choice of being healthy. She states that in the process of achieving health, people need *to be made aware of what health is*, they need to become concerned with their health, and need support in selecting health goals:

you have to identify your own (health)goals, and everybody's different, different problems, different interests, different capabilities, so you kind like identify it, and then take from there, you say, ok, this what I would like, these are the steps I would like to take, how do I get there? And that's where we come in –health companies come in⁵.

All people need a “push” because acquiring healthy routines – thus, acquiring health - is difficult to initiate and maintain by oneself. She states that some people are very interested in changing and having control over their health, while other people are indifferent to this project or even scared of it; yet the project of health is uniformly beneficial if people can embrace it.

While this is the first line of interpretation, V also intersperses a series of qualifying takes according to which people have in fact less control over their health than usually affirmed: “you are born with whatever issues you're born, but it is up to you to take it from there and better your health.” Then she adds: “‘cause many times you can, and many times you cannot, yet it's up to you to try to make it better.”

⁵ Note on generational differences in pursuing health. In relation to pursuing health through change and control of healthy routines, V. distinguishes an old a new school. “Everything is good if it feels good and if the doctors say so” stands for the old school. Here, if something goes wrong, it's for the doctors to fix it. People of the old school don't take responsibility for their health, and, additionally, are nervous and scared about all the current information about proactively achieving health; sometimes they even have an added sense of nervousness for “being left behind the times.” People of the new school, young people in general, have health concerns learned well and solidified into their routines, assume responsibility for their health and, overall, “feel more in control” – this is a generational distinguisher that other health coaches describe.

In discussing the adoption of healthy lifestyles, the same pattern of affirming a key tenet and then qualifying it is visible: it is good for people to adopt healthy lifestyles and becoming healthier is up to the individual; yet later on, healthy routines are seen as largely influenced by what people have and, conversely, by what they don't have:

(...) identification as to what one can do, I mean if you're a runner, and you're young, and you have access to a gym, if it's nice weather, depending on the part of the country you're in, how much time you have, you know, it's up to you to take advantage of what it is that you can make, you know, of what's accessible to you and what's not, in many people's cases what's not...

The same pattern is apparent when V talks about individual responsibility for health. V states boldly that individuals are responsible for their health:

- Who is responsible for one's health?

- First and foremost, the individual, (...) responsibility-wise I think it's up to the person.

Later in the interview, V returned to the issue of personal responsibility for health. She deplored the fact that in the debates surrounding the new health care act many people inadvertently think that "it's a money issue, or that it's going to take the responsibility away from everybody except for yourself." Her own position is that health should be about a coordinated effort that should go beyond "only (...) the topics (deemed) important right now." Different from her first position, responsibility for health "needs to be a bit of everybody's responsibility, from the insurance companies to the doctors, to the people, to nutritionists (...)"

I think it's a lot... properly eating, I would say, you must take an active role in it, but before you take a role in it, you have to have the money, you have to have a good job to have the money, so it's... and the government is out there supposed to be policing this stuff, so I think it's a... a lot of... I think it's pretty even (responsibility), it's a fairly... a mixed bag... sort...

In this rendering, the current general approach to health at various levels in society seems tenuous. The view of individual responsibility is adjusted here to that shared societal

responsibility. Additionally and importantly, contextual determinants of health - a term that I use to equate what we generally understand by structural or social or supra individual determinants of health: here one's job or community of residence - make their way into the discussion about choice and individual responsibility for health and become significant in a chain of determinations leading to one's choice of health. Again, this happens at the periphery of the account, as is the case in other occasions in the interviewsⁱ.

Another contradictory appreciation regards the new health consciousness: the pervasive, generalized concern with achieving individual health. V initially stated without reservation the beneficial stature of this "new school" of proactive health. On a secondary line of elaboration, this new health consciousness appears as "a mixed bag" of factors and consequences, some good and some problematic. People are currently more aware, concerned and proactive about their health, and this comes with an increased sense of personal responsibility for health. She sees the medical care industry as a key player in the process of educating the new health consciousness by shifting the responsibility for health care (and, by extension, for health) to the individual: "I think the health care industry as a whole has put a lot of responsibility on the person (...)." Yet this situation is a complicated one: on one hand, people are made more responsible about their health and are presented with key messages about being fit and healthy; on the other hand, behind these evolutions there are money interests, and it is suggested that the pursuit of health is driven by avidity and by the principle "money is God" – this is seen a problematic issue for the state of affairs in society. In light of these considerations, it can be inferred that rather than the result of an emancipatory dynamic in society, the "new school of health" appears linked to the actions of a health care industry-media-government conglomerate in their pursuit of influence, power and profit.

On a related line of discussion, V sees the “enculturation” of the new health consciousness as a result of the media pushing health agendas that translate into new societal pressures and concerns. As a result of this, the awareness and reactivity of people to others displaying healthy lifestyles has changed: tobacco, exercise or fat in foods become elements of moral categorization; tobacco is bad, cholesterol city is bad and people judge one another based on these elements:

I know with myself, smoking is a big deal, every place has joined front in pushing the non-smoking thing, makes everybody aware of people who do smoke, lie you know, don’t bring that in, or it’s not good for you, or look at you, this is not good for you, even if you don’t know them, you know, you shouldn’t be eating that in a restaurant.

This reasoning provides the description of one mechanism of moralizing health in society.

According to V, this mechanism explains why something formerly not an issue in the public sphere, such as exercising, becomes now a wide-spread concern. She also remarks about how cultural images about health change as a result of the media: not too long ago the preoccupation with slimness was paramount, “more of a social thing”; this has been replaced with a concern for being fit and healthy irrespective of physical appearance.

Another summary is useful for appreciating the complexity of views expressed in the interviews.

Interview with L

L interprets health first as an individual and individualized process. According to a first line of reasoning in the interview, people have to have an individual, conscious drive in order to become aware of their health needs, to respond to these and to take control over their health. Many people don’t go this way, and this happens because they are self-defeating themselves with negative ideas about their lack of control; in fact, they do have control. According to L, exerting

control and achieving health often requires only small steps and a balanced lifestyle. Disciplined and proactive health actions include: what one eats, how one spends work and leisurely time, relationships, etc. Personal balance and moderation in lifestyle are, according to L, key aspects impacting one's health. A "tolerant" regimen for health – thus not requiring one's life be turned upside-down - is recognized as not easy to achieve. For instance, L. talked about her own resistance in making her health care visits a priority; she also talked about people who go so far in their project of achieving health and then "fall out of wagon" or fall back to their old and unhealthy routines.

Enveloping the view of an individualized rational and disciplined yet moderate plan for health, L also proposes a broader understanding of achieving health. This is the view of health as holistic process where all things fall into the right place if the person's priorities in life are meaningful and respectful of the self. Among the many sources of the holistic health, L enlists social and environmental factors that are hard to control by the individual. Nonetheless, she asserts that people still have strategies for controlling their circumstances and for bettering their lives: while she could not change the air we breathe in Pittsburgh, she did control her career course so that she would not be forced to work in unhealthy environments in the fast food industry. An additional level of complexity in explaining the pursuit of health is introduced by L when talking about God. If the achievement of health starts with the internal determination and with a conscious effort of the individual toward improving her life conditions, lifestyle and health, God, "the Big One", also plays an important role. In one of her final interventions, L. suggested that finding a life of purpose has to do more with God than with anything else; a life of purpose means a good life, and a good life leads, in turn, to good health. Here God supersedes individual self-determination.

L also offered very rich elaborations in discussing the relationship between society and health. She talked about the noxious insistence on health in the media, where health is tied “to the superficial,” to weight management in particular. According to her, there is a lot of confusion about health priorities; as a nation, “things are out of whack” and people are “hurting badly” because either because they don’t understand their health needs and neglect their health, or because they assume the pervasive view of achieving health as an overexerting “total overhaul”. To this situation, L opposes the view of a life of meaning and balance characterized by a holistic and moderate view to pursuing health. Otherwise said, to the logic of excess in society and in pursuing health, she opposes the restorative logic of personal good balance, harmony, and meaningfulness - in her case, caring for others. According to L, this restorative process is eminently an individual one and is up to each person. Thus, the logic of individual control is eventually reasserted by L in the process of achieving the good life of health and balance. Of note, in the dialectic of health production described by L, the personal and individualized side remains dominant and fully explicit, while the structural - contextual, economic, social - side makes an appearance and turns invisible.

In the entire group of interviews as in the accounts detailed above, tensions, contradictions and ambiguities in the narrative of health are concentrated around a few aspects. First, they are manifest in participants’ challenging or undercutting the main tenets of the narrative of health, particularly in exposing the limitations to the view of exerting total rational individual control and responsibility over (the plan for) one’s health. For systematization, these can be regarded as internal challenges to the key narrative of health, in the sense that they reflect inherent limitations to these tenets.

Secondly, challenges to the narrative of health are formulated by participants in critiquing various aspects of social life such as the new health consciousness in society and the forces that shape it, particularly the media. Additionally, critical reflections about the moralization of pursuing health in society and in the health care establishment also challenge the core narrative. These fragments of socio-cultural and professional critique configure a set of external or contextual challenges to the narrative of self-health. In the next pages I will discuss in more detail these two sets of challenges visible in the elaborations of health coaches.

2.4.4.2 Challenges to the tenets of individual choice-control-responsibility (internal challenges to the narrative)

The participants qualified, at various points in the interviews, their clear-cut statements about health as rational choice, control and responsibility with more subtle takes and sometimes with totally opposite considerations. In such statements, health appears less controllable than usually accepted. Additionally, from peripheral incidences, the choice for being healthy appeared in fact inherently contrived by personal, family, cultural, financial and social issues – in other words, by one’s life contexts.

Examples:

- Is health an issue of choice, and in which way?
- Yes, I think so, people choose whether they want to be healthy or not by choosing to smoke or not, to eat right or not (...)
- How much control do you see people having over their health?
- I would like to say that I have a hundred percent control over my health because it’s my choice to... if I choose to smoke, drink, eat bad, whatever, that’s my choice, but if I choose to exercise, eat right, you know, the other good part, that’s also my choice, and except for things like heart disease, or cancer, that we can’t change, other, you know, cancer we probably can, I don’t know, some people get cancer whether

they smoke or not, you know, but because of the choices I make I think would determine whether I live longer or healthier⁶. (B)

Apparently, we are here in the domain of plain contradictions. Of note, the idea of total control over one's health is introduced as desiderate rather than as certitude: "I would like to say that I have one hundred percent control." This is not a tenable proposition; there are serious health conditions, such as cancer or heart disease that may not be preventable. B acknowledges this limit to rational choice and control, and immediately brackets it as she moves on to framing the issue of control of lifestyle choices toward a healthier and longer life in a way that is commonly rationalized by most of us and by health promotion national agendas alike: controlling proactively one's lifestyle and health condition, we get to live a longer and better life. In B's spoken elaboration, the disproportion between first enumerating quickly, swiftly, almost automatically trivial healthy lifestyle elements and the momentous scope of the desired outcome – a better, longer, healthier life - becomes ironically striking. This elaboration suggests an aspect noted before: healthy lifestyles are, in some sense, simulacra of controlling one's health, while pursuing a healthy regimen or the rational project of health as healthy living is a substitute of the good life – long, healthy, happy, and productive.

An additional limitation is revealed by acknowledging that practices of rational health self-awareness, choice, and health directed action are nowhere near daily life experience. One participant supported in adamant terms the proactive self-made health and one's moral responsibility toward being healthy and declared herself "a firm believer in (health) awareness."

⁶ Two additional aspects are interesting here: 1) the prominence of healthy eating in the series of healthy behaviors that characterizes many of B.'s - and E.'s, as well as of many of the lay participants' elaborations; 2) in the interview, the question about control addressed "people" in general; the answer came in the first person, a characteristic of this interview, and a good example for how the issues discussed encompassed both self and others, and the professional and client roles.

Below is a fragment from discussing one of the elicitation materials, “Women, take care of your health”:

- Do people generally think about all these points of health awareness?
- You mean like wake up and think: “oh, I feel good today, I wonder if I should take an HIV screening? (laughs)
- Yes, exactly, or “oh, my, I have to take the daily steps to health.
- (Laughter) (N)

In another instance, talking about how people take note of their health the same participant said with irony that she does not wake up every morning and think where she may be on the “wellness continuum,” and she knows that she is overall healthy. These remarks suggest that the type of rational self-scrutiny and health awareness advocated profusely by common health promotion and disease prevention initiatives is actually felt as incongruous with the phenomenology/experience of (health in) daily life.

Another example: one participant described in detail how people’s health, her own health included, can be controlled by a proper lifestyle and proactive health care. Later on, when talking about what makes a good life, she referred to her own life as being good by virtue of being able to practice a healthy lifestyle regimen together with her dear ones, and for having family around her that is healthy. At this point she knocked on wood. This is a telling detail about the ambiguity and uncertainty involved in trusting the logic of control, and of the fear of the ultimate uncontrollable - serious illness, life threatening situations and conditions - that persists well camouflaged in the shade of affirming the belief in the full controllability of health

The undisputed and integral responsibility of the individual for his health maintained at the core of the narrative also acquires new interpretations on its periphery. The idea that rather than the sole responsibility of the individual, health should be “everybody’s responsibility” was

already apparent in the summary of the interview with V. Another example is illustrative for the conversion from the initially expressed position of “the individual is for her/his health,” to “the community is responsible for health” This happened within several paragraphs:

- (...) I think as adults we are responsible for our own health... I think, ah, if we don't know something we definitely have the resources to seek out... yet children, on the other hand, they look at their parents as role models, their parents are providing the food, and, you know, the guidelines for children... so, you know, if they don't grow up with good healthy habits, you know, it's hard to say, I think it's maybe not their kind of fault, you know, if they're overweight, or unhealthy...⁷(...) you know, it's not their fault that they're overweight if their parents are the ones supplying the food, you know, they can't cook for themselves, so they're kind of helpless in their own health. (...) I think they're not responsible for their health, as children, we as adults are responsible for their health.

- Right.

- The other thing may be that the elderly, you know, sometimes we need to look at the elderly as children, they can't get out, they can't drive, they can't get to the doctor, they can't get to, you know, source of food that they need, so... then again, as I'm talking, I'm thinking of all these other situations that, you know, like homeless people, or people that you know can't afford good food, so, you know, so community health is gonna be very important for those kind of people so... Now I'm kind of changing my mind...

- That's part of the process...

- I guess the community, community is responsible for health. (...) Yeah, at first I thought it's all our... you know... (laughs). (G)

We see how this participant changes her position as she reflects on her first statement. Interestingly, this realization comes with genuine surprise – an indication that in the latter conceptualization is not the domain of evidence/habit of thinking in the professional practice of the participant.

⁷ Obvious in this paragraph is the moral valuation of being healthy and responsible for achieving health. “Growing up with good healthy habits” suggests a strong approving moral stance; if kids are unhealthy or overweight it's not their fault, but, presumably their parents' fault in failing to provide proper care and role modeling.

As exemplified above, there are many instances in the interviews where explicitly or implicitly the tenets of individual choice, control, and responsibility at the core of the narrative give way to ambiguous or contradictory reflections by the participants. From these incidences, the total character of the claims at the core of the narrative appears problematic and conceptually untenable and, in the words of one health coach, “not realistic.”

The challenge of supra-individual factors influencing individual health

Another set of qualifications of the core tenets derives from the unavoidable recognition of contriving factors outside the individual’s control that, nonetheless, influence one’s health. One health coach stated clearly the personal responsibility for one’s health: “I’m responsible for my own, we’re all responsible for our own health.” Two pages later she discussed how money sets the tone for health:

- I think a lot depends on how much money you have and that kind of definitely sets the tone for health... if you can’t afford it, you eat what you have to, you eat what you can, or you grab and go... (...) sometimes when you’re busy (laughs⁸), you know, that’s what you grab (fast food), it’s cheap, it’s convenient, so yeah, I think a big factor is money a lot of times too, you can’t just afford what other people may eat though you know it’s better, just can’t afford it. (E)

In another interview, the participant reflected on the issue of choice as follows:

- I don’t think people in our country value health (...)
- Is it a lack of conscious choice for health that you see in people?
- I think people feel powerless, they don’t realize what they have within themselves to make changes to make healthier choices. I think a lot of people

⁸ Laughter in the interviews frequently introduces an implicit commentary on the things just said. Usually, laughter subverts or mollifies a statement suggesting that the participant holds multiple views on the issue discussed. In this case, the participant may suggest something along the following lines: I know that buying cheap food because of being busy is a pretext or a shallow justification for not doing the right thing; I know I’m a little guilty, but I’m also right in thinking this way.

feel that they're powerless against their environment and to a degree there is probably some truth to that, but I think that a lot of people don't realize what they have within them.

- What do you mean by environment?

- Can be access to good grocery stores, ah, farmers markets, it can be a nurturing supporting environment, so that can be work, anything, I think that all these impact your health, you know, I had jobs where it wasn't this nice of an environment, and it impacted every day (emphasized) that I was there. And I felt it.

- Ok, so let me ask you... how does choice marry environment? How can people solve this?

- I don't know... I can't choose the air that I breathe here in Pittsburgh because that's bigger, I can choose where I decide to live, I can choose, to a certain degree where I want to work, you know, I worked (in an industry where things were not good) – I don't even want to go back to that environment. Ah... so I've made a choice of, ok what do I need to do to make sure that I don't need to go back, you know... does it, does this answer your question? (L)

At another point in the same interview:

- Is health a choice for a person?

- I want to say... most of the time... it is. If you're born with things, if there are, you know, socio-economic factors that play into that, but I think that most of the time it's a health... health is a choice. Whether it's a conscious choice, or not that most people are aware of is... isn't...

- Can people have a lot of conscious choice regarding their health, in your experience working with clients?

- I think they can, but it's kind of this negative self talk, it's like a tape recorder, you know, self defeating talk that they play over and over and over again... (...)

- Do you see people changing easily their ways of living, of being more health proactive?

- Ah, that's interesting... ah, yes and now. Yes in that I see people change easily when they are ready to. It's basically: I made my mind up, and I'm gonna go for it. Or my doctor told me that if I don't start doing something, I'm gonna have a heart attack (...) it's almost like they're scared into it, but I think

for everybody it's a little bit different. Ah... no, in that I've seen people come so far, and then with like the slightest little thing, they fall right off the wagon and go right back to their old ways... it's... it's a phenomenon, I mean, it's like a tough thing to figure out. But I think that it starts mentally. That's just my belief. (L)

An array of typically ignored factors in the narrative that influence personal health such as access to supporting environments, to good foods, good jobs and clean air are mentioned by the participant while reasoning on the issue of individual choice; their importance for health is clearly acknowledged, and their complicating the assertion of personal choice and control is implied. However, introducing this set of new determinants that challenge fundamentally the individual rational determinism of health maintained by the narrative is overridden by the reassertion of individual choice and control: "I think it all starts mentally." The typical pattern of construing the narrative of health: introducing qualifying or contradicting statements to the defining propositions at the core of the narrative yet maintaining and affirming its overall dominance is well exemplified in the quotes above.

We have seen above a series of internal challenges to the key tenets of the narrative. In addition to these, the participants commented on larger societal contexts within which the pursuit of health is configured.

2.4.4.3 Fragments of socio-cultural and professional critique offered by the participants (external challenges to the narrative)

Lively commentaries in the interviews referred to health, media, society and the new health consciousness characterizing present day U.S. These commentaries linked the promotion and pursuit of health to larger contexts and forces in society, and reflected on the impacts of the dissemination of dominant views of health among laity. In other words, the participants reflected

on the ways in which the idea of achieving health is enculturated presently in society. Additionally, the participants offered insights on the moralization of health in the health care establishment. I will substantiate some of these facets of socio-cultural and professional critique offered by participants.

(i) Media, society, and health

A general assessment

Many considerations in the interviews indicate the explanatory importance that the participants attached to the ways in which societal forces and the media in particular portray and influence the contemporary pursuit of health. Proof of the significant role ascribed to these larger forces in patterning the pursuit of health by the participants is the fact that considerations on the media, society, and their influence on health (promotion) occurred in the interviews not only in answering media-related questions in the interview guide, but also spontaneously.

The common assessment offered by health coaches is that media's involvement in promoting health is profuse, pervasive, confusing and misleading. According to most of the participants, there is too much health talk in the media; too much conflicting and out of context information; too many turns in guidelines and recommendations for health; too much of an inclination for recommending quick fixes; too much pressure for the achievement of ill-advised or superficial images of health: "look like Hollywood"; too much emphasis on unilateral aspects of health, like weight; and an ill-advised cultivation of an attitude of constant overexertion in achieving health.

The following excerpts offer illustrative examples:

- Do you see a lot of health materials and health talk in the media?

- Here is my... (laughs)... I think that there's too much of it out there. I think consumers don't know... you know, it's like you're being bombarded by it

constantly... and some people are very into that, some people I think shut down by it, it's just like sensory overload... Ah... one of the things that really annoys me, and I don't mean this in a bad way of what we're doing, but I think that the media takes a hold of a snippet of research that's not even done yet, and they exploit it. You know, for instance, eating this one week is so good for your health, and next year it was the worst thing that you could do, you know, and I think consumers are confused... I think too we're always going, going, going... people don't know how to shut off

- So you are saying that the overall message, if I understand this correctly, is that the media pushes an attitude of overexertion?

- Yes, categorically, yap... I think most of the time, but I think that it's not just the media I think that most people have conditioned themselves to be wired that way (...)

- So what we see as this preoccupation with health that in our society is more like this doing-doing-doing?

- Yeah!

- You mean how society is preoccupied with health?

- Oh, I think that we totally tied health to the superficial, if you want to know. Like how you look, if you have, you know, I think that we focus too much on weight management, which I'm not saying weight is not important, but I think that society puts a lot of pressure on 'look like Hollywood', you know, 'healthy is if you look like this', and that's not realistic. (L)

In the quote above we see how the discussion transitions from the media to how society in general understands now the issue of health: "it's not just the media, but people also." Here, as in other instances in the interviews, media is seen as a correlate of the state of affairs in society. Marginally suggested in the quote is an aspect usually absent from most elaborations, namely that the professional health establishment may be part of the same dynamic of forces active in shaping the concern with health in the media and society: media gets a snippet of medical or health research and saturates the public sphere with it. (The participant emphasizes that this is not a criticism of her job yet this suggest that the disclaimed connection may be indeed justified.)

Similar points are made by another participant:

- How do people react to the wealth of information on health?

- Well, I think we change our minds a lot (laughs), you know, one minute they're saying 'don't eat eggs, then they're saying, yeah, you can have so many eggs, then they're saying eat this kind of eggs, these eggs are healthier for you, that's something that somebody (...)... all these drink these, you'll get skinny, take these pills to lose weight, you know, I think that's just so confusing. I think that we're trying to do it too quickly, in not the right way, I think we confuse the daylights out of everybody.

- Does this (wealth of health info) make your job easier?

- I think it makes my job more complicated.

- (...)

- Many people think that that if you're overweight you're not healthy. That's what society tells us. I mean, if you watched the news, they're saying 'go on this diet', you know, do this, do that, they'll show having people walking down the street or they'll show someone, usually a pretty girl in bikini sell something, you know, here's this new product to make you healthy, put somebody in a bikini, or a tight exercise outfit, I think that's what people tell us. Yet you can look healthy, and drop dead of a heart attack.⁹

- Do you see a lot of concern (for health) in the media?

- Sure. I think **we** talk a lot about it. I think the media, the community, I think it's talked about it a lot, right now the big thing is, ah... health conscious, everybody wants to be health conscious, I think some of the restaurants are backing down on that biggie size, I don't think they're taking it away, I think they're not advertising it as much, you know, let's don't sell the big gulp, we'll sell it, we just don't make it the big selling point right now. Right now we're gonna make it like fruit juice, or, you know, that kind of thing... decaf coffee. (B)

In addition to reinforcing aspects already visible in the first quote, this participant adds a note of irony and disapproval of the persuasive/manipulative techniques in health communication/advertising practices: put anything in a bikini in order to sell it. She also appears

⁹ A fit body is not necessarily a healthy body. A related observation was offered by another participant: not all health inducing regimens make people healthier.

to doubt the sincerity of health promoting practices by food vendors that is suggested to be more of a hypocritical compliance with the general concern for obesity rather than the genuine engagement in providing good quality products in appropriate amounts. There is irony and ambivalence in the way this participant qualifies the new health consciousness as a sort of concern or craze of the moment. Also, it is interesting to note in the first passage of this fragment how the phrasing moves from “we” in “we’re changing our minds a lot” to “they” in “they’re saying.” As in the first interview quoted in this section, media, society, and health care expertise appear conjoined in the sweeping dynamic of the new health consciousness: “we confuse the daylights out of everybody” is an important statement that very likely refers to the media and the professional expertise jointly disseminated to the public.

If most health coaches accused too many sources of information about health and too many channels and voices – some of these purely commercial - communicating this information in the public sphere, an alternative position was offered by one participant who pointed out that although the voices and sources promoting health may be numerous and different, their fundamental message in the same resulting in reinforcing similar themes about health and heightening the general sense of health awareness: be proactive about your health, take care of your health by adopting healthy measures, etc.

Media was spontaneously linked by participants to the development of a generational and cultural shift in health consciousness, with older generations being less concerned with achieving health, and younger generations embracing the new health consciousness that translates into the rationalized and individualized pursuit of health. This situation is not without its own set of implications and ambiguities. For instance, there are several references in the interviews to times when people were not health conscious; grandparents of today’s (older) adults may have not

been concerned with their health yet, nevertheless, they lived more healthily than we do – working physically harder, cooking everything from scratch - and still could enjoy long and healthy lives.

Society and media inadvertently equating health with weight (management) and body shape is another aspect criticized by many participants. The pressure for slimness and fitness is considered misleading - to be slim is not an equivalent of health; as the participant above noted, one can drop dead even if slim. According to another participant, the emphasis on weight and body shape and image can be very detrimental as some people become concerned to the point of obsession with these aspects, and girls become anorexic precisely because of these messages.

Overall, media's involvement with health emerged from the interviews as a problematic social practice with important impacts and mixed benefits. The major benefit of media's involvement in health promotion was identified in the creation of a heightened individual and collective awareness to health issues. Yet when I asked some of the participants if the new health consciousness makes people healthier, the answer was that it makes people aware although not necessarily healthier. Angst, culturally induced disorders such as anorexia, indifference by overload, ill-advised priorities or excessive measures for health were all quoted as negative consequences of the profuse health communication in the public sphere. Considered in this context, the task of professional health coaching appeared critical in dispersing the confusion and clarifying adequate individual priorities, and also rendered more complicated by the interfering “noise” of health talk.

Pressures in society and the pursuit of health

The participants referred in the interviews to what they considered prevailing lifestyle modes in society. These were generally defined like pressures or stresses and included: a highly paced life; an excessive achievement-driven approach to life; the demands of busy lives and multiple family and professional roles. These societal pressures were considered to have a detrimental effect on health. One participant reflected about previous times in her life: growing a family meant being in a constant hurry, and despite her efforts at being proactive about her health, in retrospect she can see that “I was busy, but not healthy.”

Another participant elaborated:

- (...) you know, people have these misconceptions that healthy living is plain broccoli, and grilled chicken, no chocolate and no this, and no that... you know, we've gotten into this like good and bad war with what I should do (emphasized) you know and that's... that's what meant by that (distortion)

- Why do you think this has happened?

- Hmm, I don't know, I think I have to think about that a little bit more... it's very simple: eat good, unrefined food, in moderation, but I think... it happened because pace of life is much faster than it used to be, and I think sometimes, even myself, people find it hard to deal with that, so you cut corners. Where can you cut corners, where can you simplify, I need to make a living, I need to work, so that that might take priority over having good quality food in your house, or might take precedence over me going and getting you know, yearly exams, you know, prevention, so these are all things that I think happen... I don't know... I can't speak for a whole, but I look at our culture, compared to other cultures and I feel sad for us, because our priorities are so out of whack” (in the context of the interview, this means pressures, money driven, hurried and harried lives). (L)

Here work and job demands are directly opposed to the demands of healthy lifestyle regimens such as good food or preventive exams. Additionally, a different type of pressures is also apparent, like the distortion of health priorities in society whereby weight control is considered a paramount health issue and treated aggressively and superficially as the adjustment

to an ideal fit and slim body image; or the “push” for a total control of (socially displayed) healthy behaviors leading to “this good and bad war with what I should do;” or the mode of overexertion and over action generally favored in society and that also echoes in the way health is pursued by individuals: “doing-doing-doing,” “going-going-going.”

While pressures impinging on health are generally understood as limiting the potential for health, there is another category of pressures that only a few participants mentioned. These are pressures for enrolling in the project of proactive health that employers and the health care industry enforce:

- I think... a lot, I think some of the important things that make people healthy, I think as far as my job is concerned, is employers pushing stuff, so it's a lot of pressure on people to try to get healthy, lots of benefits for you if you do (...)
that's ... I think pressure is a big thing...'

- So is this pressure a benefit to health, or...?

- I think so, pressure and kind of... like a monetary value to it, you know, people are offering this if you do this, and a lot of people are changing, and I'll note this too, it's not only young people, is older people, they're probably sick and tired of paying insurance premiums that are so high, so... I think that that's a big thing. They kind of pressure, but on the other hand you get people that will say 'they're not pushing me into doing this, and I'm not gonna do it, but it's more the opposite, that people feel the pressure and they do it, they want to be... I think it's more... and just feeling better about themselves, I think that was a big thing for me.”

Differently from assessing the other types of pressures in society, these specific health promotion pressures are deemed beneficial to health.

(ii) The moralization of health in society and in the health care establishment

“We have gotten into this war of good or bad” said one health coach about the moralized connotations of healthy eating. While incorporating into their accounts many elements of the moralized professional view of health promotion, the participants also deplored the fact that there

are health aspects that receive an unwarranted moral treatment in society and in the health care establishment. The most common illustration on this point is the issue of body appearance and the stigma attached to overweight and obesity.

I think now, with all the things of improving your health, people kind of look down on you... I spoke with somebody more recently that said they just can't understand how people just kind of... and they put it like "let yourself go"... it's not particularly that you're letting yourself go, some people don't have the time (...) and some people don't have the resources, the money, you know, the energy, some people just don't have it, it's nice that (other) people do, but some people just don't, so I think they kind of look down on... (...) I honestly think that, you know, heavier people get spoken about, and whispered, and, you know, things like that. (E)

Moreover, judging people for not taking care of themselves happens in health care environments as well:

I know from working in the hospital (...) people who are unhealthy or bigger, they would definitely be viewed... differently. (...) I don't think people get as good a care because of it, unfortunately. I think is... to me it's disgusting, but it happens. (...) It's a hard thing to say, but I know it, I heard a lot of times: they don't need help, they've made themselves this way. I just don't know... to me, that wasn't right. (E)

Another participant:

I used to look at people down the nose, figuring they get the burger and the fries, but last several years I've changed my view: sometimes people work hard, but other issues keep them overweight, just because they're overweight doesn't mean they're unhealthy. (B)

The critical positions exemplified above suggest that people should not be judged based on their interest in cultivating their health, nor on their healthy habits or their body shape. Yet, as one health coach quoted above noted, "we all do it" despite the fact that this is not "fair" neither for the one being judged nor for the person who makes the judgment. Indeed, although we are all granted the right to choose freely without being sanctioned for our choice by "big brother," as stated by another participant, the moralized valuation of most aspects of pursuing health is

unavoidable. Proof to this is the result of contrasting the interpretations quoted above with statements of the same participants affirming their (moral) responsibility for health, or describing their own challenges in achieving health as moral shortcomings. Differently said, how these anti-moralizing stances play in the context of the moralization of achieving health in the core narrative? The answer is: ambiguously.

2.4.5 Concluding observations about the professional narrative of health

As extensively described in the sections above, nuance and contradictions are apparent in some of the discussions offered by participants about the key tenets of the rationalized and individualized narrative of (self-made) health. These lateral formulations challenge the total character of the tenets of rational choice, control, and responsibility of the individual in achieving and securing her health previously affirmed by the participants.

Additionally, criticism characterizes the ways in which health coaches interpret the dense and complex communicational, cultural and social contexts in which the individual pursuing her rational plan for health is immersed. As we have seen, the general societal and communicational climate driving/governing the contemporary concern for health is generally seen as problematic by the participants and resulting in significant negative pressures and distorting the understanding and practices of achieving health. Furthermore, criticisms were formulated regarding the moralization of overweight and healthy behaviors in the healthcare establishment and in society.

These elaborations on the periphery of the narrative are very significant from at least two perspectives. First, they give the measure of the inherent existential, moral, social and cultural complexity of the issue of health and of its promotion. Thus, they provide a counterbalance to the

reductive view of achieving health configured by the core tenets of the professional narrative of health. Despite the fact that these elements of social, cultural, and professional critique remain entirely secondary in the framing of the professional narrative, their latent presence as a domain of reflection for the participants is nonetheless important and introduces elements of ideological hybridity in the narrative.

Secondly, it is remarkable that the insightful criticisms directed at the larger contexts of pursuing health – societal, cultural, commercial, communicative, scientific and technocratic – that are seen as impacting (negatively) the production of health, are not linked to the main conception of health in the professional narrative of health promotion that the participants assert. Nor are the supra-individual factors in the equation of health discussed by the participants. Despite the fact that these are mentioned as contriving the acquisition of health through the rationalized and individualized regimen advocated by professional health promotion, supra-individual determinants occupy no distinct place in explaining the production of health or in justifying alternative approaches to individual and collective health promotion. In the narrative, the conceptualization of health as generated from inside the individual: health from inside-out is dominant, and does not meet conceptualizations of health as produced from outside the individual: health from outside-in.

Thus, in the dialectic of construing the professional significance and discourse of health, the narrative rests solely on a reductive rationalized, individualized and moralized ideology of health. In fact, my critical argument is that this view is boldly rationalistic/voluntaristic, perfectionist and moralizing precisely because it can only ignore its limitations and contradictions – or, using a Jungian suggestion, its shadows.

Health is construed as individual health and is conceived as generating inside the individual. Commensurate with this view of health “from inside out,” where personally controllable behavioral and lifestyle are key generators of health, the narrative promotes a regimen of self-made health centered on the individual rational control of behavioral and lifestyle factors.

The descriptive analysis presented in this Chapter 2 illustrates in detail: the identification of a professional narrative of health; its anatomy/structuring; the logic embedded in construing its main tenets; the contradictory implications of statements on the margins of core propositions; and the dialectic of articulating a dominant technical/professional project and regimen for (self-made) health. Based on this analysis, I advance the argument that the narrative of health in discussion is defined by its core tenets and signifies health as a narrowly rationalized, individualized and moralized project. The core tenets provide the narrative with a dominant explanatory framework for the production of health that justifies a perfectionist regimen for health promotion; this regimen is represented by individual behavioral and lifestyle rational controls and actions. The core tenets provide the narrative with a dominant ideological identity. Counter-narrative explanatory and ideologically hybrid elements on the periphery of the narrative do not impact its overall coherence and do not broaden its explanatory framework by the inclusion of supra-individual determinants of health.

Our exploration would have stopped here had we had reason to believe that the professional narrative of health described is particular only to this group of professional health coaches. Numerous important socio-cultural critiques as well as direct personal experiences describe precisely the pervasiveness and dominance of this narrative in the public sphere and throughout important segments of health promotion practice.

It is important to consider if and how the professional narrative in this group of interviews relates to the ideology of health in official/authoritative professional health communication materials. Thus, it is opportune to launch an additional empirical examination of the discourse of health in professional health promotion.

3.0 FRAMING HEALTH IN CDC HEALTH PROMOTION DISCOURSE FOR THE GENERAL PUBLIC. A QUALITATIVE VISUAL AND WRITTEN DISCOURSE ANALYSIS

3.1 INTRODUCTION

Building on the findings about the professional narrative of health described in Chapter 2, it is relevant to expand the scope of the investigation and to assess the dominant conception of health advanced at other sites of professional health promotion discourse, specifically at the level of official professional discourse. Toward this aim, I will examine the ways in which health and its pursuit are framed in health promotion discourse at the Centers for Disease Control and Prevention (CDC). Specifically, I will consider two manifestations of health promotion discourse: print images used for public display as part of health promotion/social marketing campaigns at CDC, and health communication materials published online at CDC.gov, the web entity of CDC.

The very process of arriving at the topic under investigation is constitutive of the research itself. It is thus relevant to outline the inspiration for this study.

Over the last several years, I have noticed many messages with health content in different places: on the side of roads and highways, in airports, bus stations, buses and metros, in the mail, in the media, and also in the virtual sphere. In the fall of 2008, only a week apart, in two different

U.S. airports I came across two large images of Katie Couric promoting colorectal cancer screening. It was a formative experience for the current study. I found one of the images particularly striking: it was a large poster hung above an open waiting area in a busy airport. From high-up, Katie Couric, standing fit and shiny on a deep blue background was smiling at the people in transit from behind a massive gilded empty frame held by her hands. (See Appendix C, CDC Public Display Advertisements.) The image contained also some text, yet I could only distinguish the first written line of it: “Are you the picture of health?” The CDC logo was recognizable at the bottom of the large poster. Later on, I researched the images and located them within CDC’s “Screen for Life” colorectal cancer prevention campaign.

In the interviews with health coaches, a cluster of elaborations spoke about a sense of excessive and distorted communication about health in the public sphere. One participant suggested that a more adequate health communication climate would be one driven by CDC or other official sources rather than from industry ones. This statement reinforced the relevance of a research question posed at the very beginning of this dissertation research: what is the face of – or language with which - the meaning of health is offered to the public by products of expert health promotion in the public sphere?

Health promotion discourse at CDC is interesting as a choice of study for several reasons. CDC represents the official professional authority in public health and health promotion in the U.S. Self described as “the nation’s premier health promotion, prevention, and preparedness agency and a global leader in public health (<http://www.cdc.gov/about/history/ourstory.htm>, April 12, 2013,) the organization has the mission “to create the expertise, information, and tools that people and communities need to protect their health – through health promotion, prevention of disease, injury and disability, and preparedness for new health threats”

(<http://www.cdc.gov/about/organization/mission.htm>, April 12, 2013). This mission is accomplished, to a large extent, through language and communication. It is my premise that much of the organization's discourse is created purposively for effective communication about health to the general public and specialized audiences.

The communicative function of CDC acquired a new dimension with the use of digitized information that recreates the Centers' expertise and activities in the virtual domain. CDC.gov, the web entity of CDC, transformed the institution literally into a vast communication interface; this represents a universally accessible and virtually unlimited authoritative professional textual body about health¹⁰. In addition to casting its expertise onto the digital communication interface at CDC.gov, there are other ways in which CDC disseminates health discourse in the public sphere. For instance, CDC produces its own health communication and social marketing campaigns that employ a variety of media products disseminated through multiple channels in the public sphere. Additionally, CDC disseminates press releases, media advisories and statements (<http://www.cdc.gov/media/archives.htm>) and serves as authorized source of information about health in media outlets. Moreover, CDC is influential in less obvious ways in framing health for the public as exemplified by its partnership with the "Hollywood, Health and Society" program of the Norman Lear Center, Annenberg School of Communication which imparts health concerns and suggests relevant storylines to the entertainment and film industry (<http://hollywoodhealthandsociety.org/about-us/about-us>)

These considerations substantiate the claim that CDC represents the official expertise in framing health promotion issues for the public. CDC has the authority and resources to disseminate its understanding of health and it accomplishes this through messaging and

¹⁰ This study is based on examining the information provided by CDC.gov.

communication activities in the public sphere, including the virtual sphere. My literature searches of prominent health sciences publications, including the *Journal of Health Communication* and *Health Promotion Practice* as well as searches of the communication and cultural studies literature did not identify existing studies analyzing CDC's discursive or textual framing of health promotion. Thus, my study contributes much needed insight for an overdue discussion about the main contents and forms of current health promotion official discourse and about its likely impact in patterning or enculturating a dominant understanding of health in society.

The central objective of this study component, then, is to examine how health and its pursuit are presented in two domains of CDC health promotion discourse for the general public. Namely, I will examine current CDC "Features" - on-line health communication texts that are readily visible and accessible from the main CDC page. These have the style of professional health communication for general audiences and reflect items on the current health promotion agenda at CDC. Additionally, I will examine the imagery and messaging strategies of print public display advertisements – or ads - that are part of health promotion social marketing campaigns created by CDC. Display advertising refers to "printed, painted, or electronic displays; and/or placing such displays on indoor or outdoor billboards and panels, or on or within transit vehicles or facilities, shopping malls, retail (in-store) displays, and other display structures or sites" (U.S. Census Bureau, <http://www.census.gov/econ/industry/def/d54185.htm> May 22nd, 2013). CDC social marketing campaigns commonly employ large size print images that are displayed in areas with high volume of pedestrian or motorized traffic – these type of displays will be considered in this study. I will also assess the health promotion contents of principal pages at CDC.gov.

These two types of products are clearly instances of health communication designed with the purpose to engage the attention of the public with professionally framed health promotion concerns. In examining these materials, I consider the important question about the possible convergence or divergence between the framing of health in CDC's official health promotion discourse and that identified in the professional narrative in a group of health coaches. The narrative of health in the interviews with health coaches appeared structured around a number of tenets that did not include any systematic understanding of supra-individual, structural or social determinants of health. Are there, or not, affinities between the conceptualization and framing of health at these two main sites of inquiry - CDC and professional health coaches? I am hypothesizing that it is likely that significant affinities between the two exist.

Upon beginning this part of investigation, the questions to address are: How is health framed in CDC print public display advertisements and in on-line health communication pages that address the general public? Specifically, what is the dominant content of health promotion images and of virtual pages designed for the general public? What are the key messaging strategies employed and the meanings of health that they convey? How are social or structural determinants of health (re)presented at these two locations of CDC health promotion discourse and on main on-line pages of the organization?

3.2 METHODOLOGY

For the purpose of this study component, public domain secondary data is used. No IRB approval is necessary. CDC materials are not under copy right law and their use and reproduction is free.

3.2.1 Methodological approach

This study is exploratory and primarily observational. It employs qualitative discourse and visual analysis methods. The discourse analysis methodological component takes as reference texts of James Paul Gee (1999, 2010) that rests on the premises that discourses are social languages enacted within situated meanings, identities and cultural models. Interpreting discourse requires, thus, multiple sets of historical and inter-textual contextualization. Procedurally, the general qualitative approach employed in interview analysis is employed in qualitative discourse analysis – of either written text or visual imagery. This rests on the repeated observation of an existing universe of data, accompanied by descriptive, analytical and interpretive thinking, and writing processes.

In advancing the current analysis of discursive official health promotion products, a special place is given to assessing whether thematic categories identified in the interviews with health coaches - such as health as rational plan, health as individual effort, health as overexertion, health as change, health as personal control, health as individual management plan, or health as personal responsibility – are also represented, or have equivalents in the current data.

For structuring the examination of visual materials, I use as inspiration Kress and Van Leeuwen's semiotic functional analysis method detailed in *Reading Images: The Grammar of Visual Design* (2006). The two authors favor the description of formal aspects in the image, and describe several dimensions of analysis: a representational dimension - narrative elements and ideas in the frame of the image; an interactive dimension one that reflects the exchanges between image and viewer – gaze, significant lines in the image, the codification of social distance on a scale ranging from intimate to public, and the modality or the overall mode of representation; and the dimension of layout and composition that refers to the position of visual elements in the frame, their relationship and relative importance in the context of the image (idem, 2006). According to social semiotic analysis perspective, of interest is the “study of images in their social context, as a critical form of visual discourse analysis” (VanLeeuwen & Jewitt, 2001, p.4). This is an additional reminder of the importance of contextualization in analyzing and interpreting visual discourse.

Inspired by these authors, my proceedings here rested heavily on descriptive processes that grounded interpretation. The images were assessed by focalizing attention on their constitutive elements, such as composition, chromatics, figures and actions, framing and angle, graphology, as well as to the interrelation between image and written text within its frame. Analyzing the dynamics of these elements, inferences can be made about the mechanisms by which meaning is encoded in the images.

Additionally, I used categories of narrative theory, such as genre, narrative time, or narrative voice (Herman, Jahn & Ryan, 2005) that are important in constructing meaning. A special dimension of contextualization in conducting discourse or visual analysis regards the category of genre. The data under investigation is the product of deliberately applied techniques

of professional health communication and marketing. Thus, discourse data has to be analyzed considering and understanding the conventions of its specific genre – here, the professional¹¹ communication and advertisement genre (Wodak, 2006).

Finally, the contextualization of the researcher’s position is critical. My rapport and engagement with the data was guided by two apperceptions: first, that of the casual reader/viewer of official health promotion materials; secondly, that of the researcher. As a member of the general public, I am exposed to and consume health promotion messages; I make sense of this exposure from the perspective of someone socialized over more than a decade to the forms of American contemporary life in which a pervasive feature is the definition of norms, values, and identities through media products in the public and in the virtual sphere. In this role, I am not the detached observer of a phenomenon considered for objective examination within some scientific parameters. On the contrary, I have an experiential, rationally and emotionally complex relation with the “data.” To further compose this complexity of reception, I also assume the lens of the health researcher socialized within the conventions of professional health promotion and public health as imparted by an academic professional institution. Thus, my approach is respectful of the rigors of systematic analytical and interpretive inquiry and my work is guided by the interest of clarifying critical disciplinary concerns, such as the paradigmatic discursive and ideological orientation of common/typical health promotion practice.

¹¹ Professional” in professional communication stands here for a double expertise: that of the health promoter or health expert, and that of the communication or marketing and advertisement expert. It is my assumption that a combination of these two sets of expertise is employed toward generating health promotion materials for the general public at CDC.

3.2.2 Forming two sets of data

As already mentioned in the introductory section above, the interest of this study was to identify relevant instances in which the “face” of CDC health promotion is broadly presented to the general public. Practically, the first major methodological task of the study consisted of acquiring familiarity with the CDC.gov site and identifying general and health promotion pages at CDC.gov. The following operations were possible based on exploring CDC.gov: a) the identification of key health promotion contents readily accessible by visiting main pages; b) the identification of a good example of current health communication materials for the general public, namely the “Features” rubric; and c) the identification of print public display communication/marketing campaign ads. Specific proceedings are detailed below.

I first explored freely CDC.gov. Subsequent iterative, extensive searches of the site allowed me to construct a list of links that represent, for the purpose of this study, the general domain of health promotion at CDC.gov, out of which the two sets of data were identified.

For the purposes of this study component, over several periods of time and most recently from February through April of 2013, I conducted an extensive search of CDC.gov. The search consisted of exploratory browsing sessions, systematic reviews of pages and links, and keyword searches on CDC.gov search engine.

A CDC page that opens on the computer screen is most commonly divided into a multitude of fields, each with headings and links, and comprising both written texts, and ubiquitous images – either still images like photos, drawings, charts, graphs, and logos, or images revolving interactively. Entry-pages for CDC or for its centers, divisions, and programs contain a wealth of topical categories with subsumed linked information. Moving from link to link resembles a maze of continuously forming ramifications. The sequencing, direction, or

relationship of pages can become quickly lost or irrelevant. My first browsing sessions of the site gave a sense of suffused novelty, of unstable and endless information. Not only was the experience interactive and fluid in the sense that the reader determined her way from link to link in a virtual domain of undetermined boundary, but some of the content and imagery of pages shifted from visit to visit. However, by repeated browsing, the initial impression of disorientation in face of vast information receded. I soon realized that cross-referencing information was intrinsic to the structuring of CDC.gov. Due to this feature, missing critical data upon repeated explorations of health promotion-relevant pages was unlikely, though initially feared.

As a general trajectory to understanding the data, I first familiarized myself with the main page at CDC.gov. I reviewed information about CDC's organizational structure, and explored extensively those centers/divisions deemed of relevance, such as the National Center for Disease Prevention and Health Promotion, the National Center for Environmental Health, or the National Center for Injury Prevention and Control. For each, I explored subsumed divisions, offices, programs, and resources. Additionally, I used the search engine at CDC.gov and introduced such terms as: health promotion, health promotion campaigns, health communication, public display advertisement, community health, healthy communities, healthy lifestyle, healthy living, social health, social determinants of health, or structural determinants of health. For each list of search results, I explored the first five pages of links offered by the search engine.

A number of pages recurred in my searches as important entry points toward delineating the data. They are listed below:

- CDC.gov main page <http://www.cdc.gov/> (last accessed April, 29, 2013); from here:
- The "Healthy Living" page <http://www.cdc.gov/HealthyLiving/> (last accessed May, 3rd, 2013). I took note of the "campaigns" field in the upper right area of the page.

- “Features” domain from main page, exemplified by “On a Budget? Learn Cheap Ways to Be Healthy” at <http://www.cdc.gov/Features/BudgetForHealth/> (last accessed on May 9, 2010).
- The National Center for Disease Prevention and Health Promotion, at <http://www.cdc.gov/chronicdisease/index.htm> (last accessed on April 29th).

Here of particular interest, were all the “Programs” links: cancer; community health; diabetes; heart disease and stroke; nutrition, physical activity and obesity; oral health; population health; reproductive health; preventing chronic disease journal; reproductive health; smoking and tobacco use. Additionally, interesting are the general descriptions about chronic disease and about the National Center for Disease Prevention and Health Promotion. Of particular interest is the button “Tools and Resources” <http://www.cdc.gov/chronicdisease/resources/index.htm> (last accessed...). Included here is the “Campaigns” link at <http://www.cdc.gov/chronicdisease/resources/campaigns.htm>;

Health Equity button: <http://www.cdc.gov/chronicdisease/healthequity/index.htm>, Under this, the first two links: Promoting Health Equity, A Resource to Help Communities to Address the Social Determinants of Health at <http://www.cdc.gov/healthycommunitiesprogram/tools/pdf/SDOH-workbook.pdf> ; and Social Determinants of Health Maps http://www.cdc.gov/dhdsp/maps/social_determinants_maps.htm.

I browsed all the seventeen programs under the National Center for Disease Prevention and Health Promotion: seventeen program areas: arthritis, cancer control, diabetes, epilepsy, health related quality of life, healthy ageing, healthy communities, healthy youth, heart disease and stroke; nutrition, physical activity and obesity; oral health; preventive health and preventive services block grant; prevention research centers; REACH; reproductive health; tobacco; and

WISEWOMAN. I have reviewed each of these programs searching for imagery used for public display.

- Another key reference was “Gateway to Health communication and Social Marketing Practice” <http://www.cdc.gov/healthcommunication/>, and in particular the Campaigns and Other Materials button <http://www.cdc.gov/healthcommunication/>
- The National Center for Environmental Health, <http://www.cdc.gov/Environmental/> , and specifically “Healthy Places” <http://www.cdc.gov/healthyplaces/> , and “Designing and Building Healthy Places” at <http://www.cdc.gov/healthyplaces/>

I considered these to be key references for identifying the data for the following reasons: they reflected the general domain of health promotion; they were main pages that subsumed many sub-domains with corresponding links; they reflected the general domain of health promotion; they recurred in multiple searches and from multiple entry points; they responded specifically to some of the criteria used in constructing the two bodies of data for the study – these will be specified below for each; and their number was manageable.

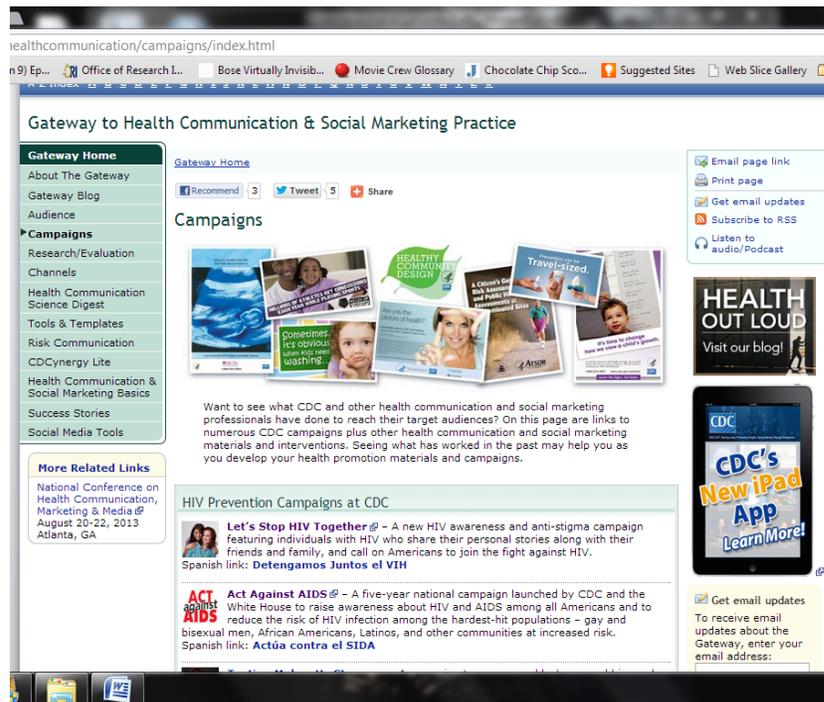
3.2.2.1 Data set 1: Print Public Display Advertisements from Health Promotion and Disease Prevention Campaigns

I selected six campaigns from those reported at CDC.gov. These included the dissemination of their messages through public display advertisements in areas of high pedestrian or motorized traffic. The selection process is detailed below.

I first identified through extensive searches a number of health communication and social marketing campaigns produced by CDC through searching extensively the site. CDC, specifically the Division of News and Electronic Media, maintains a “Gateway to Health

Communication and Social Marketing Practice” (<http://www.cdc.gov/healthcommunication/>).

This is a resourceful interface for the practice of health communication and social marketing in public health; more importantly for my interests, under the “Campaigns” button is a list of current major campaigns at CDC (<http://www.cdc.gov/healthcommunication/campaigns/index.html>). I reproduce this page below as Figure 1, comprising five distinct windows due to the length of the screen page.



ealthcommunication/campaigns/index.html

Office of Research... Bose Virtually Invisib... Movie Crew Glossary Chocolate Chip Sco... Suggested Sites Web Slice Gallery

Spanish link: [Actúa contra el SIDA](#)

 **Testing Makes Us Stronger** – A campaign to encourage black gay and bisexual men to get tested for HIV.

 **Take Charge. Take the Test.** – A multi-faceted social marketing initiative designed to increase HIV testing among African American women.

 **HIV Screening. Standard Care.** – A campaign to encourage primary care providers, gynecologists, and other health care providers to promote routine HIV testing during patient visits.

 **One Test. Two Lives.** – Information and materials to encourage health care providers to test pregnant women for HIV infection and help reduce the number of infants born with HIV.

 **Prevention IS Care** – A campaign to encourage health care providers who treat patients with HIV to screen their HIV-infected patients for risky transmission behaviors, and reiterate to HIV-infected patients the importance of protecting themselves and others by reducing risky behaviors.

Other Health Campaigns at CDC

Tips From Former Smokers – Multi-media Campaign - In 2012, CDC launched the first-ever paid national tobacco education campaign—Tips From Former Smokers (Tips). In 2013, CDC built on the success of the 2012 Tips campaign by launching a new round of advertisements. The Tips campaign raises awareness of the negative health effects caused by smoking, and encourages smokers to quit and nonsmokers to protect themselves and their families from exposure to secondhand smoke. The 2013 campaign feature additional health conditions not included in the first phase of the Tips campaign—such as chronic obstructive pulmonary disease (COPD), asthma in adults, and smoking-related complications in a person with diabetes. Also, web content is tailored to different population groups such as American Indian/Alaska Natives, LGBT, (Lesbian, Gay, Bisexual, and Transgender), African-Americans, and Hispanics.

Inside Knowledge: Get the Facts About Gynecologic Cancer Campaign – Raises awareness of the five main types of gynecologic cancer: cervical, ovarian, uterine, vaginal, and vulvar. When gynecologic cancers are found early, treatment is most effective. Spanish link: [Conozca su Cuerpo: Infórmese Sobre los Cánceres Ginecológicos](#)

Get Smart: Know When Antibiotics Work – Award-winning, national campaign aims to

Centers for Disease Control and Prevention
1600 Clifton Rd
Atlanta, GA 30333
800-CDC-INFO
(800-232-4636)
TTY: (888) 232-6348
[Contact CDC-INFO](#)

ealthcommunication/campaigns/index.html

Office of Research... Bose Virtually Invisib... Movie Crew Glossary Chocolate Chip Sco... Suggested Sites Web Slice Gallery

Spanish link: [Conozca su Cuerpo: Infórmese Sobre los Cánceres Ginecológicos](#)

Get Smart: Know When Antibiotics Work – Award-winning, national campaign aims to reduce antibiotic resistance by promoting appropriate prescribing guidelines among providers and educating adults and parents of young children to decrease demand for antibiotics for viral upper respiratory infections
Spanish link: [A Veces, el Remedio Es Peor que la Enfermedad. Campaña para Promover el Uso Correcto de los Antibióticos](#)

Brush Up on Healthy Teeth: Simple Steps for Kids Smiles – This is a health education campaign including a Brush Up Quiz for Parents.

Choose Respect – An initiative to help adolescents form healthy relationships to prevent dating abuse before it starts.

VERB™ It's what you do. – A national, multicultural, social marketing campaign to increase physical activity.
Spanish link: [VERB™ Ponte las Pilas](#)

BAM – Interactive website for youth that will answers question related to fitness, disease, peer pressure.

It's A SNAP (School Network for Absenteeism Prevention) – A hands-on initiative for middle schools that's designed to help keep students in school and learning by improving overall health through promoting clean hands.

Nutrition for Everyone: Calcium and Bone Health – Information on bone health and osteoporosis.

5 A Day for Better Health – Information on fruits and vegetables and their sources of vitamins, minerals and other natural substances.

Screen for Life: National Colorectal Cancer Action Campaign – Informs men and women aged 50 years or older about the importance of having regular colorectal cancer screening tests.
Spanish link: [Screen for Life: Campaña Nacional de Acción contra el Cáncer Colorrectal](#)

Learn the Signs. Act Early. – Be aware of milestones that show a child's development. Acting early can make a real difference!
Spanish link: [Aprenda los Signos. Reaccione Pronto](#)

You Are Not Alone: Toolkit for Parents of Teens with Epilepsy – Supports parents with

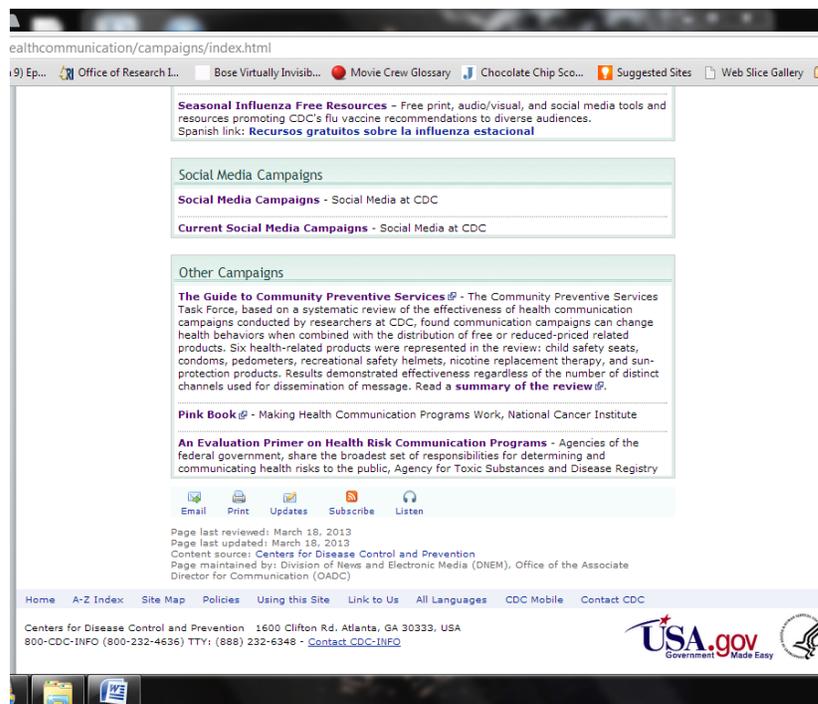
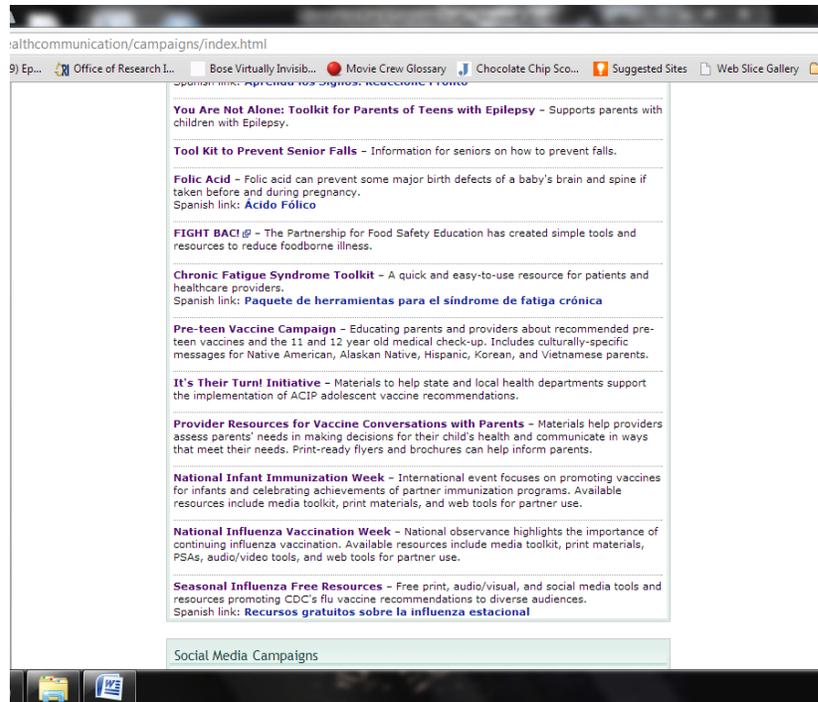


Figure 1. Gateway to Health Communication and Social Marketing Practice, CDC.gov

I have explored in-depth all the campaigns listed on this page. Additionally, I combed the references pages listed above for campaign activities, and I also performed keyword searches. In

this way, I identified a few additional campaigns to the ones listed on the “Gateway” page. Subsequently, I compared my list of campaigns with the categorized lists of publications at CDC – Info (<http://www.cdc.gov/cdcinfo/publication.html>) and at CDC Publications (<http://www.cdc.gov/publications/>). As I did not identify any additional campaigns in this way, I assumed that the health communication/marketing campaigns with general health promotion content reflected well this domain of activity at CDC.

Based on the extensive review of the information and materials provided for each campaign, I selected six for the purpose of this study. The following criteria were used for selecting campaigns and images of public display ads: a) the campaign was current or recent, b) the campaign targeted lay audiences; c) the campaign had, preferably, national coverage, and c) the campaign made use of print images in large format, such as banners, billboards, posters, transit ads and bus shelter ads, displayed in public spaces with high traffic. Excluded from the selection were: all the campaigns geared at health providers; campaigns about smoking and tobacco use due to the long and special professional and cultural history of this portfolio; two current sub-campaigns of the “Act Against AIDS” general campaign for their particular content or target of distribution: one is an anti-stigma and anti-discrimination campaign, the other one is likely distributed in environments where gay couples congregate. Several of the campaigns considered for inclusion did not specify the venue for displaying poster images. I considered that if the specific campaign also included public radio announcements and media print advertisements, it was likely that some of its images were aimed at general public display. This is the case with the recent “Inside Knowledge” awareness campaign about gynecological cancers. Judging the imagery and the visual quality of the poster production, it was likely that two of them would be distributed generally. By contrast, posters with detailed anatomical schemes and

detailed written information were most likely created for display in medical offices. I contacted CDC – Info with questions about specific venues of display for the folic acid and preconception care campaigns, yet the answers provided were only general. I decided to include these two campaigns in the group studied here for their eminent health promotion content and based on their visual quality that suggests both a professional design and a wide distribution.

Table 1 below presents the title of each selected campaign, its description and the name of advertisements selected as offered by CDC. All the advertisements selected in this group of data are reproduced in Appendix C, Public Display Ads from CDC Campaigns.

Table 1. CDC Health Communication and Social Marketing Campaigns Included in the Study
(Source: CDC.gov)

Campaign	Description	Selected Display Images
<p>Take Charge. Take the Test. (part of five-year Act Against AIDS national campaign, launched 2009)</p> <p>Content Source: CDC</p>	<p>Multi-faceted social marketing initiative designed to increase HIV testing among African American women. Helps African American women recognize their risk of getting HIV and the need for HIV testing. It also empowers them with information, encourages them to get tested, and enables them to take charge of their lives—whatever their HIV test result.</p> <p><i>Take Charge. Take the Test.</i>TM focuses on African American women ages 18 to 34. Young African American women can take charge of their lives by knowing their HIV status – and by taking steps to protect themselves from HIV. This campaign, which was first piloted in Cleveland and</p>	<p>Billboard</p> <p>Hug Transit Add</p> <p>Kiss Transit Add</p> <p>Banner</p>

Table 1 Cont.

	Philadelphia, helps reach thousands of African American women with important health messages about taking charge of their lives and getting tested for HIV. Visit the campaign's new Web site here 	
<p>Inside Knowledge: Get the Facts about Gynecologic Cancers</p> <p>Content Source: National Center for Chronic Disease Prevention and Health Promotion, Centers for Diseases Control and Prevention</p>	<p>Raises awareness of the five main types of gynecologic cancer. It encourages women to pay attention to their bodies and know what is normal for them, so they can recognize the warning signs of gynecologic cancers and seek medical care. When gynecologic cancers are found early, treatment is most effective.</p>	<p>“Be Brave. Ask Questions” Poster</p> <p>“Here’s What Happened” Poster</p>
<p>Screen for Life: National Colorectal Cancer Action Campaign</p> <p>Initiated in 1999</p> <p>Content Source: National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention</p>	<p>Informs men and women aged 50 years and older about the importance of having regular colorectal cancer screening tests.</p>	<p>“No Excuses” Tall 3 People Poster</p> <p>“No Excuses” Wide 4 People Poster</p> <p>“Screening Saves Lives”</p> <p>“This is Personal” Poster (color and black and white, both tall and wide)</p> <p>“Are You the Picture of Health?” Poster</p> <p>“Are You the Picture of Health?” Wide Poster</p> <p>“Art Gallery” Poster</p> <p>“Busy People” Poster</p> <p>“True or False” Poster</p>
<p>Folic Acid</p>	<p>The materials were designed, tested, refined, and produced</p>	<p>“Ready...Not” Poster For women not considering</p>

Table 1 Cont.

<p>Content source: Division of Birth Defects, National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention</p>	<p>for their specific audiences and are available for personal use or use in community activities. (Note: It is unclear if some of the materials designed are for general public display.)</p>	<p>pregnancy now or in the near future (non-contemplators).</p> <p>“Running”Poster</p> <p>“Veggies” Poster</p> <p>“Water” Poster</p> <p>These posters encourage women to make folic acid part of their healthy routine before becoming pregnant.</p>
<p>Physical Activity. The Arthritis Pain Reliever</p> <p>Campaign revised in 2010</p> <p>Content source: National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health, Centers for Disease Control and Prevention</p>	<p>Health communications campaign for general use by state health departments, their partners, and other community organizations. The campaign was developed to promote physical activity as a method of arthritis self-management. The campaign is designed to: raise awareness of physical activity as a way to manage arthritis pain and increase function; Increase understanding of how to use physical activity (types and duration) to ease arthritis symptoms and prevent further disability; enhance the confidence of persons with arthritis that they can be physically active; increase trial of physical activity behaviors.</p>	<p>“Physical Activity. The Arthritis Pain Reliever” Billboard</p> <p>“I Can’t Let Arthritis Stand in My Way” Billboard</p> <p>“Show Arthritis Who’s the Boss” Bus Shelter</p> <p>“I Need to Stay Strong” Bush Shelter</p>
<p>Show Your Love</p> <p>Content source: Centers for Disease Control and Prevention</p>	<p>National campaign designed to improve the health of women and babies by promoting preconception health and healthcare. The campaign’s main goal is to increase the number of women who plan their pregnancies</p>	<p>Posters for Women Who Want to Become Pregnant (4)</p> <p>Posters for Women Who Do Not Want to Become Pregnant (4)</p>

Table 1 Cont.

	<p>and engage in healthy behaviors <i>before</i> becoming pregnant. For those women who don't want to start a family in the near future or at all, the campaign encourages them to choose healthy behaviors so that they can be their best and achieve the goals and dreams they have set for themselves.</p>	
--	---	--

3.2.2.2 Data set 2: Health promotion/communication materials at CDC.gov readily accessible for the general public on a specific, randomly-selected day

Rather than analyzing a static set of data, my approach here was to survey a group of materials that reflect main health promotion contents at CDC.gov that are communicated to the general public and are readily available on main pages of the organization. The descriptive analysis will focus on a group of “Features” publications at CDC.gov that were available on-line on a randomly selected day: May 3rd, 2013. Under the heading of “Features”, the Office of the Associate Director for Communication, Digital Media Branch, Division of Public Affairs publishes materials of a professional communication style. Noteworthy topics include CDC observances, advice about seasonal activities and associated health risks, specific diseases, travel advisories, outbreaks, important national and global health events, or publication releases by the organization. Most of the materials are of general interest and framed for an unspecialized readership.

In addition to the “Features” items, other pages of broad interest for the general public, such as “Healthy Living”(<http://www.cdc.gov/HealthyLiving/>) and “Family Health”

[\(http://www.cdc.gov/family/\)](http://www.cdc.gov/family/) will be discussed. [\(http://www.cdc.gov/family/\)](http://www.cdc.gov/family/). These pages are likely to offer an integrated view of health promotion contents advocated to the public.

3.3 FINDINGS

3.3.1 Content, form, and the codification of health in public display ads

Public display ads in public health/health promotion. The convention of genre. (important for contextualization of analysis)

Printed health promotion posters have long been a means by which health authorities communicate specific messages to the public (Serlin et al, 2011). Speaking about the symbolical importance of health posters in public health is the celebratory publication of the volume “Public Health Campaigns: Getting the Message Across” (WHO, 2009). Created for marking sixty years of WHO existence, the book exemplifies health posters produced during the 20th century around the world. Today’s public health advertisements are generally the product of joint health professional expertise, and specialized health communication and marketing expertise. In fact, what distinguishes the current practice of health promotion/communication for mass audiences is the open adoption of principles and skills of professional marketing and advertisement communication by the health promoter or public health expert cum communicator. (ref CDC)

The authors of “Getting the Message Across” (WHO, 2009), state in the foreword of their book:

Defining what makes an effective poster is not a simple matter. Like any piece of propaganda, it is designed to persuade the viewer to do something – either to buy a product advertised or in the case of the public health poster, to modify or eliminate destructive habits. A poster can implore us to stop smoking, get vaccinated, use

condoms or not share needles. At the very least it must make us stop, if only for a few seconds, to absorb its message – a message that typically takes the form of a forceful image accompanied by hard-hitting words (WHO, 2009).

This characterization of visual health advertisements volume suggests a few important traits of these materials that are relevant for the current analysis. Public health ads are described here as persuasive discursive expression or as propaganda. Though extremely important a distinction, for my immediate analytical purpose it is less relevant to debate whether health advertisements are to be seen as expressions of an ideology in manipulative offensive – thus, as propaganda, or as ideologically neutral technical products simply borrowing commercial marketing techniques for social marketing purposes. What is pressing, though, is to clarify what is the genre to which these health advertisements belong. As discussed in the methodological section, the texts need to be properly contextualized within the conventions of a genre in order to make the discourse and visual analysis relevant. I consider that the genre of health communication through images for public display is very close to that of marketing and advertisement communication, as CDC's own descriptions suggest. Official health advertisements at CDC share with the latter the fundamental objective of a programmatic and effective manipulation of meaning in a compressed frame of visual representation. This objective is achieved by creating and refining a type of unidirectional, close-ended, usually concise communication where visual messages – usually a combination of picture and text - are deliberately encoded in such a way as to obtain a predetermined set of meanings, reactions, or behaviors in a mass audience. This is an eminently instrumental - means to ends - type of communication where, generally, a source – various entities and industries holding power and resources – transmits to the public, understood as mass consumers, engineered/crafted messages of highly intensified and concentrated contents.

Topics and objectives

The images for public display from six current CDC communication and social marketing campaigns selected here reflect their varied of topics: HIV/AIDS prevention, chronic disease prevention, including cancer and preconception preventive care. Information about these campaigns and selected images are summarized in Table 1. The campaigns selected are sponsored by different CDC organizational structures. Judging by the number, contents, and quality of their images, the campaigns are likely to have been produced with varying amounts of funding. For instance, the Act Against AIDS and the Screen for Life campaigns were probably more generously endowed, and used the expertise of highly skilled marketing and design specialists. Yet despite differing topics and resources, a first general observation to be made about the six campaigns discussed here, as well as about all the campaigns identified on the CDC.gov site, is that all reflect health concerns situated at the level of the individual.

A second important observation is that most of the times the descriptions offered in descriptive materials for the campaigns do not state directly their persuasive rationale. Instead, the objectives are described as: to help, to inform, to empower, to encourage adoption of some behavior, to raise awareness, to increase understanding, to enhance confidence, or to promote healthcare. These mild descriptors are in bold contrast with the compelling character of the images and of the messages promoted, usually framed as concise commands.

Convention of a format and the construction of message and meaning

To analyze some of the constitutive elements of the images and the techniques employed for the constitution of their message, I will describe several of the images selected starting with the “Screen for Life” portfolio. Table 2 (see page 123) offers a concise view of the texts

inscribed in each of the advertisements. I make use of these in analyzing written text in the advertisements.

3.3.1.1 Screen for Life Portfolio

- a. **“Are You the Picture of Health?”** is the poster name for two images having Katie Couric as protagonist (aside: this would make such a good title!)



Figure 2. Are You the Picture of Health? (2005), CDC.gov



Figure 3. Are You the Picture of Health? (2007) Tall, CDC.gov

In the first image, characterized by a royal blue background, we see Katie's beautified face, fit body and gym-shaped arm draped in a cream silk shirt. She offers a large smile of confidence and reassurance. Her celebrity adds a note of glamour and attractiveness. The image is conceived in a few contrasting elegant colors, and an undulating line separates the upper three quarters of the image from the bottom where several logos, including that of CDC, are inscribed. The suggestion of elegance is emphasized by the heavily ornate golden frame that Katie is holding. On the side, at the height of her head and flowing over the frame is the main text of the image framed as a question in bold white letters: "Are You the Picture of Health?" In smaller fonts, there is more text that is a direct quote from Katie; here she explains that one cannot rely on feeling and looking fine, because colorectal cancer can have no symptoms; thus, one has to get the inside story – allusion to the colonoscopy procedure that is not mentioned as such. The text only says: "so please get tested, I did." We may or, most likely, may not be able to read this paragraph from a distance. However, to the main question posed in bold letters it is obvious that we are offered an answer: Katie is a picture behind the frame that she is holding and she looks directly at us conveying the full assertive vigor of a stately standing portrait. Indeed, Katie is not only a picture, but the very picture of health and its embodiment. Why is this? Because she's famous, glamorous, associated in the public memory with losing her husband to colon cancer, and, more importantly, because it's a known fact, reiterated here, that she "got tested." The text asks about a picture, and talks about an inside story and a test; the image provides both a frame and a picture, thus suggesting two related meanings: the test is about a picture of the inside, while its result it's about being entitled to call oneself the picture of health, just as Katie is.

Another meaning is suggested by the interplay of notions of image and frame. This time, the frame may be that of a mirror and it is by mirroring processes that we, the viewers, exchange places or identify with the glamorous protagonist. To be her or to be like her, we just need to do as she did: take the test – an image-based test!

Yet the ad carries not only the image of its strong protagonist - famous, with a fit body, a muscular arm, a perfect smile and perfect make up and, but her words also. As described already, the larger sections of text in this image are direct quotes in which Katie is talking to us, questioning us, offering explanations and, finally, urging us to take action in order to be the reassured image of health that she is. Additionally though, the presence of another voice is framed in the image in the form of secondary text with information about colorectal cancer, and a final urging to talk to “your” doctor and get screened; this is accompanied by the logos of health promoting institutions. Someone else is, thus, talking directly to us from the image, though we may not be able to read the written text. Examining the ad, Katie’s voice gives way, with no transition other than that marked by smaller print fonts, to the voice of the health expert who enumerates facts about colorectal cancer and then addresses us directly (see Table 2 for the text).

Before leaving this ad, it should be noted that not only does the message convey assertiveness and reassurance, but also the suggestion of doubt. “Are you the picture of health” is a question with two possible answers, not only an affirmative one. Doubt turns to a sense of ominous danger as we are told that we may feel and look fine, but that our “inside” story might be different. However, to these worrisome suggestions, Katie’s expression and silhouette give a reassured, optimistic answer.

The second “Are you the picture of health” Katie Couric poster is constructed by building on the message and form of the previous ad – the two were produced two years apart. This time the image is downplayed in formality. Katie is still the protagonist, but dressed in cotton and not in silk; the previous frame is replaced by her hands delineating a screen or a small frame. This is a head portrait. Her smile is less open, yet still confident and encouraging. The expression of her eyes, though, retains a streak of worry and tenseness. The palette here is light, and the chromatic contrasts are subdued. Katie asks the same main question as before, and toward the bottom she tells us: “colorectal cancer is the 2nd leading cancer killing. But it doesn’t have to be.” This is signed Katie Couric, Co-Founder EIF’s National Colorectal Cancer Research Alliance. Here the signal of fear in the expression “leading cancer killer” is followed by a composed and resolute continuation: “but it doesn’t have to be.” Additional text from the health expert informs about the cancer, and ends with the same urging to get screened. The screening, alluded to by Katie’s hands, is the weapon against the leading cancer killer and her expression gives both reassurance and gravity and implies a note of serious responsibility: it’s up to you to stop the leading killer – this is not directly said, but it is, nonetheless, the irrefutable reasoning underpinning the message. The fact that it remains unspoken adds to its suggestive and persuasive power¹².

b. Another celebrity-centered piece the CRC portfolio¹³ is the Terrence Howard 2009 “**This is personal.**”

¹² I have interpreted this duo of images before (see comprehensive exam paper) as an illustration of the control-release dynamic described by Crawford as characteristic of pursuing health; additionally, it is suggestive of another dynamic described by Crawford: that of a spiraling process of escalating anxiety and worry over a health issue, followed by appeasing of the issue through exerting of some control

¹³ Meryl Streep appeared recently in a public service video – this is the newest material added to the in the “Screen for Life” campaign.



Figure 4. This is personal, black and white, CDC.gov



Figure 5. This is personal, color, CDC.gov

This is a simple image-portrait in two versions of framing of the protagonist: tighter, in black and white; and upper body in a blue sweater on a light grey background. While the framing, color and tilting of the head is different, the expression in the eyes is similar: heavy, regretful, pained, conveying not only sorrow, but a serious and subdued warning. As we understand it, this is not only personal, but frightening and serious. The rest of the text is a direct quote signed by Terrence who is addressing directly the viewer/reader: “My mother was the cornerstone of our family. When she was diagnosed with colon cancer, it was like the whole family got cancer. She died when she was only 56. Let my heartbreak be your wake-up call.” Terrence Howard, actor/musician.

The image and the text are indeed personal. The direct look and simple words and the simplicity of the composition led us to identify with the loss suffered by Terrence, and this on a very personal level where general human emotion and empathy is shared. Not only are we inclined to feel empathic with the artist, but, on his turn, he appears not only saddened about his mother, but worried for us all; hence, the urging: “let my heartbreak be your wake-up call.” The content of the wake-up call is detailed at the bottom of the image, in small prints, and it is unlikely to be readable at a glimpse; this is the informative message from CDC that is repeated in all the advertisements in this campaign; after a series of impersonal informative statements, the conclusion becomes personalized as a direct address from the expert to “you”, the viewer (see Table 2 for full text). Yet the main message of the poster is in the portrait of the artist and in his words by virtue of which the compassion we feel for him turns into a cautionary tale of danger and in a state of alert for our own health and wellbeing.

c. Another example in the “Screening for Life” series is the ad “**Busy People**” ad.



Figure 6. Screening for Life, "Busy People" ad, CDC.gov

Here again, similarly to the Katie Couric posters, the structuring device of the message is a question-answer one. The question posed, “What do these busy people have in common?” is not only a strategy for enticing the interest of the viewer, but also the visual high point of the ad.

On the left side, a rhythmic succession of images depicts a couple chatting in the middle of what is, presumably, a climbing session in open air; they are well equipped for their activity (jackets, knee pads, arm supports); they converse and smile with the bold satisfaction of those seeking and achieving, on a background of purple fades. Below is a lady with eye glasses, engaged in an intense communication, probably working, then a diver echoing with the line of the body the line of the eye glasses in the previous image, and, finally a helmeted man caught in the middle of physical exertion and exploration in open space, probably on a bike. There is a continuity of rhythm and chromatics in this series of images, all representing mature, ordinary people caught in instances of intense activity. Neither of these people looks at us, they are all in worlds oblivious to ours. Blue is the color theme of the ad, and it is a main vehicle in creating the message: one of strength, control, confidence, and determination. At the bottom of the image, the chromatic scheme of writing and background in the question part is reversed: here, on a white background, the answer to the question is written in two shades of blue; it reads: "They all got tested. If they have time, so do you." This comes as a cold, stern urging, almost as an administered injunction of reprobation for the procrastinating viewer who feels cornered and guilty. This time, the address is made by a voice from above or beyond the picture: it is the health expert who orders us in words and also provides us with role models for testing for colorectal cancer. This voice that stages the question-answer session is here the protagonist of the image. The tone of persuasion is one of bold no-nonsense command. This is direct and heavily worded, and is complemented by the images on the side that represent the illustration of the idea of ordinary but health achieving people: they are not only presented in the midst of responsible, intense and rewarding action, but we know about them that they also got tested. Since our likely excuse of being busy is squarely refuted, we are left with a sense of remorse that

can only be relieved by taking the appropriate action: getting tested as recommended. This message is openly playing with a sense of guilt, moralization, and applied injunction by the invisible expert-author behind the writing.

d. The same reference to active, mature, and responsible figures seen above is employed in the series **“No Excuses.”**



Figure 7. "No Excuses", Tall 3 People, CDC.gov



Figure 8. "No Excuses", Wide 4 People, CDC.gov

“Why Should I Get Screened?” is the question-anchor for the message. This time, the question is uttered by the ordinary people depicted in the ad – three in one version, four in another version. The umbrella question: “why should I get screened?” is answered in two ways: first, directly under the question is the answer given by the expert with no quotation marks used: because “colorectal cancer screening saves lives.” Then, as answers to a series of counter-arguments that people may raise to the proposition of testing/screening that are attached to each

proudly, confidently, victoriously, and happy – the two left and center second row images. Presumably, all these people were saved by a screening test and now continue their lives of balance, peace, simple pleasures, reassurance, and happiness.

As demonstrated so far, the “Screen for Life” portfolio is rich, with many chronological phases and likely different producers. One of the ads, titled “Art Gallery” alludes to the style of The New Yorker’s cartoons, and introduces a light, humorous note through the looks of the couple and the statement “now, that I understand” that acknowledges both the importance of screening and the unnecessary sophistication of abstract art. The “True or False” ad uses the format of a board game to convey its key information.

As clearly illustrated in the review above, the designers of the ads employed different mechanisms for viewer engagement and different tones and regimes of persuasion. This is a finding relevant for the variety of means of composition and message codification generally employed by the public displayed campaign ads discussed here. While the first written lines and their subsequent elaborations varied in the ads, all the materials in the portfolio carried also the standard text of the campaign (see Table 2) giving the public needed information about the condition and about the role of screening, and closing with an urging to get tested. This is the invariable CDC “pitch” in the ads. Table 2 provides summaries of principal and secondary texts in the images.

3.3.1.2 The Inside Knowledge Portfolio

“The Inside Knowledge” portfolio is a campaign for gynecological cancer awareness. In the posters selected here, testifying are not surviving family members of cancer victims – like Katie Couric or Terence Howard, but the illness survivors themselves.



Figure 10. Be Brave. Ask Questions, CDC.gov



Figure 11. Here's what happened, CDC.gov

The images are compelling portraits with carefully toned colors that unite protagonists and backgrounds in a sense of depth, pausing, and graveness colored by a restrained strength and hopefulness. The composition is simple, with two human figures directly looking at us. In both posters, the human figure shares the field of the image with a second presence: that of the written message. This is so placed and proportioned in the frame of the image as to suggest that the key to the poster rests precisely with it. The two women tell their story directly to us and urge the viewer for to take the desired action: pay attention to one's body signals and see the doctor. This is a relatively mild prescription that contrasts with the sense of graveness, dread, and danger hidden in the neglected and unknown "inside" connoted by the diagnoses of the two

protagonists. The key message is, in fact: you may be in serious danger; you have to be brave and ask the terrible questions.

3.3.1.3 The Act Against AIDS Portfolio

“Take Charge. Take the Test” is another high end campaign in the Act Against AIDS portfolio. “Take charge” consists of two photographic images of a couple hugging and about to be kissing, and of a poster graphics poster constructed around on the HIV letters.



Figure 12. Kiss Transit Ad, CDC.gov



Figure 13. Hug Transit Ad, CDC.gov



Figure 14. Billboard, CDC.gov

In the kissing image, we can only see the face of the woman: she is the target of the message, with her are supposed to identify other young African-American women looking at the ad. The image has a highly cosmetic quality, with elaborate makeup and nail care. Tenderness and erotic attraction envelops the two young and beautiful people in the image, while their lips and the space between them configure the visual high point of the picture. Tenderness is also the

theme of the hugging image that emphasizes now more a sense of closeness and security rather than one of eroticism. The same chromatics unite the two posters: subdued pinks, purples and browns give an air of protected intimacy and secludedness. The written part of these two images employs the red, black and white color scheme that distinguishes the entire Act Against AIDS portfolio, and that configures the third ad shown here where “take charge, take the test” accompany a modified graphology of HIV: the high geometry of H and V written in white on the black background is centered by a metamorphosis of the letter A: an elegant woman silhouette distinguished by force: the movement of the arms, the muscular shape of the legs. In all these ads, it is the expert author who articulates the written text and the implicit message. In fact, there are two conflicting messages that the ads set in motion. On one hand, the images affirm, accept, and celebrate a sense of mutual trust, tenderness, and erotic attraction. On the other hand, the compellingly presented text says otherwise: the woman needs to preserve a sense of doubt and suspicion about her partner; it is not about his person, per se, but about his history. Furthermore, while the images acknowledge and reinforce a woman’s legitimate right to enjoy unrestricted emotional and physical closeness in a couple, the text introduces a conflicting cautionary demand: you should stay alert, you should go beyond your feeling of knowing him in every way, you should investigate your HIV/his HIV status, you should be in the know, and, above all, be in charge of your life. The text advocates a sense of deliberate distancing of the woman in order to achieve self emancipation for health interests. Grounded in the tension between the conflicting urgings in the picture and in the accompanying text, the recommendation to simply and free of charge get tested becomes virtually irrefutable. In doing so, the woman is acknowledged to respond not only to a health imperative, but to the demand to break her dependence to a man by taking charge and control of her own self and life.

3.3.1.4 Other Campaign Portfolios

Differently from the group of ads described above, the ones in the “**Arthritis pain**” (see images 1-3 x Appendix) and the ones in the “**Folic acid**” – for the latter, specifically the posters titled “Veggies”, “Walking” and “Water” (images 2-3y Appendix) display a simpler orchestration of message and meaning, in the sense that there is a straightforward continuity between image, text, and the title of the ads. The images serve as bold illustration to the text and present happy individuals asserting prescribed actions: walking, eating properly, exercising, and enjoying their activities.

In-between this usage of image illustrating straightforwardly the message characteristic of these two campaigns and the sophisticated interplay of image and text in the previous group probably stand the posters in the “**Show your love**” campaign for preconception care.

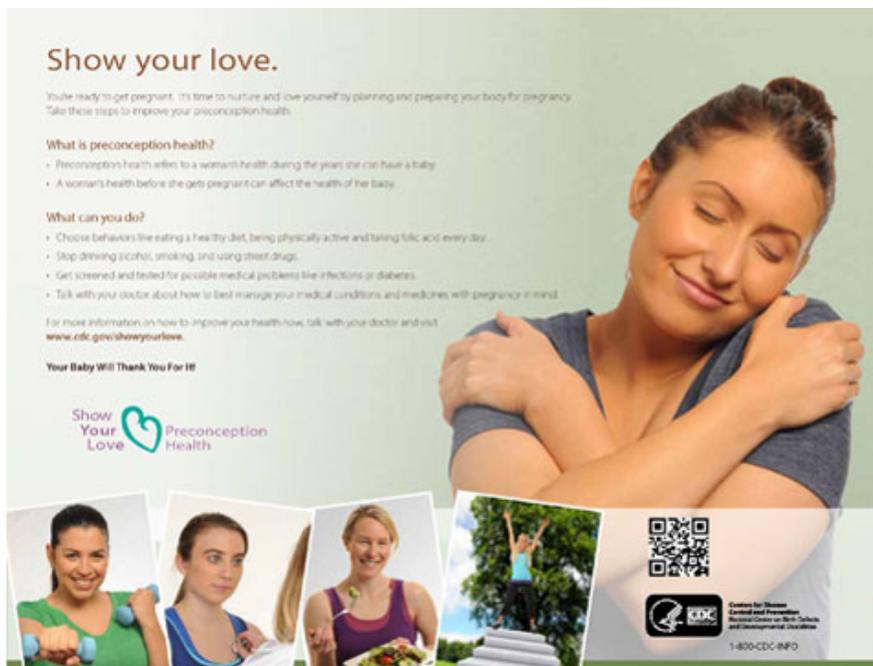


Figure 15. Show your love, Caucasian female, CDC.gov

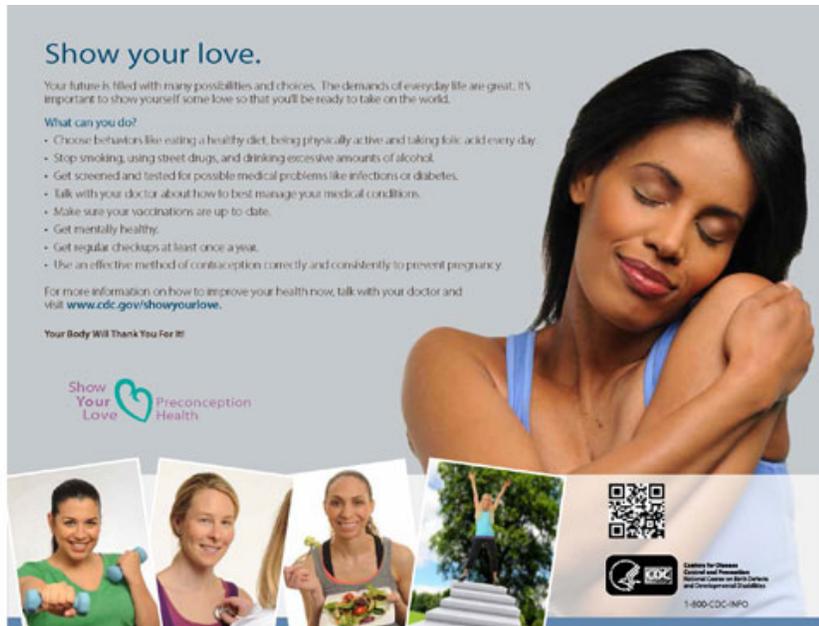


Figure 16. Show your love, African American female, CDC.gov

Here, the images of the woman-prospective mother and of the child free woman are only evocative of the desired outcome: a happy, healthy baby, and a healthy life with or without a baby. Smaller images at the bottom of some of the posters in these series model the actions by which this state is to be achieved, while the lengthy written text details these measures in a laundry list of healthy lifestyle measures. Reproduced below is the text in the “Poster for Women who Do Not Want to Become Pregnant”, part of the “Show Your Love” national campaign.:

Your future is filled with many possibilities and choices. The demands of everyday life are great. It’s important to show yourself some love so that you’ll be ready to take on the world.

What can you do?

- Choose behaviors like eating a healthy diet, being physically active and taking folic acid every day.
- Stop smoking, using street drugs, and drinking excessive amounts of alcohol.

- Get screened and tested for possible medical problems like infections or diabetes.
- Talk with your doctor about how to best manage your medical conditions.
- Make sure your vaccinations are up-to-date.
- Get mentally healthy.
- Get regular checkups at least once a year.
- Use an effective method of contraception correctly and consistently to prevent pregnancy.

For more information on how to improve your health now, talk with your doctor and Visit www.cdc.gov/showyourlove.

Your Body Will Thank You For It!

Here in eight bulleted command sentences is concentrated a regimen for/of health that will ensure that one is adequately ready to “take on the world.” The discrepancy between the triteness and discrete character of these presented measures and the scope of the motivating outcome – a life filled with the promise of great opportunities, demands, and, maybe commensurate success – is the same noted in the interviews with health coaches. “To improve your health now” - the one before last sentence in the ad, means not only that your body will have reason to thank you for it, but also that your life will be good. As an aside, it should be noted the involuntary humor in the order to “get mentally healthy,” as well as the reinforcement of a formal health care standard by which a healthy young woman should see the doctor at least once a year. An additional point that deserves mentioning on the side of the “Show your love” ads is that for the purposes of this campaign, the authors felt that it was enough to use the same picture-text structure for urging “preconception care” in both women planning or not planning to have children. “Show your love” could mean both showing love and care for oneself as for one’s prospective baby, and

preconception care could easily mean general care. This would be a generous and suggestive take, yet the advertiser opted for the communication technique whereby the message in the beginning – here “show your love” – is echoed and reinforced in the last sentence of the text. Here, we are left to understand that there is no difference of nature between the motivator love for one’s baby and love for one’s own body. In the effort of applying persuasive techniques by the book, the designers of these ads overstepped a deeper and far more important layer of meaning, namely the sacrificial nature of motherhood. This has nothing to do with one’s body thanking oneself for its fitness and healthfulness. This is but one instance that exemplifies how health advertisements with moral codes in society, as the advertisement genre more generally has been shown to do since Goffman’s groundbreaking “Gender Advertisements” (1979). I will return shortly to the aspect of morally charged roles and meanings configured by this collection of public display ads after reviewing the vocabulary displayed in the ads analyzed here.

Vocabulary and speech

In section above I focused on the interplay of image and written text in encoding meaning in the messages analyzed. It is now helpful to analyze the language and style of address used in creating the advertisements. Table 2 offers a compressed view of the text included in the ads in this selection.

Table 2. Texts in Selected Public Display Advertisements (Source CDC.gov)

Advertisement Title	Main Text	Secondary text
Take Charge Billboard	Take Charge. Take the Test.	Get an HIV Test and Look Out for Yourself
Take Charge Hug Transit	You know him. But you can’t know everything.	Get a free HIV Test
Take Charge Kiss Transit	You feel like as if you’ve known him forever, but that doesn’t mean you know	Get a free HIV Test.

Table 2 Cont.

	everything.	
Take Charge Banner	You know him. But you can't know everything.	Get a free HIV Test.
Be Brave. Ask Questions	Be Brave. Ask Questions	<p>I had abdominal pain and periods that weren't normal for me. Menopause, I thought. But no, I had uterine and ovarian cancers.</p> <p>If you have symptoms lasting two weeks or longer, be brave. Go to the doctor. Ask questions. —Jenny Allen Writer/performer</p> <p>“I Got Sick Then I Got Better”</p> <p>Symptoms are not the same for everyone. Learn more. Get the Facts</p>
Here's What Happened	<p>Here's what happened... (My story may help you “I knew something wasn't right. I had a little bloating and some lower back pain. But what really worried me was the bleeding between periods. It wasn't normal for me. It turned out I had ovarian and uterine cancers. Getting diagnosed and treated wasn't easy. But now my doctor and I are optimistic about my future. Please listen to your body. If something doesn't feel normal for two weeks or longer, see your doctor.”</p> <p>– Jennie M., Washington, D.C</p>	<p>Gynecologic cancer includes cervical, ovarian, uterine, vaginal, and vulvar cancers. Signs and symptoms are not the same foreverybody...so get the facts.</p> <p>Get the Inside Knowledge. Get the facts about gynecologic cancer.</p>
No Excuses Tall 3 People No Excuses Wide 4 People	Why Should I Get Screened?	Colorectal Cancer Screening Saves Lives. Colorectal cancer is the 2nd leading cancer killer in the U.S. But it can be prevented. Screening helps find precancerous polyps so they

Table 2 Cont.

		<p>can be removed before they turn into cancer. Screening can also find colorectal cancer early, when treatment is most effective. If you're 50 or older—don't wait. Talk to your doctor and get screened.</p>
<p>Screening Saves Lives</p>	<p>Colorectal cancer is the 2nd leading cancer killer in the U.S. But it doesn't have to be.</p>	<p>Getting screened for colorectal cancer beginning at age 50 helps prevent the disease. Screening finds precancerous polyps so they can be removed before they turn into cancer. Screening also finds colorectal cancer early, when treatment can be most effective. This is one cancer you can prevent! If you're 50 or older, get screened for colorectal cancer. Screening Saves Lives.</p>
<p>This is Personal (color and black and white, both tall and wide)</p>	<p>This is personal. "My mother was the cornerstone of our family. When she was diagnosed with colon cancer, it was like the whole family got cancer. She died when she was only 56. Let my heartbreak be your wake-up call." --Terrence Howard, actor/musician</p>	<p>Colorectal cancer is the second leading cancer killer in the U.S., but it is largely preventable. If you're 50 or older, please get screened. Screening finds precancerous polyps, so they can be removed before they turn into cancer. And screening finds colorectal cancer early, when treatment works best. If you're at increased risk—if you have a personal or family history of polyps or colorectal cancer, or you have inflammatory bowel disease—ask your doctor when to start screening. Screening saves lives.</p>
<p>Are You the Picture of Health?</p>	<p>Are You the Picture of Health? "You might look and feel fine, but you need to get the inside story. Colorectal cancer often has no symptoms, so please get tested. I did."</p>	<p>Screening can detect precancerous polyps so they can be removed before they turn into colorectal cancer. Screening also can find colorectal cancer early, when the chance for a full recovery is very high. If you're 50 or older,</p>

Table 2 Cont.

	Katie Couric, Co-Founder EIF's National Colorectal Cancer Research Alliance	talk to your doctor and get screened for colorectal cancer.
Are You the Picture of Health? Wide	Are You the Picture of Health?	<p>“Colorectal cancer is the 2nd leading cancer killer. But it doesn't have to be.”</p> <p>Katie Couric, Co-Founder EIF's National Colorectal Cancer Research Alliance</p> <p>Colorectal cancer and precancerous polyps don't always cause symptoms. So you can look healthy and feel fine and not know there may be a problem.</p> <ul style="list-style-type: none"> • Screening helps find polyps so they can be removed before they turn into colorectal cancer. This is one cancer you can prevent! • Screening can also find colorectal cancer early, when treatment often leads to a cure. • If you're 50 or older, make sure you really are the picture of health. Get screened for colorectal cancer.
Art Gallery	Colorectal Screening Saves Lives. “Now THAT I Understand”	<p>If you're over 50, get tested for colorectal cancer.</p> <p>Polyps and colorectal cancer don't always cause symptoms. That's why screening is so important... screening helps find precancerous polyps, so they can be removed before they turn into cancer.</p> <p>See your doctor and get screened.TM</p>
Busy People	What do these busy people have in common? They all got tested for colorectal cancer. If	<p>Screening saves lives.</p> <p>Screening tests help find precancerous polyps so they</p>

Table 2 Cont.

	they have time, so do you.	can be removed before they turn into cancer. If you're over 50, take time to see your doctor and get screened.
True or False	"True or False?"	Testing for colorectal cancer can save your life. Screening tests can find precancerous polyps so they can be removed before they turn into cancer. Screening can also find colorectal cancer early, when treatment is most effective. Talk to your doctor and Screen for Life.
Ready...Not	You may not be ready to have a baby, but your body's been preparing for years. Folic Acid Now.	So your body's ready when you are.
Running Veggies Water	Folic Acid is part of my healthy lifestyle!	I take 400 micrograms (mcg) of folic acid every day as part of my daily routine. Just like eating nutritious food, drinking plenty of water and exercising is important for my health, taking folic acid every day can help me get my body ready for when I decide to have a baby. Folic acid is a B vitamin that helps prevent some birth defects of the baby's brain and spine. You can help prevent serious birth defects of your baby's brain and spine. Talk with your doctor about taking 400 mcg of folic acid. There are two easy ways to be sure to get enough folic acid each day: 1. Take a vitamin that has folic acid in it every day. Most multivitamins sold in the United States have the amount of folic acid women need each day. Women can also choose to take a small pill (supplement) that has only folic acid in it

Table 2 Cont.

		<p>each day. or 2. Eat a bowl of breakfast cereal that has 100% of the daily value of folic acid every day. Not every cereal has this amount. Check the label on the side of the box, and look for one that has “100%” next to folic acid. www.cdc.gov/ncbddd/folicacid</p>
Physical Activity. The <i>Arthritis Pain Reliever</i> ”	<p>Physical activity. The <i>arthritis</i> pain reliever. www.cdc.gov/Arthritis</p>	<p>Arthritis Foundation. Take Control. We Can Help.</p>
I Can’t Let Arthritis Stand in My Way	<p>I can’t let <i>arthritis</i> stand in my way.</p>	<p>www.cdc.gov/Arthritis Arthritis Foundation. Take Control. We Can Help.</p>
Show Arthritis Who’s the Boss	<p>Show arthritis who’s the boss.</p>	<p>Living with arthritis pain? Time to show it who’s boss. Studies show that regular, moderate physical activity helps reduce arthritis pain and fatigue and improve your mood. www.cdc.gov/Arthritis Physical Activity. The Arthritis Pain Reliever.</p>
I Need to Stay Strong	<p>Even with arthritis I need to stay strong.</p>	<p>People are depending on you. Don’t let arthritis slow you down. Studies show that regular, moderate physical activity can reduce your arthritis pain and fatigue and improve your mood. www.cdc.gov/Arthritis Physical Activity. The Arthritis Pain Reliever.</p>
Posters for Women Who Want to Become Pregnant	<p>Show Your Love. Your Baby Will Thank You for It!</p>	<p>You’re ready to get pregnant. It’s time to nurture and love yourself by planning and preparing your body for pregnancy. Take these steps to improve</p>

Table 2 Cont.

		<p>your preconception health.</p> <p>What is preconception health?</p> <ul style="list-style-type: none"> • Preconception health refers to a woman’s health during the years she can have a baby. • A woman’s health before she gets pregnant can affect the health of her baby. <p>What can you do?</p> <ul style="list-style-type: none"> • Choose behaviors like eating a healthy diet, being physically active and taking folic acid every day. • Stop drinking alcohol, smoking, and using street drugs. • Get screened and tested for possible medical problems like infections or diabetes. • Talk with your doctor about how to best manage your medical conditions and medicines with pregnancy in mind. <p>For more information on how to improve your health now, talk with your doctor and visit www.cdc.gov/showyourlove. Your Baby Will Thank You For It!</p>
<p>Posters for Women Who Do Not Want to Become Pregnant</p>	<p>Show your love. (Your Body Will Thank You For It!)</p>	<p>Your future is filled with many possibilities and choices. The demands of everyday life are great. It’s important to show yourself some love so that you’ll be ready to take on the world.</p> <p>What can you do?</p> <ul style="list-style-type: none"> • Choose behaviors like eating a healthy diet, being physically active and taking folic acid every day.

Table 2 Cont.

		<ul style="list-style-type: none"> • Stop smoking, using street drugs, and drinking excessive amounts of alcohol. • Get screened and tested for possible medical problems like infections or diabetes. • Talk with your doctor about how to best manage your medical conditions. • Make sure your vaccinations are up-to-date. • Get mentally healthy. • Get regular checkups at least once a year. • Use an effective method of contraception correctly and consistently to prevent pregnancy. <p>For more information on how to improve your health now, talk with your doctor and Visit www.cdc.gov/showyourlove. Your Body Will Thank You For It!</p>
--	--	--

Several elements can be readily noted. The communication is made from the protagonists in the ads – represented by images or, rarely, by text only - to the viewer/reader. The voice making the address is most of the times that of the main character complemented by that of the impersonal expert author. In a few cases, the voice of the expert is the main voice directly manifested in the ads. The communication in the ads is concentrated in action verbs that are in many cases used in the vocative verbal tense. These verbs center succinct sentences of command. Throughout the text of the ads, the first person pronoun for the source making the utterance/speech is sublimated in the verb, while the second person pronoun stating the receiver - “you” - is repeatedly emphasized. This compression of the authorial presence in the verbs with

the emphasizing of the addressee contributes to the persuasive tone of the ads and emphasizes the unbalanced power dynamic between the two terms of the communication: author/protagonist and reader.

Another aspect of importance is the recurrence of lexical terms constitutive of the language of health as individual rational control and moral responsibility – the language of “self-made health” analyzed in the narrative of health offered by health coaches. A review of the texts employed by the ads, including their titles, speaks clearly about this preference for the language of individual control that is accompanied, in some cases, with plain expressions of moralizations. For exemplifications, collected from Table 2, a list of these expressions includes: take charge, look out for yourself, take control of your life, show arthritis who’s the boss, don’t let arthritis stand in your way, be brave, go the doctor, ask questions, learn more, get the facts, no excuses, wake-up call, my healthy lifestyle, this is personal, be ready, or I need to stay strong, or take these steps.

Conclusion

In the analysis above, a series of important features of health promotion and disease prevention public display advertisement were apparent. For instance, all the ads analyzed use a single-frame representation, typically consisting of a combination of image, writing and other graphic symbols, such as logos. We have seen that most of the ads employ an imagery of photographic quality with little spatial depth in composition. Almost unanimously, the main characters in the ads are human figures. Some ads have a single dominant figure, other use series of human figures. The human figure can be famous or ordinary. All characters are visually treated so as to attain the cosmetic “poster” quality typical of entertainment products; looking in

this way, they represent active, determinate, brave, euthymic and responsible adults. Without the specific dimension added by the written text and logos that codify the voice of the expert, the imagery employed in these ads is not specific to health messages, but is interchangeable with the imagery of advertisements for any other products, such as bank financial services, fitness clubs, or spas to name a few. As one health coach said, the images can speak about anything, that is, they might try to sell anything and nothing in particular. A cultural and moral stereotype is reinforced here: that of the responsible individual who is strong, proactive, and upbeat, and thus a personification of successful control of self and of one's life.

The specific messages proposed are articulated by the association of picture and text in a register of eminent directness, while less visible mechanisms of suggestion, mirroring, introduction of leverage points, and association of meanings are responsible for the overall persuasive effect of the ads. The persuasive potential of the ads rests to a good extent on encoding – in images and in words – such notions as success, achievement, responsibility, attractiveness, but also of notions of worry, suffering, worry, guilt, fear, alert and insecurity. Expressions of optimism and triumphant confidence alternate with those of angst and dread of cancer - the ominous unknown.

The perspective or angle from which the messages are framed is typically that of the main character(s) in the image; to this angle, a second perspective, that of the official expert is added. Sometimes the integration of the two is very tight in the creation of the message; other times, they remain distinct. A single voice, that of the expert, or multiple voices, necessarily including the presence of the expert author manifested through official recommendations and technical descriptions, as well as through institutional logos, such as CDC, are employed in each piece.

The persuasive strength of these images for public display derives from yet another mechanism in addition to their encoding voices of authority and a repertoire of ideas, emotions, and moral codes mentioned above. This additional persuasive potential derives precisely from the format and situations in which the ads are displayed. Usually large singular structures, the ads rise above the mass of anonymous passers-by; in contrast to the look of street level life, these images profess a degree of cosmetization and glamorification of physical appearances. They look like a reality enhanced by means of processed, marketable images characteristic of the representation of celebrity in entertainment media. While nothing in the frame of an ad is there by accident and every detail is the effect of tight calculation, the highly elaborated messaging procedures and the composition of the ads lead to an impression of spontaneity, authenticity and attractiveness.

Overall, the main subject of these ads can be said to be precisely the pervasive professional conception of health promotion. More specifically, as this analysis demonstrates, the major theme in this group of health promotion ads is that of individual assertion of control or simply of control. In all the messages, the key recurring motif is that of the recovery of the individual from an existing or potential health problem through expert-prescribed action. Both theme and motif emerge from linguistically and also encoded in the visual imagery employed. Thus, health promotion public display ads consecrate and reinforce in the social space a specific notion of health: health as expert-recommended individual control. By repetition, these messages ritualize the conception of individual mastery and control over health through active health measures, and, more generally, of individual mastery and control over one's life.

A final observation regards the topical contents of the campaigns at CDC listed in the "Gateway to Health Communication and Social Marketing" page address: infectious disease

prevention (AIDS); cancer prevention (colorectal cancer and gynecological cancers); secondary prevention of chronic disease (arthritis, heart disease); birth defects prevention; healthy habits: smoking and tobacco, exercise, nutrition, interpersonal respect; developmental milestones in children; antibiotic use – all address factors and conditions at the level of the individual. Under the title “other campaigns” several resources about setting community health programs are listed, yet these are in no way community health campaigns. Thus, a most notable finding of surveying CDC.gov in this study is that CDC’s portfolio of public communication campaigns does not include, to date, any campaign about community, social, structural or environmental determinants of health.

These things being said, it is now time to turn our attention to how is health signified in health promotion in on-line health communication discourse at CDC, specifically in the permanently renewed “Features” production available at the top of the main page of CDC.gov.

3.3.2 Health communication for the general public in main CDC on-line pages

I examine here materials posted on the main page of CDC.gov, and especially “Features” materials highly visible and readily accessible on this page. These are posted on the top of the main online page and contain written and visual texts framed for general audiences. The following descriptive-analytical account is composed by re-enacting in real time the trajectory of many searches of CDC.gov performed previously for the purpose of this study. This is a “hic et nunc” compositional device whereby I describe and analyze the contents of materials as I open their on-line pages. In doing so, my assumption is that this process is similar to that likely undertaken by any interested reader of CDC.gov that has had the attention caught by a “Features” item at the top of the main page and then moves freely from link to link.

I start my exploration on the main page at CDC.gov, and I simply follow principal links and read the materials provided. As a rule, I try to avoid telescoping into multiple ramifications of referenced links. On May 3rd, a randomly selected day for the search detailed below, CDC's main page presented itself as follows:



Figure 17. Budget for Health Feature, CDC.gov

Upon opening www.CDC.gov, on the top front there is an image accompanied by some text; more such materials, in smaller size, are listed on the left field of the page. All of them are part of the “Features” publications at CDC.gov. This rubric is maintained by the Division of News and Electronic Media, and has an important purposive communication agenda that covers many health promotion items. By clicking the “All CDC Features” link, the content previously offered on the left of the main page now becomes center-page, while what was previously listed on the main page under “Health topics and conditions” and “For specific groups” is now presented in a bar on the left of the page. I will analyze sequentially the elements of the page reproduced below:

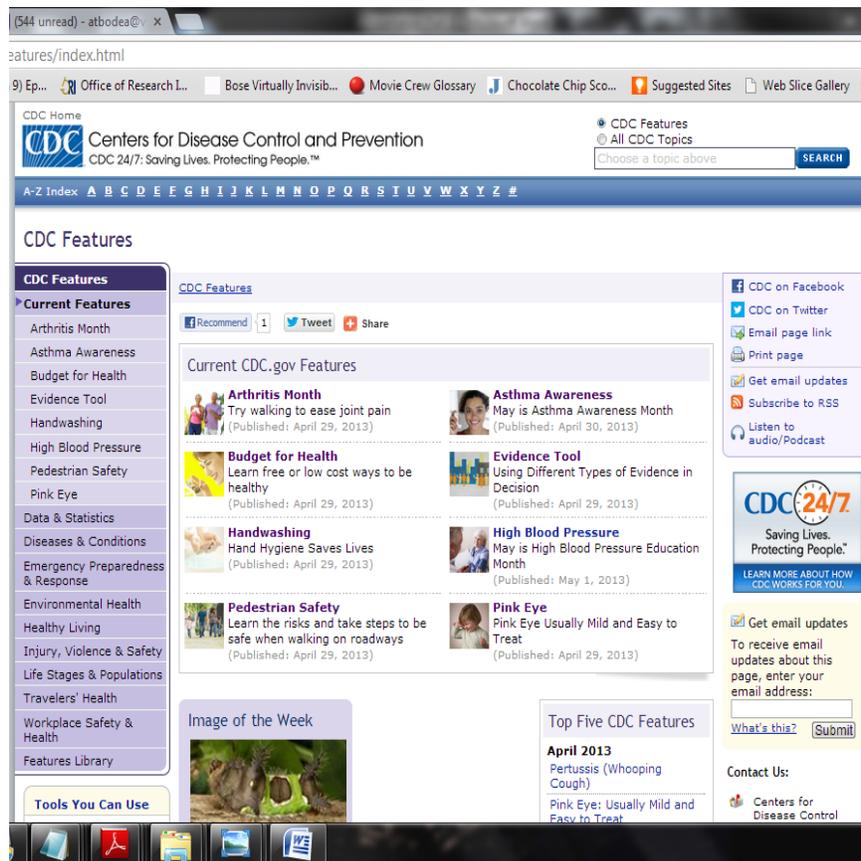
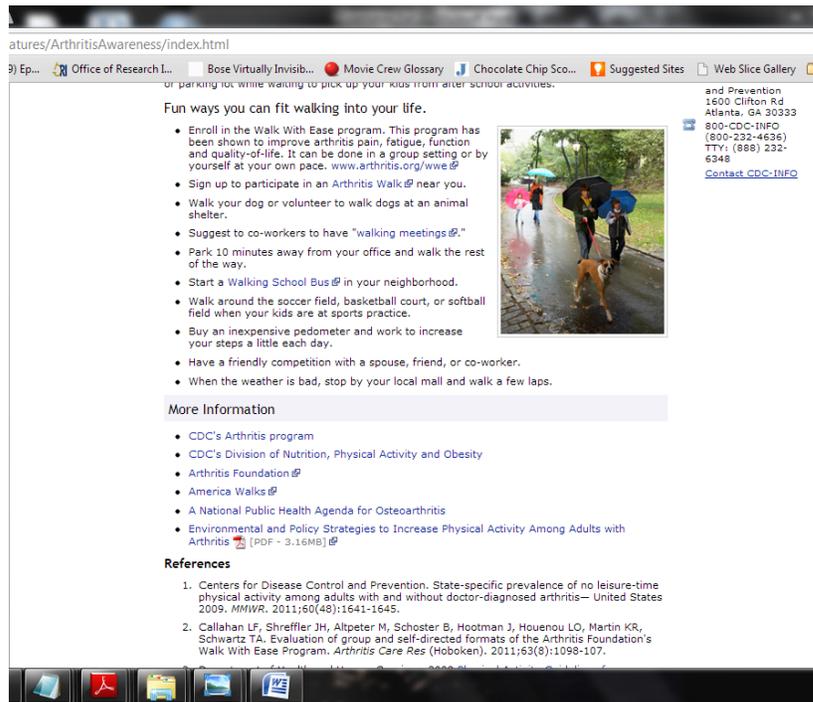
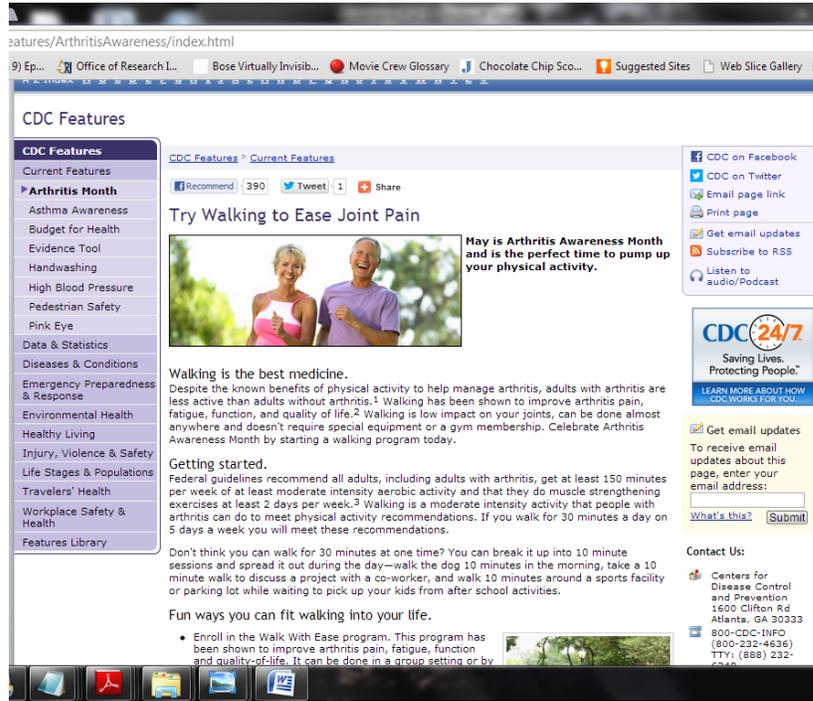


Figure 18. CDC Features, May 3rd, 2013, CDC.gov

Arthritis Month is the first item on the left column. Its page is reproduced below, in

Figure 20 that comprises three

windows(<http://www.cdc.gov/Features/ArthritisAwareness/index.html>, accessed May 3).



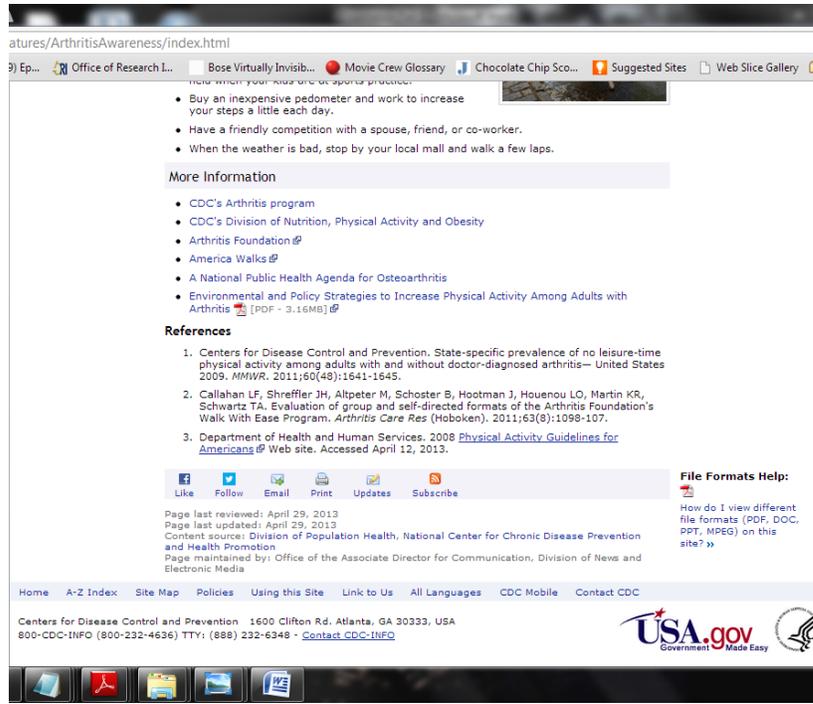


Figure 19. Arthritis Feature page, May 3rd, 2013, CDC.gov

The key message of this material is conveyed by the image on top and the associated writing in bold prints:



May is Arthritis Awareness Month and is the perfect time to pump up your physical activity.

Figure 20. Arthritis Month Feature, May 3, 2013, CDC.gov

The image is centered by a couple moving in open air, on a sunny, green background. Framed from bottom of ribcage up, the two figures move shoulder to shoulder and are perfectly synchronized. Judging by the slant of their bodies and the position of their arms they are either running or walking briskly. They are dressed in sporting apparel of pastel color. The tilted bodies

energize the entire image by pulling the eye it toward the right corner in the viewer's perspective. The woman is looking at us and has an open, energized and confident smile. The man's gaze is not discernible, yet his mouth is open in a large smile of satisfaction and enjoyment. The wide white of their teeth is two-fold focal point of the image. They are feeling good, worry less, confident and they are exercising. Next to the image, in one composed sentence we are given the key to the message of active and happy adulthood embedded in the image: this is about arthritis, awareness, and taking action in the form of intensified exercising: "May is the Arthritis Awareness Month and is the perfect time to pump up your physical activity." While this announcement-command is adjoined to the image, there is no confusion about the fact that the words are not spoken by the couple shown in action, but by another authorial instance: the health expert at CDC. The written message first states authoritatively that "May is Arthritis Awareness Month" - the capitalized name of the event, part of a series of health observances maintained by CDC, gives stature to the topic. The word "awareness" signals that something needs to be known and done better about the topic. What is due for accomplishment is specified immediately as a statement-recommendation that clarifies the goal of this particular observance: you need to "pump up" your physical activity. In a reversed ordering of words, the message says: you need to exercise vigorously and you have to be aware of your arthritis; this is imperative because of the "awareness month" and it's also perfectly matched with the nice weather; so you have to do it.

Subsequent text gives the rationale for enhanced physical activity and specifies means for doing it.

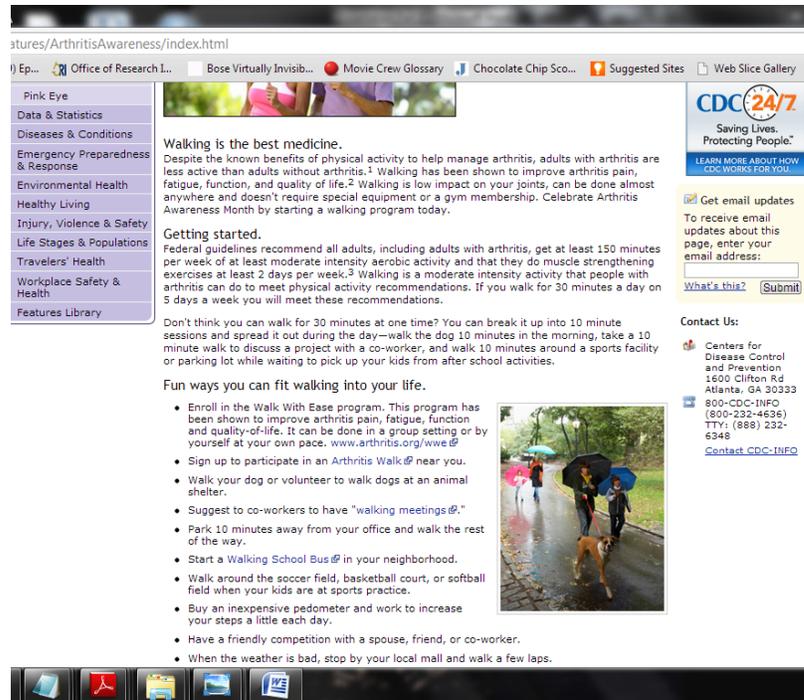


Figure 21. Detail from the Arthritis Month Feature page, May 3, 2013, CDC.gov

Under “Walking is the best medicine,” we are told that according to research persons affected by arthritis tend to exercise less; this is framed as one of the problems with arthritis. Immediately after this elaboration, walking is presented as readily accessible anywhere and anyhow. The prescribed solution, framed grammatically as an imperative, reads “celebrate the Arthritis Awareness Month” by means of “starting a walking program today.” Of note, we see associated here two action verbs, start and walk, coupled with the imperiousness of “today” and with the idea of a deliberate, rationally structured activity: a program. Overall, we are presented with a persuasive message grounded in the apodictic authority of arthritis science that is conveyed by expert health communicators. The message advocates a rational solution to the problem of people affected of arthritis who are avoiding exercise: a program of “pumped up” physical activity.

In the second paragraph, “Getting Started”, the same structuring of information as above is employed: first we are told what are the federal guidelines for physical activity, and then we

are offered practical suggestions for situations when walking can be readily implemented by individuals. Here walking, a fundamental human function is presented as a scientifically proven medium for achieving moderate intensity activity. Walking is justified as a means to an end and not only feasible and accessible, but having the merit of helping people “to meet physical activity recommendations” set by health experts. The subsequent paragraph, together with the information under “Fun ways you can fit walking into your life” mollify the sternness of the previous recommendations by letting people see that walking sessions do not have to be 150 minutes, but as short sessions as one can take, even only 10 minutes. The official, serious, and consequential imperative to be physically active is here turned into unthreatening moving around, accessorized with the quality of being “fun.” Toward the end of serious purposeful health action cum fun, the experts provide a list of suggestions, such as walking alone or in a group of people, walking in or around the mall or the sports field, in the park, on the street, around the work place – accompanied not only by colleagues but by a pedometer, and so on.

Deconstructed, the reasoning in the page appears as follows: science and experts show that pumped-up physical activity is good for your arthritis; thus, you have to be aware both of your condition and of the recommendations for it, and to take action: walk! It can be fun too, or even – as the people on the top of the page tell us – it can turn into exercise bliss: anywhere, anytime.

A few communicative strategies are apparent in this example. First, the voice of the expert is embedded in two distinct registers: one scientific and one colloquial. Using the informality of vocabulary of the latter, bold prescriptions-commands are addressed to the public with just a hint of technical jargon, such as “awareness.” The second element that can be observed in the construction of the page is the association of written text with images, whereby

images light up the page and concentrate in an appealing form the model action proposed in the material. The function of images placed on the page is different according to their position: the image on top is designed to carry the persuasive thrust of the featured material, while other images on the side support or laterally illustrate the written text without making an impact on their own. Additionally, the association between two contrasting domains of meaning is obvious on this page: on one hand, the domain of seriousness, obligation, accountability, planned action and effort, and, on the other hand, the domain of fun, triumphant achievement, worry free fitness, or relaxation. The health communicator assumes here that health prescriptions/orders are, can be, and must be fun. Finally, we should note the triteness in the content of suggested physical activities: these are simple and common facts of daily life draped in the tone of technical expertise.

“Budget for Health” (<http://www.cdc.gov/Features/BudgetForHealth/index.html> accessed on May 3rd) is another feature of the month at CDC. It presents itself as a combination of image and text, as follows:

On a Budget? Learn Cheap Ways to Be Healthy



Learn free or low-cost ways to be healthy.

Any time is a good time to save money, be healthy, and be informed. Making healthy choices may help prevent injury, disease, and disability. Stay healthy on the cheap by including smart choices that are low-cost or free. Many are simple too, such as the following.

Figure 22. Top Image CDC Feature "On a Budget?", May 3, 2013, CDC. gov

The opening image is striking through the color of the background: poster-like neon citron on which the woman is tightly framed in a three quarter profile and in neutral colors. The image is punctuated by the line of the eyebrows and eyelashes, the tint of lipstick, and the pearl in the ear lobe that add lively visual interest. An engaged teeth smile is present as the woman counts 20 dollar bills, looking at the money. She is happy – presumably about the money she has saved; she also looks beautiful, young, healthy, and active: so many more reasons to feel happy. Overall, the image conveys a sense of practicality in daily life discreetly imbued by a hint of glamour and desirability. Applied to the image, the key written message is “she has learned free or low-cost ways to be healthy.” The phrase emphasizes the link between the notions of learning, budgeting, and being healthy. The introductory text is composed of several brief sentences. In a slight variation from the text next to the image, this time connected in the first sentence are the notions of saving money, being healthy, and being informed; to these, “time” is added as an additional key word. The tone is that of a house-keeping magazine, quickly replaced by a health professional one: “making healthy choices may help prevent injury, disease, and disability.” Here, “making healthy choices” is the catchphrase while the use of “may” introduces the suggestion of probabilistic science and is followed by plain health jargon: “prevent injury, disease, and disability.” The urging in the message is to stay healthy on the cheap by making smart choices. The last two sentences solidify the direct relation between being healthy and making inexpensive choices; both are “smart choices”, and making these, as the image recommends us, is implied to address simultaneously one’s health and budget with the added merit of being - albeit only sometimes – the simplest way to follow. In the subsequent text, expert explanations are accompanied by practical tips organized in two categories: “every day health” and “nutrition and physical activity.” Under each, there are itemized straightforward

commands. Their list is very telling for the domains of life and health addressed here by the health expert: stop smoking; find affordable health care; subscribe to text4baby; get recommended vaccines; avoid unnecessary medicines; be active; choose beans instead of meat; breastfeed; have an “ingredient potluck”; buy seasonal; buy canned or frozen fruits and veggies - note the childishly endearing shorthanded version for “vegetables”; grow your own food; limit food portions; drink water; look for store brands; and use coupons. For each item, succinct rationales are provided, and the angle of cost is incorporated in all as a leverage justification/motivator for “taking control.” Practical advice for saving money is used here as a device to capture the good will of the reader and to motivate him to make expert-supported healthy or “smart” choices.

The eye goes next to the **“Asthma Control”** feature (<http://www.cdc.gov/Features/AsthmaAwareness/index.html>, accessed on May 3rd, 2013). This page is also driven by an opening image accompanied by a line of text:

May is Asthma Awareness Month



Learn to control your asthma.

Figure 23. Asthma Awareness Month CDC Feature, May 3, 2013, CDC.gov

Dominant here is the urge to learn to control one’s asthma. This is framed as a direct communication from the health expert who is embedded in the imperative verbal tense (learn) and also codified in the top captioning as well as in the white medication device. Like in the previous items discussed, the communication is apodictic, unidirectional, and boldly prescriptive.

This is a common characteristic of much of the communication directed at the generic individual in the general public on the pages of CDC.gov. It can be observed that features of stern clinical environments, such as the bluish background and the white device in the first plan, are masked under devices of attractiveness common to the advertising industry. Here, the young woman whose face is tightly framed fills most of the field of the image; she is frontally looking at us with a sincere and warm gaze accompanied by a pleasant, warm and large smile that shows white beautiful teeth. She gives the impression of serene confidence and control as she holds, in the first plane of the image, the inhaler ready to be used. In the rest of written material on this page, each paragraph opens with an epidemiologic and clinical knowledge laconic phrase “asthma is one of the most common lifelong conditions”, “asthma affects people of all ages and all backgrounds.” The crux of the message follows this stage setting and consists of urging those affected by the condition to control it and to ensure its successful management. This is stated to result in a symptom-free, unrestricted life regimen. Mirroring the current ideology of “patient-driven” healthcare, in this text the medical care providers are portrayed as subordinate helpers of the person affected by asthma. The latter is supposed to drive and direct the process of controlling the condition, which, to be successful requires no less than the affected individual having the responsibility to know and recognize symptoms and triggering factors, to ask medical providers for the right medication and the right dosage, and to administer it judiciously. The page also contains an image with two bikers on a trail, and a toddler playing by the sea. Control leads to an active, pleasant life free of the worries of breathing with difficulty. There is no mentioning in the text about any research efforts at understanding the causation and prevention of asthma. Recommended at the end of this text is a link for The National Center for Environmental Health at CDC. Opening this link <http://www.cdc.gov/nceh/>, the page appears headed by the asthma

piece discussed above and by two additional items (see image on next page.) One is “asthma awareness month” – this time talking about asthma in children and urging parents to “help your child gain control over asthma.” Again, there is no discussion on this page about the role of environmental factors in asthma. The other one, is titled “Your Health, Your Environment” and presents a woman wearing lab protection equipment and operating a piece of machinery. Under the image, a subtitle reads: “coming out of the toxic clouds.” While both titles suggest toxic pollutants in the atmosphere, additional text explains: “Work in NCEH’s Tobacco Laboratory helps reduce exposure to secondhand smoke.” For the reader who would stop her explorations of environmental health on this page, the contents of this public health domain appears drastically underrepresented.



Figure 24. Asthma Awareness and other items on the page of the National Center for Environmental Health, May 3, 2013, CDC.gov

Going back on the “Features” page, “**Pedestrian Safety**”

(<http://www.cdc.gov/Features/PedestrianSafety/index.html>) is another publication of the month.

The top of the page is reproduced below:

Walk This Way! Taking Steps for Pedestrian Safety



Take steps to be safe when walking on roadways. This includes exercising caution at intersections and crosswalks and increasing your visibility at night by wearing retro-reflective clothing and carrying flashlights.

Walking is good for your health, and it's good for the environment too. But before you head out on foot for a stroll, power walk, or errand, there are important safety tips to remember.

Figure 25. Walk This Way! CDC Feature, May 3, 2013, CDC.gov

Here, the reader receives the encouragement–command to “walk this way!” This refers precisely to walking not in a recommended direction but in a recommended fashion. If walking is considered “good” for both one’s health and for the environment, it is also presented here as a major vulnerability in traffic. Thus, it is not enough for the individual and his/her family to stroll or walk, but to analyze the risks of walking before leaving the house, and to take necessary safety steps. The image employed depicts a leisurely family stroll in an urban context. The image is differently designed from the ones discussed before: rather than the effect of the deliberations in a photographic session, it feels more like a real life snap shot illustrative of casual walking. The expert advice provided for walkers on this page is divided under the headings: “what’s the problem?”; “who’s at risk?”; “take steps for safety”; and “special tips for children.” It is remarkable how walking is framed first as a problem for which predisposing risk factors are

epidemiologically identified and for which action is recommended in the form of “steps for safety.” These so called steps are, in fact, common sense measures constitutive of the daily life of people who adapt spontaneously to their environments of either high or low traffic risks.

I will leave aside the features “Evidence Tool” and “Handwashing” – the former clearly addressing professionals, the latter emphasizing handwashing in clinical settings, as well as the “Pink Eye” material, this simply for the interest of not overburdening my reader, and I will discuss the last feature piece offered on the day of May 3rd: “**High Blood Pressure**” (<http://www.cdc.gov/Features/HighBloodPressure/index.html>). The heading of the page presents itself as follows:

When it comes to Blood Pressure, Make Control Your Goal



May is High Blood Pressure Education Month. Have you talked about a goal for your blood pressure with your health care provider? If not, do it at your next visit.

Figure 26. Blood Pressure Control, CDC Feature, May 3, 2013, CDC.gov

The written line on top of the image introduces the topic: blood pressure in the context of the Education Month. This is followed by the core of the message, the recommendation to “make control your goal.” This action is detailed in the text below the image: the individual is urged to make controlling blood pressure a personal deliberate goal; to give the goal some concrete measure; and, finally, to be in control of it – one is considered in charge when engaging purposefully the health care provider toward obtaining a preselected value as blood pressure goal. A gently pointing finger of the health promoter/communicator is manifest here: “have you

done this yet? If not, do it at your next visit.” The tone conveys the confidence of the expert communicator that the reader has the necessary sense of determination, empowerment, and personal responsibility to do as recommended in the ad. Like in the previous images, the smile is not absent here either. The “provider”, most likely a male physician who is interacting with the smiling woman in the second plan of the image, seems pleasantly smiling, the head tilted, stethoscope in the ear; he is shown from the back in a partial profile. The fact that we can see the patient’s face as she interacts with the doctor may be a suggestion of the fact that the patient is the one leading the therapeutic plan for high blood pressure. Yet the dyadic framing of the two in the image may equally suggest that the power and responsibility dynamic is evenly shared between the two actors, or even a contrary idea to the one advertised in the material: you are in control and in charge precisely because you are in your doctor’s hands. An indication of the relevance of the latter interpretation is the progression of paragraph titles in the subsequent text from the excessively informal “keep it down there!” to “make control your goal” to the concluding section on “helping patients make control their goal.” The programmatic insistence on deliberate action and personal responsibility of the individual for controlling her blood pressure is obvious here, and involves the medical expert in a novel role - not that of treating high blood pressure, but of “helping patients make control their goal.” As in the asthma ad, what is visible here is the attempt to reformulate the traditional therapeutic dynamic by shifting the responsibility of chronic disease control from the clinician to the patient. In this redefinition of roles, what is lost in the authority of the physician is transferred to the authority of the health promoter/communicator, whose task appears to be eminently that of conveying non-essential and trite recommendations framed as scientific expertise.

After the review of the “Features” above, a number of observations are possible. First, these on-line pieces are clear examples of calculated goal-oriented professional one-on-one health communication from a generic health promoter expert to a generic lay reader. The control over the form and content of the material, over the framing of its message, and over its distribution stays entirely with the health expert.

The key feature common to all the materials reviewed above is their insistence on representing health issues, their causes and remedies as a function of deliberate individual controls and actions. This is a characteristic of most health promotion communication pieces with a persuasive agenda archived in the “Features Library,” as demonstrated by a cursory review of the items published since 2010.

Returning to the analysis of the “Features” available on May 3rd, this suggested that common messaging techniques include synergizing pictures and text and employing straightforward commands complemented by suggestive and appealing images. These messages make, evoke, enact and reinforce codes of physical, moral, and social desirability. The texts of these materials are crafted by layering technical terms, such as names of diagnoses or epidemiological notions of spread of a condition and specific risks associated, with common vocabulary and colloquial expressions whose informality almost upsets the norms of social distance in public address among strangers – “pump up,” “keep it down there!” or “veggies” introduce a sense of familiarity and closeness between the author and the reader that may serve motivating the latter: since we are buddies with the experts who speaks to us like to friends from childhood, we better do what they say. At the same time, the use of over colloquial terms contrasting with technical formal ones serves at adding apodictic authority to the latter and at infantilizing and diminishing the reader. In all the text reviewed, it is obvious the recurrence of

the vocabulary of individual rational control, programmatic action and personal responsibility: take control, be in charge, set goals, make good healthy choices, or understand risks and take action in the form of steps.

The authority and voice of the health expert representing CDC is manifest in direct and indirect ways in the messages above. Although the “I” or “we” of those making the speech are always sublimated in the direct imperatives used to mobilize the public – the text reads “learn,” not “I recommend that you learn” - there is no uncertainty about the fact that it is the health expert talking directly to a specific individual reader – “you.” At the beginning of each piece, this author usually gives a key order of varying persuasive tonality ranging from firm command to more playfully energized or gentler tones. Subsequent text, written and visual, relays the key imperative already enunciated to fanning out reprises of multiple justifying elements and advices that articulate an argument and restate in a consolidated form the key message in the first order. These techniques of structuring a message are typical of time-compressed “effective” genres of communication in advertisement and journalism, where the audiences are given the content of the message in a form likely to be decoded in ways desired by its authors.

I mentioned before the putative infantilization of the public by the usage of over familiar expressions. The “Feature” pieces reviewed here hint to another aspect of infantilizing or dumbing down the public, namely to the displacement of common sense, daily life adult autonomy over such fundamental aspects as walking, shopping for food, or cooking with friends by the expertise of the health promoter whose recommendations are trite in content.

3.3.3 An additional exploration of main pages at CDC.gov: the representation of supra-individual determinants of health

Returning on the main page of CDC.gov, I explored the rubric “Health and Safety Topics” that is offered right under the selected “Feature” of the day. I went directly to the link for “Healthy Living” (<http://www.cdc.gov/HealthyLiving/>), with the assumption was that a reader interested in the proactive cultivation of health would select this title. The link is in the second position after “Diseases and Conditions.” Additionally, this “Healthy Living” link was referenced as additional resource in the “Features” publications reviewed above. My guiding question at this point was where can the general public learn about structural, environmental, or social determinants of health, about community health and about supra-individual actions for health?

The page “Healthy Living” offers, under the title “Staying Healthy” a variegated alphabetical list of thirty nine links that map the domain of health.



Figure 27. Staying Healthy, May 3, 2013, CDC.gov

Most of these links offer a mix of technical and general use information about health concerns situated at the level of individuals on biological and functional dimensions (e.g., genetics, folic acid, bone health, sleep health, oral health, mental health); related to gender and age specific issues (reproductive health, pregnancy, breastfeeding, adolescent health, ageing); related to risk factors (tobacco, overweight, alcohol); situational (travel, swimming); or condition-specific levels (cancer, stroke, blood pressure). The only representation of the category of system-level health issues in the list of thirty nine items is offered by two links: environmental health and food safety. Before visiting these pages, I stopped on an additional link offered on the “Healthy Living” page, in the upper left rubric titled “Campaigns and Programs:” “Healthy Communities Program.” The “Healthy Communities Program” page <http://www.cdc.gov/healthycommunitiesprogram/> opens as follows:

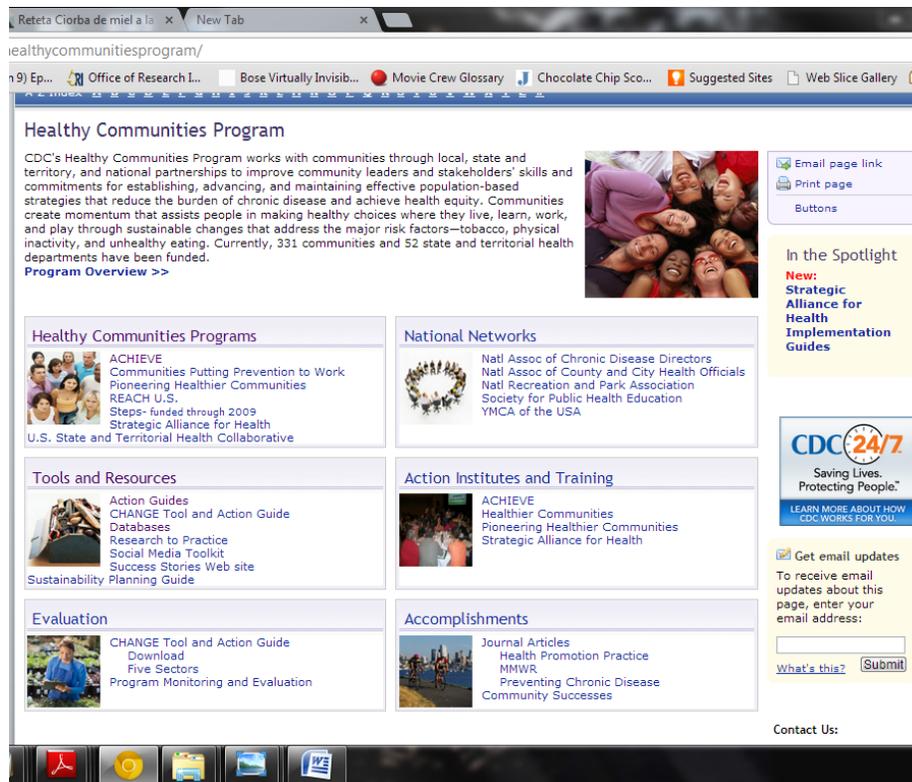


Figure 28. Healthy Community Program, May 4, 2013, CDC.gov

The image accompanying the introductory text represents a group of young women lying with their heads in a circle, seen from above. They are all smiling or laughing. There is no readily available message for the general public about what constitutes community health, why this is important, or how is it to be pursued. The introductory text reads:

CDC's Healthy Communities Program works with communities through local, state and territory, and national partnerships to improve community leaders and stakeholders' skills and commitments for establishing, advancing, and maintaining effective population-based strategies that reduce the burden of chronic disease and achieve health equity. Communities create momentum that assists people in making healthy choices where they live, learn, work, and play through sustainable changes that address the major risk factors—tobacco, physical inactivity, and unhealthy eating.

(<http://www.cdc.gov/healthycommunitiesprogram/> accessed on May 3rd, 2013)

Clearly, this is a general informative description without persuasive elements, that employs an overall phrasing structure and jargon characteristic of the technocratic and

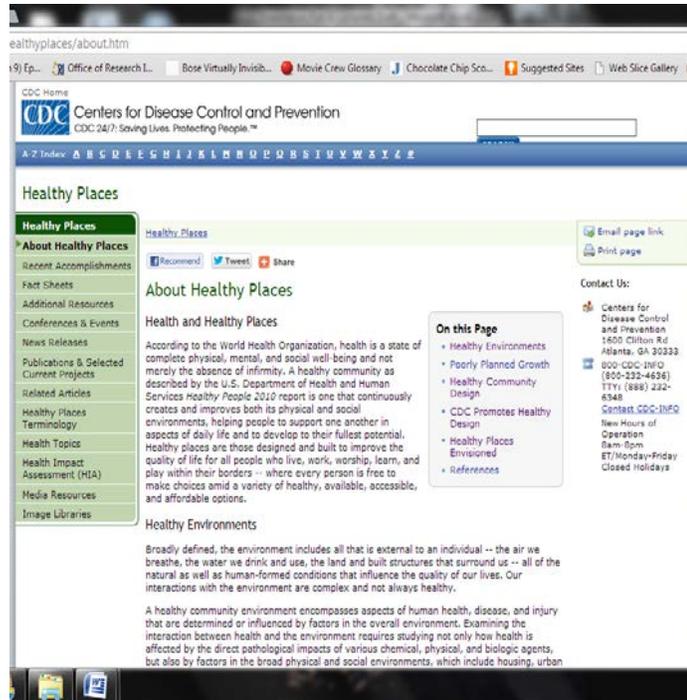
managerial/organizational discourse of the public health planner: long syntactical structures, cumulative nouns, and unexplained technical notions such as “health equity,” “population-based,” or “burden of disease,” or “sustainable changes.”

The page about “Food Safety” (<http://www.cdc.gov/foodsafety/>) talks mainly about outbreaks and foodborne diseases; information about the safety of food systems in general, including issues of food production, processing, or the distribution and quality of widely available foods is not present on this page.

The page “Environmental Health” (<http://www.cdc.gov/foodsafety/>) offers a series of links; the eye is caught by “healthy homes” and “healthy places”. “Healthy Homes” (at <http://www.cdc.gov/foodsafety/>) offers a brief description of the importance of home environments that support and promote health in a holistic fashion. The page is relatively light in links and imagery and of a technical-informational rather than persuasive tone.

The Healthy Places link leads to the page “Designing and Building Healthy Places” (<http://www.cdc.gov/healthyplaces/>) This page as well as some affiliated links, such as “About Healthy Places” <http://www.cdc.gov/healthyplaces/about.htm> speak directly to the understanding of health promotion characteristic of the “third revolution in public health” whereby the generation of health is linked to the equitable premises for a good quality of life for all members of society and to complex interactions among multiple determinants. The understanding of the interplay among supra-individual natural and built environments, social-political and cultural environments, and biological determinants of health is critical in this equation. However, other than a heading about activities directed at policymakers, there is no direct mentioning of social and political determinants of health on this page.

The page “About Healthy Places”, see Figure 30 below, <http://www.cdc.gov/healthyplaces/about.htm> offers an all text screen divided in several titled sections. No images are included here.



healthyplaces/about.htm

9) Ep... Office of Research L... Bose Virtually Invisib... Movie Crew Glossary Chocolate Chip Sco... Suggested Sites Web Slice Gallery

interaction between health and the environment requires studying not only how health is affected by the direct pathological impacts of various chemical, physical, and biologic agents, but also by factors in the broad physical and social environments, which include housing, urban development, land use, transportation, industry, and agriculture.

Since 1900, life expectancy in the United States has increased by approximately 40 years. Only seven of those years can be attributed to improvements in disease care while the rest are the result of improved prevention efforts (such as immunizations) and improved environmental conditions, including sanitation and water. The link between the nation's health and the environment is unmistakable.

Poorly Planned Growth

Poorly planned growth that fails to consider regional implications is often referred to as "sprawl." Sprawl is a complex pattern of land use, transportation, and social and economic development. Traits associated with the concept of sprawl include--

- The disappearance of farmland, fields, and natural woodland as cities expand outward and consume once-rural or natural areas
- Large tracts of land converted into low-density housing, commercial settlements, or paved parking lots
- Widespread strip commercial development along major transportation corridors
- Low-density residential and commercial developments
- Sporadic (or "leapfrog") developments with large spaces of vacant land between them
- No centralized planning of land uses
- Zoning laws that segregate land uses into isolated categories, separating housing from schools, businesses, and recreational areas
- Dominance of the automobile as the primary means of transportation
- Extensive road construction to accommodate the automobile -- development that either ignores or eliminates the social integrity of neighborhoods
- Increased traffic congestion, poor air quality, contaminated water and land, and scarce affordable housing
- Less safety for pedestrians, bicyclists, and automobile occupants

[Top of Page](#)

Healthy Community Design

In April 2002, the American Planning Association (APA) adopted a definition of smart growth, with one of the six critical elements being to promote public health and healthy communities. APA defines smart growth as using comprehensive planning to guide, design, develop, revitalize and build communities for all that:

healthyplaces/about.htm

9) Ep... Office of Research L... Bose Virtually Invisib... Movie Crew Glossary Chocolate Chip Sco... Suggested Sites Web Slice Gallery

[Top of Page](#)

Healthy Community Design

In April 2002, the American Planning Association (APA) adopted a definition of smart growth, with one of the six critical elements being to promote public health and healthy communities. APA defines smart growth as using comprehensive planning to guide, design, develop, revitalize and build communities for all that:

- Have a unique sense of community and place;
- Preserve and enhance valuable natural and cultural resources;
- Equitably distribute the costs and benefits of development;
- Expand the range of transportation, employment, and housing choices in a fiscally responsible manner;
- Value long-range, region-wide sustainability rather than short-term, incremental, or geographically isolated actions; and
- **Promote public health and healthy communities.**

[Top of Page](#)

CDC Promotes Healthy Community Design

CDC is committed to forming new partnerships and seeking solutions to community-wide public health problems. Every person has a stake in environmental public health. As the environment deteriorates, so does the physical and mental health of the people within it.

In a commentary appearing in the *Journal of the American Medical Association* (Vol 284, Oct 4, 2000), Jeffrey Koplan, MD, MPH, then director of CDC, stated that in spite of earlier progress, "The environment will be increasingly challenged by toxic exposures, population growth, continued urbanization, and urban design that hinder healthy behaviors, such as physical activity."

The former director of CDC's National Center for Environmental Health, Richard Jackson, MD, MPH in the preface to the monograph *Creating a Healthy Environment* (2001), stated:
 "We must be alert to the health benefits, including less stress, lower blood pressure, and overall improved physical and mental health, that can result when people live and work in accessible, safe, well-designed, thoughtful structures and landscapes."

[Top of Page](#)

Healthy Places Envisioned

Since World War II, the American landscape has changed. The growth of suburbia was fueled in the 1950s and 1960s by a growing trend in automobile ownership and government-subsidized road-building projects. Some residential areas were well-served by economic and industrial

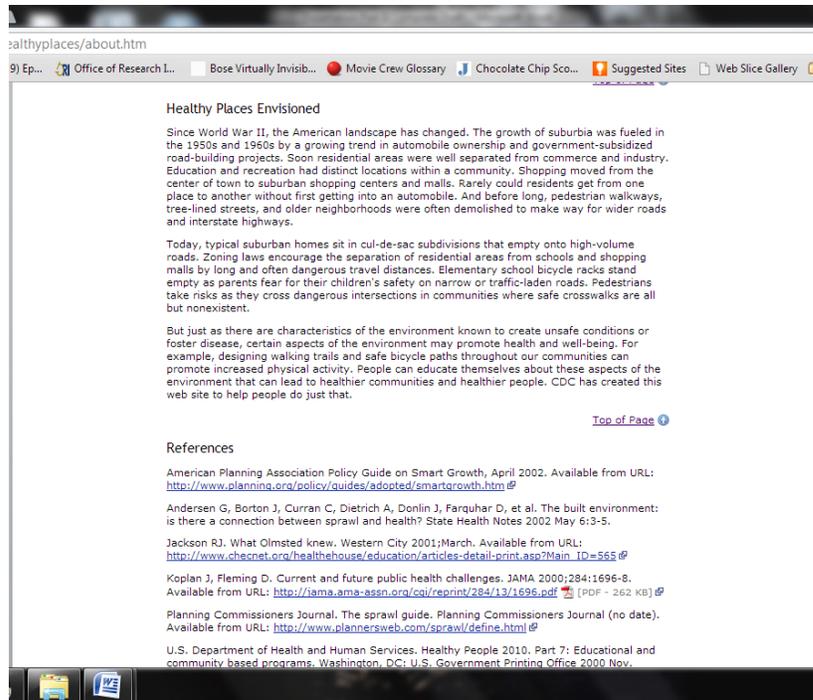


Figure 29. About Healthy Places, May 22, 2013, CDC.gov

At about the middle of the scrolled image, healthy community design is described as follows:

Healthy Community Design

In April 2002, the American Planning Association (APA) adopted a definition of smart growth, with one of the six critical elements being to promote public health and healthy communities. APA defines smart growth as using comprehensive planning to guide, design, develop, revitalize and build communities for all that:

Have a unique sense of community and place;

Preserve and enhance valuable natural and cultural resources;

Equitably distribute the costs and benefits of development;

Expand the range of transportation, employment, and housing choices in a fiscally responsible manner;

Value long-range, region-wide sustainability rather than short-term, incremental, or geographically isolated actions; and

Promote public health and healthy communities.

<http://www.cdc.gov/healthyplaces/about.htm> accessed on May 3rd, 2013

This framing of promoting healthy communities is solitary and hidden in the numerous pages reviewed in my extensive browsing of CDC. The place where this information is available and its abstract and descriptive rather than prescriptive content suggest that this is not a page written with the general public in mind.

If the pages above address health in relation to people’s homes, places, and communities, CDC also offers a page about “Family Health” (<http://www.cdc.gov/family/>). This page is accessible from the main page at CDC.gov and is also cross-referenced on many disease prevention and health promotion pages. The “Family Health” page is very dense in links and resources that cover a vast domain of practical and health advice of general addressability. Like the “Features” page, it employs revolving highlighted topics by seasonal interests – such as advice for a healthy swimming or for Memorial Day gatherings.

This page has as logo the following image accompanied by text:

Family Health



Helping families be safer, healthier, and stronger.

Figure 30. Family Health, CDC.gov

Here, as the composite image suggests, health it’s all about individuals in interaction with their family members. The overall aspect of the page is very dense; because the page is unusually long, it is reproduced below in Figure 32 in four distinct frames:

CDC - Family Health - Home | Reteta Ciorba de miel a la | New Tab

www.cdc.gov/family/

GradeBook | MADE (Season 9) Ep... | Office of Research I... | Bose Virtually Invisib... | Movie Crew Glos

Family Health

Resources

- Family Health Home
- What's New
- Health-e-Cards
- Podcasts
- Widgets
- Site Map

Healthy Living

- Check-Up Checklist
- Check-Ups are Important
- Five Minutes for Health
- Five-Minute Weekly Tips
- Health and Safety Quizzes
- Healthy Living Calendars
- Healthy Living Tips
- Tips for a Healthy Life

Healthy Times

- Autumn Tips
- Camping Tips
- Family Reunion Tips
- Gardening Tips
- Halloween Tips
 - Healthy Halloween
- Prom Tips
- Spring Break Tips
- Valentine Tips
- Wedding Tips
- Winter Holiday Tips

Healthy People

- Administrative Professionals
- College Students
- Families with Special Needs

Family Health



Helping families be safer, healthier, and stronger.

In the Spotlight

2013 Healthy Living Calendars
Healthy Living calendars promote daily tips to use for a safer and healthier life. Calendars are now available for download.

Kids' Health RSS
Stay updated with new content from CDC on kids' health. From this page you can subscribe to CDC or other US Government RSS feeds or view content directly on this page without having to use an aggregator. [Subscribe to the Kids' Health RSS feed.](#)

Healthy Families

Engaged Parents Have Healthier Adolescents
Students whose parents are engaged in their school lives are more likely to practice healthy behaviors and succeed academically.

Chickenpox Can Be Serious: Protect Your Child
Most children with chickenpox completely recover. But it can be serious, even fatal, for babies, adolescents, and adults. Be proactive. Get vaccinated if you are not protected against chickenpox.

Antibiotics Aren't Always the Answer
Antibiotics do not fight infections caused by viruses like colds, most sore throats and bronchitis, and some ear infections. Unneeded antibiotics may lead to future antibiotic-resistant infections. Symptom relief might be the best treatment option.

Traveling Overseas? Consider Getting Insurance
If you are planning an international trip, there are 3 types of insurance

[Email this page](#)

[Printer-friendly version](#)

[Get email updates](#)

[XML](#) | [RSS](#) | [RSS Help](#)

Free Information for You & Your Baby.



Text **BABY** to **511411**

[text4baby](#)

Alcohol Awareness Month

Take a **day off** from **drinking** this week.

[healthfinder.gov](#)

Winter Tips

- CO Poisoning
- Handwashing
- Influenza (Flu)
- Natural Disasters

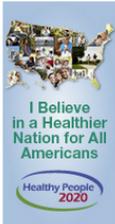
CDC - Family Health - Home | Reteta Ciorba de miel a la | New Tab

www.cdc.gov/family/

GradeBook | MADE (Season 9) Ep... | Office of Research L... | Bose Virtually Invisib... | Movie Crew Glos...

- Families with Special Needs
- Kids and Teens
- Women
- Men
- Spanish Speakers

Contact Us
Centers for Disease Control and Prevention
4770 Buford Highway,
MS E-89
Atlanta Georgia 30341
Phone: 770-488-8190



Traveling Overseas? Consider Getting Insurance
If you are planning an international trip, there are 3 types of insurance you should consider: trip cancellation insurance, travel health insurance, and medical evacuation insurance. These will cover different situations and may give you financial peace of mind, as well as allowing for safe and healthy travel.

Inspiration for a Healthy New Year
Make being healthy your resolution and find ways to get and stay healthy this year. Meet three people who changed their health habits—and their lives. Here are their stories and tips for making healthy living easier.

Helping Parents Cope With Disaster
Anyone who is a parent knows how hard it can be to raise a child. Add a stressful situation, like a natural disaster or other emergencies, and a difficult job gets even harder. If you are prepared for potential disasters, you can be more confident in your ability to keep your family safe, and your children are likely to handle the disaster better as well.

[TOP OF PAGE](#)

Healthy Communities

Making Health Easier: Healthy Changes Start in Preschool
The video highlights the efforts of one educational organization, Los Angeles Universal Preschool (LAUP), to keep kids healthy at an early age. Childhood obesity now affects approximately one in six kids and disproportionately affects low-income and minority populations.

2013 Student Opportunities in Public Health
Whether you are looking for a summer internship or a year-long fellowship, these programs provide valuable exposure to a wide range of public health opportunities. Jump Start Your Future - Apply Today!

Provider Resources for Vaccine Conversations with Parents
Making time to talk with parents about vaccines during the well-child visit may be challenging. Provider Resources for Vaccine Conversations with Parents help you assess parents' needs, identify the role they want to play in making decisions for their child's health, and then communicate in ways that meet their needs.

Let's Stop HIV Together
Let's Stop HIV Together highlights the fact that HIV touches every corner of American society and that people with the infection are part of the fabric of our families and valued members of our communities.

Related Links

- Influenza (Flu)
- Natural Disasters
- Pneumonia
- Winter Travel
- Winter Weather
- Asthma
- Family Health History
- Parent Portal
- Vaccines and Immunizations

More Information

- Women's Health
- Men's Health
- Kids' Health
- Health Disparities
- CDC Healthy Living
- Spanish: Etapas de la vida

CDC - Family Health - Home | Reteta Ciorba de miel a la | New Tab

www.cdc.gov/family/

GradeBook | MADE (Season 9) Ep... | Office of Research L... | Bose Virtually Invisib... | Movie Crew Glos...

Let's Stop HIV Together
Let's Stop HIV Together highlights the fact that HIV touches every corner of American society and that people with the infection are part of the fabric of our families and valued members of our communities.

[TOP OF PAGE](#)

Science and Research

2011 Sexually Transmitted Diseases Surveillance: STDs in Adolescents and Young Adults
Sexually Transmitted Disease Surveillance 2011 presents statistics and trends for sexually transmitted diseases (STDs) in the United States through 2011. This annual publication is intended as a reference document for policy makers, program managers, health planners, researchers, and others who are concerned with the public health implications of these diseases.

National Surveillance of Asthma: United States, 2001–2010
The number of persons with asthma increased 2.9% each year, from 20.3 million persons in 2001 to 25.7 million persons in 2010. Of the 25.7 million, 7.0 million were children and 18.7 million were adults. Among children aged 0–17 years, current asthma (prevalence increased at a rate of 1.4% per year.

STD Trends in the United States: 2011 National Data for Chlamydia, Gonorrhea, and Syphilis
STDs are a significant health challenge facing the United States. CDC estimates that 19 million new STD infections occur every year in this country.

HIV Among Youth in the U.S. Vital Signs
About 50,000 people are infected with HIV each year, and 1 in 4 is 13 to 24 years old. Youth make up 7% of the more than 1 million people in the US living with HIV. About 12,000 youth were infected with HIV in 2010. The greatest number of infections occurred among gay and bisexual youth. Nearly half of all new infections among youth occur in African American males.

Vital Signs: HIV Infection, Testing, and Risk Behaviors Among Youths — United States
Prevalence of diagnosed HIV was 69.5 per 100,000 youths at the end of 2009. Youths accounted for 12,200 (25.7%) new HIV infections in 2010. Of these, 7,000 (57.4%) were among blacks/African Americans, 2,390 (19.6%) among Hispanics/Latinos, and 2,380 (19.5%) among whites; 8,800 (72.1%) were attributed to male-to-male sexual contact.

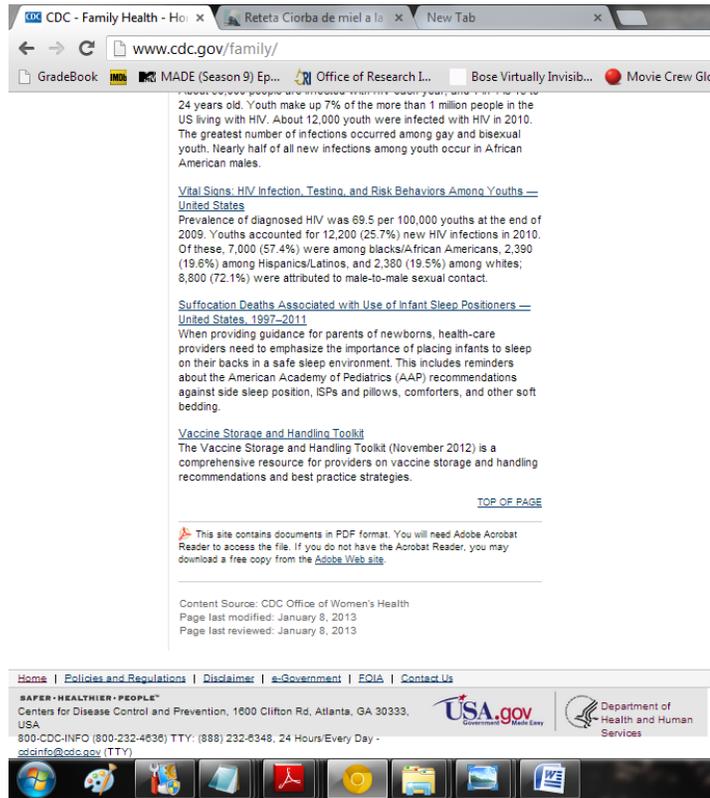


Figure 31. Family Health page, CDC.gov

Community health is represented here by a special rubric, toward the middle of the scrolling page. The links subsumed to this heading are reproduced below:

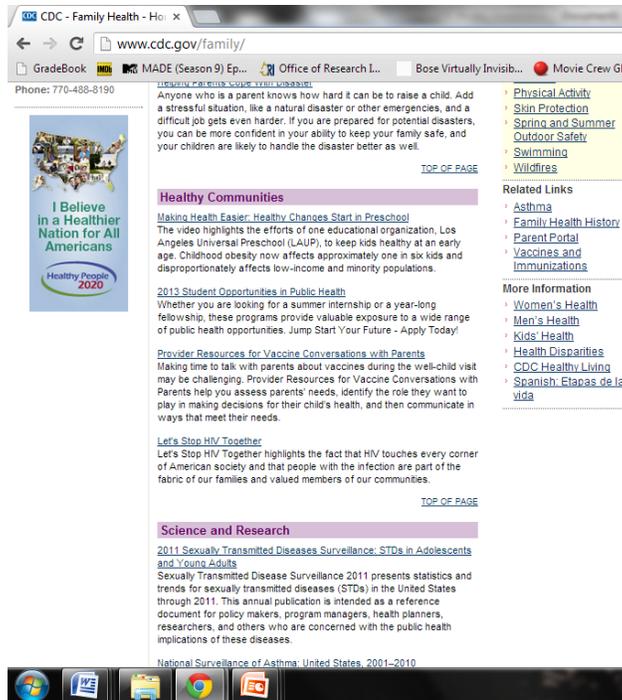


Figure 32. Healthy Communities, Family Health page, CDC.gov

In stark contrast to the information about community health provided in the pages regarding environmental health, the four links listed here suggest an accident of editing or a lack of understanding of the topic. Despite this aspect, the “Family Health” webpage contains a wealth of informative and prescriptive-persuasive commentary and resources, both written and visual that frame the dominant understanding of health promotion as rational control and responsibility of the individual. Each link on the left bar deserves special attention, for both style of communication and for the minutia of common sense advice amassed here that encompasses the attractions of each season, traveling advice, prom party advice, wedding advice, and so on. Checklists and pages for writing one’s sets of life and health goals that are to be revisited regularly abound. The imagery associated centers on happy people shown laughing; of different ages, their images demonstrate and prescribe how good life can feel when health and all other things are under personal control. A more detailed consideration of this page can form the

substance of a distinct case-study. This expedited review can ascertain, though, that most content on this page is aimed at the general public, is communicated with heavily directive and persuasive tones, and has the goal of ensuring that the reader will embrace an individually responsible, active, and rational regimen for health promotion. All this detailed communicative exercise resembles in word and spirit the tenets of the narrative of health articulated by the health coaches. As for the understanding of community health advanced here, this is condensed in the 2013 poster-calendar offered on the page (http://www.cdc.gov/family/calendar/cal_communities_eng.pdf). Here, the title refers to health and safe communities. Under the title, the following commands substantiate the topic: eat healthy, be active, protect yourself, manage stress, get check-ups. These are all directed at the individual. At the bottom of the calendar, a conclusion reads in red fonts: “Take simple steps to live a safe and healthy life.” The view expressed here unambiguously, and that can be said to characterize much of conventional health promotion at CDC, is that health and community health in particular are mainly about personal action for health condensed in the prescription in the calendar: you, the individual reader, have to be healthy by assuming the healthy steps listed on top and illustrated in the various scenes painted on the sides.



Figure 33. 2013 Safe and Healthy Communities Calendar, Family Health, CDC.gov

A set of preliminary conclusions can be drawn from reviewing the foregoing pages.

On the interface of CDC.gov there are pages where the act of communication embedded in the content and construction of the materials displayed has a bold persuasive function, as opposed to other pages where the primary function of communication is primarily informative. The former are encapsulating a style of communication with an aggressive purposive function: that of convincing the public to comply with expert advice about health. Textual productions in this group are likely to rely on the expertise of marketing and communication disciplines. The latter are aligned more with traditional technical and scientific styles of communication for a specialized readership, are reticent in tone and morally neutral.

The pages geared at the general public typically address the health-responsible individual and employ a set of preferred constitutive techniques. These include what can be termed triggers of desirability, such as glamorous, attractive images, teeth showing smiles, faces and attitudes exuding an upbeat, confident, masterful approach to life and health promoting regimens. Additionally, “triggers of reasonability” are also used, such as the appeal of advantageous gains: specific health promotion advice is presented as cheap, simple, convenient, and, furthermore, greatly rewarding by providing a sense of wellbeing and accomplished duty. The author-expert addresses directly the reader/viewer with orders for key actions and in a variety of tonal registers - from mellow to stern, and of vocabulary - from commonsensical and colloquial to distantly, authoritatively scientific.

Finally, in light of the pages reviewed here, complemented by my extensive preliminary searches of pages with health promotion content at CDC.gov, it can be said that such aspects as supra-individual, social or structural determinants of health, or community health are significantly underrepresented in comparison to the weight given to health framed at the level of the individual. The latter form the dominant content of main pages, of readily visible materials

and recurring references at CDC.gov, and are generally the dominant if not exclusive concern of persuasive health communication pages of general accessibility and addressability. Pages that reflect in a conceptually adequate fashion supra-individual, social and structural preconditions of health or the issue of community health are few, unlikely to be easily retrieved by the average reader, and make little use of persuasive communication and marketing strategies. Additionally, in reviewing these pages it appeared that they are more often produced by sub-entities at CDC other than the National Center for Disease Prevention and Health Promotion, most notably by the National Center for Environmental Health. Focused searches show that these pages are not only sparse, but their screen images are much lighter in links and resources when compared with the typically overwhelming aspect of conventional health promotion pages. As an aside, searching CDC for the key phrase “structural determinants of health,” the first available reference was a report originating from the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. These elements suggest that a cause of the underrepresentation of supra-individual and structural determinants may be linked to an organizational status-quo that subordinates health promotion to chronic disease prevention.

As a general conclusion, based on the data reviewed, it appears safe to conclude that the main conception and vocabulary of health promotion communicated to the public at CDC.gov is one primarily focused on the individual control of health. Community health or social, structural and supra-individual conditions of health do not have a clear articulation nor a comparable representation in visibility and messaging to that of products at CDC.gov for general audiences reflecting individual determinants of health. The language of health promotion employed in most on-line material of general interest and accessibility as well as in public display ads from CDC is

clearly convergent with that expressed in the core narrative of health elaborated by a group of health coaches.

4.0 DISCUSSION AND CONCLUSIONS

I don't eat un-healthfully (...) but I'm also self-indulgent, and I know this is not good for me... I know that, I'm a health care professional, so again I'm not perfect, I'm a human being too... (From interview with N)

Like I noticed in the past couple of days, (...) when I got out I'm like "I'm gonna go for a walk just around the area" and it's a new shopping area, I was looking and everything was green (melodiously said), the sky was blue and everything was pretty, and I went home and I said to my husband: 'it's just so nice out!', like that's what feels healthy to me! (From interview with B)

I started this dissertation on the premise that the field of public health and its sub-disciplinary area of health promotion needed a self-reflexive critical evaluation of the professional ideology expressed commonly in their discursive practices. In the effort of contributing to this critical assessment, I conducted the exploratory inquiries presented above. The two mini-studies contribute important and converging insights about a dominant - or at least dominantly manifested - professional ideology of health and its pursuit identified at two distinct sites: in official health promotion discourse in CDC health communication and social marketing campaigns; and in a professional narrative of health shared among a group of health coaches. In a probabilistic sense, neither of these sites can be said to be representative of the common professional ideology of health in health promotion. However, in an interpretive sense, the corroborated findings can be regarded with confidence as relevant expressions of it. They speak about critical features of the contemporary technocratic sphere of public health and health

promotion that resonate with broader concerns about professional health promotion norms and regimens of health on far reaching societal dynamics and transformations.

In essence, based on the instances studied here, my investigation suggests that the dominant ideology of health promotion in public health appears to be paradigmatically dominated by the conception of individual rational control and moral responsibility for the production and securing of health described by Crawford (2006) and also discussed, in a public health context, by authors including Lupton (1995), Petersen and Lupton (1997) and Potvin (2002). To this literature, the present study adds an important empirical validation. Additionally, it contributes an in-depth examination of the ways in which a professional narrative of health is articulated around a core set of tenets that coexist with a disjointed set of peripheral counter tenets as well as a critical review of the doctrine of health promotion underpinning the vast majority of official health promotion communication materials at CDC.

There are many critical facets to the overall finding of this research and to detailed aspects of it. For the present discussion, I will highlight aspects that are relevant simultaneously for three related sets of concerns.

First, the findings in my study point to a set of disciplinary issues relevant for the conception and practice of current health promotion as part of public health. When pondering what is meant by health in professional health discourse, many answers are possible. Multiple meanings and referents for the notion of health are engaged in professional and daily usage alike. Recent conceptual and programmatic public health developments complicated the definition of health by emphasizing the socially produced character of health and by introducing the notion of community health. How are these recent conceptualizations reflected in the prevailing discourse of health promotion?

Secondly, it has been argued repeatedly that in modernity, and especially in late modernity, “the governance of health” (Kickbusch, 2010) acquired an unprecedented development in western societies (today a global process) that is critical in the creation of new societal concerns and fears, of new forms of personhood and citizenship, and of new forms of power, including new forms of social control with cultural, political, and economic ramifications. Concepts like bio-governance and bio-power (Foucault, 1973, 1984) medicalization (Conrad, 2007) bio-medicalization (Clarke et al., 2003) health society (Kickbusch, 2010) cynosure of health (Crawford, 2006) or biological citizenship (Rose & Novas, 2005) all gravitate around and grapple with the critical importance of the project of health in contemporary society. The practice of professional health promotion cannot be de-contextualized from these far reaching transformations and power dynamics in society which are crystallized around the issue of health.

Thus, it is important to consider - especially from the standpoint of a public health critique from inside the field - what might be the contribution of professional health promotion to configuring new societal dynamics, including forms of power and social control?

Finally, concerns about general human needs, aspirations and interests have to be considered. These regard the fundamental question of what kind of lives we aspire to live, individually and collectively? They relate to a question traditionally framed in critical theory: what should be the role and what should be the limits to the role of the technocracy of health promotion in the definition of life, social, and democratic ideals?

I will address aspects of all three orders by focusing on two findings: a) the weak and disjointed representation of supra-individual determinants of health in the dominant doctrine of health explored in the study, and b) the difficulties and problematic issues manifest in the core tents of the dominant professional doctrine of health.

A weak and disjointed representation of supra-individual determinants of health and its implications

The disjointed treatment given to supra-individual determinants of health is a foremost limitation of the dominant professional ideology analyzed here. The vocabulary of social, structural and environmental determinants of health is not an integral part of the commonly spoken language of health promotion employed by professional health coaches, nor of that disseminated to the general public through abundant CDC health communication products. Well established CDC communication campaigns in the public sphere about social determinants of health are virtually absent.

This finding speaks about the current lack of institutionalization of conceptualizations of the supra-individual, in particular, social and structural determinants of health in mainstream health promotion discourse and practice. The paradigmatic shift proposed by the Ottawa Charter for Health Promotion (1986) and reshaped in the recent definition of health promotion advanced by the Bangkok Charter for Health Promotion (2005) according to which “health promotion is the process of enabling people to increase control over their health and its determinants, and thereby improve their health” (WHO, 2005, p.1, from http://www.who.int/healthpromotion/conferences/6gchp/hpr_050829_%20BCHP.pdf) is not – according to the present findings - part of the general and commonly used professional conceptualization and vocabulary of health promotion, this despite the focus on determinants of health and health disparities in the most recent Healthy People U.S. National Agenda (Healthy People 2020, 2010). If Krieger characterized recently mainstream epidemiological theory as still concerned with lifestyle and biomedical categories (2011) in light of the current findings it can be said that mainstream health promotion thinking appears today to be primarily about individual

behaviors and lifestyles. This proposition is validated by diverse evidence, such as a statement made in the most recent edition of an influential text of health promotion theory: “behavior change is our greatest hope in reducing the burden of preventable disease and death around the world” (Glanz, Rimmer & Visawanath, 2008, p.XIII). Additionally, personal experience in assisting for a year a public health graduate level and school wide course in public health principles for practice showed that individual lifestyle determinism is the key paradigm in which public health graduates operated when asked to conceptualize public health interventions.

Present findings about the dominant character of the doctrine of rationalized, individualized, and moralized control of health in official health promotion communication and among a group of health promotion practitioners (health coaches) signal the difficulty encountered by progressive public health in standardizing a conception of health for general professional and public usage that would encompass these determinants and the underpinning ideology of social justice. Additionally, the findings suggest that the training of the health promoting workforce there may give too little attention to an integrated understanding of the determinants of health. As the health promotion workforce - health coaches included - is anticipated to increase in upcoming years at an accelerated pace (ref), it is important to consider how are health and its determinants conceptualized in the training of emerging health promotion professionals and to assess if a coherent and comprehensive training about the integrated determinism of health is actually available. This is an important aspect with implications practical and professional implications.

What my findings also suggest is that in the CDC hierarchy health promotion appears subordinated, conceptually and organizationally, to biomedical disease categories and to correlate notions of behavior change and lifestyle risks, rather than overarching or encompassing

these domains. Furthermore, CDC's reticence in informing the public about its knowledge base on social determinants of health speaks about the field possibly betraying its mission of disseminating critical information to the general citizenry. An article by Clarke, Niederdeppe and Lundell (2012) as well as the report "A New Way to Talk About the Social Determinants of Health" (Robert Wood Johnson Foundation, 2010) at <http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf63023>) discuss effective ways of presenting social determinants of health to the public and to policy makers, and emphasize obstacles to this process such as low general awareness or the politically loaded character of terms and issues pertaining to the subject. My own data from the interviews with health coaches show that forms of awareness of the importance of social determinants of health are present at the periphery of the conceptualization of health within which these health professionals operate. This suggests that health coaches have an implicit and, at times, more or less explicit understanding about the link between individual health and supra-individual contexts of life. However, this understanding does not coalesce into coherent and comprehensive conceptions of health. One explanation for this situation may be that the general cultural vocabulary of individualism (Bellah et al., 1985) as well as the professional language and narratives of health in the public sphere offer little ground for their development.

A finding related to the underrepresentation of supra-individual determinants of health regards the understanding of community health. In this respect, both the interviews with health coaches and the common representation of community health in CDC health promotion materials – the latter epitomized by the 2013 Calendar reproduced in Figure ..- speak about an inadequate understanding of community health as a collection of individual healths.

In addition to conceptual and organizational difficulties or cultural modes, another explanation should be added to the list of possible explanations about the slow advances in the institutionalization of the discourse of supra-individual determinants of health in health promotion. In “Hidden Arguments”, Tesh (1988) showed that dominant models and ideologies of public health and sub-disciplines like health promotion are a function of dominant political ideologies and the power interests of ruling elites. In the same line of thinking, Crawford (2006) noted that neoliberal economic and political ideologies characteristic of the last decades, were mirrored by the rising societal obsession with pursuing health as a function of individual actions and concerns. The mainstream professional ideology of health promotion is thus part of this development. In this light, the institutionalization of the eco-social ideology of health promotion first proposed by the “Ottawa Charter for Health Promotion” (1987) and continued with the recent establishment of disciplinary and programmatic concerns for social inequalities and health equity could only be timid given the prevailing political and economic rule.

Why would professional doctrine severely limited in its conceptualization of health and that suffers from other difficulties that will be highlighted below, be so resilient and powerful within the institution of public health and health promotion? The fundamental answer about the resilience and dominance of the rationalized and moralized doctrine of health described here may rest precisely in its being an ideological manifestation, thus a symbolic and power related social practice that participates actively in the contemporary definition of modes of identity, dominance and social control. Thus, it is thus important to consider what may be some of the less obvious impacts of the professional doctrine of health examined here.

A critical assessment of the dominant doctrine of rationalized, individualized, and moralized health and of its impacts

Turning our attention to the main tenets of the doctrine of health clearly articulated in the interviews with health coaches and predominantly represented in CDC health communication products, it can be observed that, despite its strength and its almost naturalized contents, there are many internal difficulties and important problematic implications that are usually overlooked and deserve closer attention.

According to the data in this study, the professional doctrine of health posits that health is primarily produced inside the individual and is controlled by one's reason, volition and action. Health is something that the individual achieves and can be unlimitedly improved by individuals planning and implementing rational behavioral and lifestyle changes. The demand for individual moralized rational control over health implies an ongoing and sprawling regime of health awareness and action, a process to which expert health promoters are seen as a necessary component - either working in partnership with clients, on a one-to-one basis, as in the case of health coaches; or informing, educating, and persuading the public about health promotion measures through expert communication in the public sphere, as in the case of CDC health advertisement products. The individual is morally and socially responsible for pursuing personal health and internalizing expert health promotion advice. I will highlight several difficulties and critical implications of this view.

The total character of the core tenets of the doctrine as conditions of moral acceptability

The legitimacy of the doctrine is first threatened by the total character of its tenets. On experiential grounds alone¹⁴, this view is not tenable: we know that whatever our intentions, we cannot be in full control of our health and we cannot indefinitely manipulate or enhance our health through scrutinizing and modifying our behaviors and the intricate phenomenology that makes the substance of our daily living. It was on common experiential grounds that health coaches participating in this study pointed to the difficulty of reconciling the view of seamless, neat, and effective simplified plans for health that rest on one's reason and volition with the recognition of this being in fact a process hard and difficult to implement and to sustain. "I'm trying hard, but I'm not perfect, I'm a human being too" said one participant talking about her own pursuit of health. The professional prescription for proactive rational control and achievement of health asks of people precisely to strive to embody regimens that challenge their fallible nature. The expected effect of assuming these regimens may not be so much that of transgressing fundamental biological and human limitations, but precisely that of people performing the free assertion of personal will and effort to change for health. The condition for moral acceptability is to try, and to try hard. As we have seen, having a plan for health and being willing to implement it appeared in the interviews with health coaches as an equivalent of being healthy, or healthier, and also a responsible citizen.

¹⁴ On biological grounds, Dubos (1984) argued that there cannot be a state of perfect health because biological systems are constantly adapting to new challenges in their environments.

Health is not a natural state and requires sprawling remedial controls

Related to the aspect above, the doctrine implies that health is not a natural state. The condition of being healthy rests in the extensive individual rational effort for bettering one's health. We can speak here, as Dumit (2002) did in the context of new medicines, of a view of "defective normality" according to which our normal health state is one of deficit and can only be corrected by remedial action. The key motif in CDC health communication and advertisements was the recovery of the individual from a potential or actual health threat through a professionally recommended regimen. This regimen is not static, but as Crawford (2006) and Bauman (1998) noted, one evolving through the addition of sprawling remedial actions and controls and having as result a spiraling state of anxiety that can only be temporarily relieved by taking on an additional control.

People don't know how to be healthy without professional health promoters yet health promotion advice is commonly trite

Related to the point above, another important proposition is embedded in the dominant doctrine of health promotion: left to themselves, people do not have the capacity to achieve their health. Generally, it is considered that the layety cannot have autonomously the insight, information, education, and determination for health. Without the expertise of health promoters, people's health would be poor. On the other hand, many health recommendations presented to the public as scientific facts and professional health promotion expertise are of general common sense level. Framing mundane life experiences as risks for health that require professional advice of commonsensical contents is not rare in the CDC "Features" or in other health communication materials at CDC.gov. For instance, under the heading of health promotion advice, CDC experts recommend a wide array of advice, including: what is the healthy height for wedding shoes; what

is a healthy meal on Memorial day; how many hours of sleep one should sleep before her wedding; how to cross the street; how to play safely in a pool; how to take a walk with friends or how to prepare a potluck event. One rationale for communicating this type of health advice to the public may be that of establishing and legitimizing the authority of the health promoter. Questioning the authority of lay people over conducting healthy lives serves increasing the authority of the health promoter. A related aspect of shifting lines of authority is presented in the CDC “Features” that address the management of asthma and high blood pressure. In these instances, we have seen that the traditional medical responsibility for managing these conditions is transferred to the patient, while a parallel transfer of authority is operated from clinical medicine to the professional health promoter. These are instances that speak about interesting and important dynamics in the evolution of the system of health professions.

The disproportion between the normative and diagnosing functions in the health promotion narrative of health

An additional problematic finding clearly visible in the interviews with health coaches refers to the disproportion between assuming the prescriptive legitimacy of professional health promotion without a commensurate diagnosing role. According to health coaches, while people need health experts to tell them how to achieve their health, there is no commensurate professional expertise of the health promoter for diagnosing health. This latter is unequivocally attributed to each individual and consists of an idiosyncratic, internal sense of healthiness, of things being right. This assessment takes place in the private domain of life rather and does not involve a professional expertise.

Based on the aspects reviewed so far, it can be said that the doctrine of health promotion is predicated on problematic and contradictory grounds, including the lack of integration of

complex supra-individual determinants of health and the total character of its central claims. It is a doctrine whose fundamental view is narrowly rationalistic, voluntaristic, moralizing, perfectionist-utopian, and, by means of its pervasive dissemination, regimenting. This doctrine of rationalized and moralized total health appears to be dominating the current technocratic project of health promotion. What are the consequences of this status?

A series of findings in this study converge with foucauldian and socio-cultural lines of critique (see comprehensive exam paper.) Both sets of data indicate the important contribution of mainstream health promotion to patterning and ritualizing a certain desirable type of social identity and of socially sanctioned health behavior modes. The instances of official health communication examined in the third chapter, including public display advertisements from health promotion social marketing campaigns as well as many on-line CDC health communication products, propose a view of triumphant will for/over health and modeling desirable active, masterful adults, who understand health as the proactive exertion of personal controls over their health. These subjects show a happy satisfaction for and an unfettered confidence in their achievement of health through exerting rational controls. The professional doctrine of health promotion disseminated to the public appears, thus, to contribute to the creation of a dominant view whereby morally and rationally competent individuals are responsible for achieving proactively their health through personal controls. Pursuing individual health by people who align to the dominant view and to the regimens advocated on its grounds, and who assume iconic images of health achievement in health advertisement, acquires the role of a socio-moral performance.

Considered a leading social theorist of the twentieth century (Kim, 2012), Max Weber offered two influential relevant theses: that of the rationalization of society, and that of the

protestant ethic, that together articulated a still relevant critique of modernity (idem, 2012). Weber posited that a far reaching rationalization permeated all spheres of social life and it produced “the emergence of a bureaucratic individualism and the loss of meaning in the ‘iron cage of modernity’” (Delanty, 2009, p. 27). He deplored a cultural evolution whereby humans become “specialists without spirit” and “sensualists without heart” who think of themselves as having attained the highest level of humanity (Weber, 1904-05, quoted by Kim, 2012). Weber specifically linked the process of rationalization to the rise of instrumental reason. He identified a conflict between what he termed “value rationality” which reflects general human interests, and an instrumental, means-ends rationality characteristic of the instrumentalized orders of law, science, state and economy that seemed to be breaking free from the general value system (Delanty, 2009).

Weber’ concepts were incorporated into the critique of rationalized order proposed by critical theorists of the Frankfurt School, and in the second part of the 20th century, by Jurgen Habermas (1984; 1987). Habermas (idem) proposed a conceptual framework that according to which is structured in two large domains, system world and life world. When applying the domains in this model to the case of health promotion, the system world can be understood as formed by the interplay between government, professional/expert, corporate/economic and other entities that follow specific instrumental rationalities regarding the health of individuals and populations. The life world is the domain of private experiences of day to day life. Habermas included the public sphere as part of the life world, yet this can be seen as standing and mediating the interplay of the two main domains. According to Habermas, the life world grounds all knowing and is the premise of social praxis. It is the symbolic space, the medium

within which culture, social integration and personality are sustained and reproduced (Thompson, 1984, quoted by Scambler, p. 13).

What is the contribution of the system world - represented in this study by expert and official health promotion discourse - to shaping the societal practice of health? What is the contribution of health promotion rationalities to the articulation of new power dynamics in society? What are the impacts of these on the domain of life world?

The technocracy of health promotion appears to contribute fundamentally to blurring the distinction between private and public domains of life. While health is understood as a personal obligation to be undertaken by each individual in her private life, expert recommendations for the achievement of health are framed publicly, and the assertion of pursuing health goes often beyond the private sphere, as exemplified by the health coaching partnership. This involves many a times a phone-based interaction that is documented and archived in systems into which the private individual has little insight. This is one of the mechanisms by which the technocracy of health promotion contributes to the displacement of the autonomy of private life by professional authority and professionally mediated controls.

These professional controls are often associated with market forces. As Hochschild (2012) noted, more and more experiences of life previously managed informally by individuals and societies are becoming rapidly part of market dynamics. Health coaching is only one case in the broader proliferation of coaching expert services offered for myriad common needs and situations, such as financial coaching, life coaches, relationship coaches, college coaching, clutter coaching, or personal exercise trainers. The case of health coaching illustrates well both the commodification of health promotion services, and, especially, the intrusion of professional expertise into domains of private life. The power and authority of individuals over their private

lives is displaced as the life world of regular citizens becomes subjected to the instrumental rationalities of the technocracy of health promotion. These instrumental rationalities may or may not resonate with autonomous human interests and values. As we have seen, the health coaches in this study talked about a distorted and exaggerated concern with health in the public sphere. There are many entities disseminating health messages in the public sphere. In addition to health industries, there are many other commercial entities that establish new markets by mimicking the language of professional biomedicine and health promotion, as exemplified by Race (2012) in his study about the marketing and consumption of bottled water. In this context, it appears adequate to assume that professional health promotion discourse and advertisement in the public sphere contributes, ironically, to the patterning of the overexerting attitude toward health and to the spiraling volume of sometimes conflicting information and actions for health advocated to the public that the participating health coaches deplored.

The dichotomy public-private in pursuing expertly framed health promotion regimens has multiple implications. At individual levels, we can note a weakening of the private sphere to the benefit of the public one. At a socio-political level, though, we can note the demotion of public safety networks and social and health services to the benefit of the increasing privatization, commodification, and marketization of these. These parallel evolutions are linked to the issue of control, which, in turn, relates to the issues of power and exploitation. In practicing the expertly driven pursuit of health, individuals are assumed to increase their rational control over their selves, health and lives. Yet control may also be understood as controls of human subjects deployed specifically through techniques and images of desirable healthy selves, bodies, and citizens. Both instances of control are linked to the practices of the technocracy of health promotion which may signify the development and strengthening of new forms of power

domination and social control to which individuals and their presumed autonomy in health are mere regimented pawns.

From a critical theory perspective, the new health consciousness in society appears as one of the sites where contemporary struggles for power, identity and dominance take place and where norms and values are actively created (Feenberg, 1991). As noted in the beginning of this section, the fundamental question to ask is what kind of life and what kind of health do we aspire to live, individually and collectively? The technocracy of health promotion offers us a set of implicit answers when proposing an intensive and expanding pursuit of health to be developed along expertly drawn lines, which turns into the equivalent of pursuing the good life. It operates, as already noted the erosion between public and private domains of life, the subversion of private life, and the diminishment of the autonomy of individuals. The traditional hierarchy of means and ends, whereby health is a means to a good life is reversed in this process. Health is extricated from the textures of autonomous daily life and becomes a goal to be achieved in isolation of or despite these. The doctrine of tightly rationalized and individualized control cannot make way to the richness of human experience and to a view of health embedded in daily life and resulting from the intricacy of all the domains of personal and collective life. Through instrumentalizing and rationalizing the pursuit of health, technocratic and market controls displace humanistic and general ideals of a good life. Although the Ottawa Charter for Health Promotion (1986) clearly stated that “health is seen (in health promotion) as a condition for everyday life, not the objective of living,” contemporary health promotion practice in concert with other societal forces tells us quite the contrary: pursuing health becomes, according to the project of rationalized, individualized, and moralized total health mediated by expert health promoters, the very objective of living.

Yet any ideological form, even dominant, is not a pure state. For the health coaches participating in this study, the good life did not equate pursuing health. This instance probes the existence of hybrid conceptions inherently making their way under the dominant professional ideology of health promotion. The health coaches described themselves as complying with professional regimens for health promotion on a level of rational effort and control, yet described their aspiration and definition of a good life in much less instrumentalized ways as a sense of things falling by themselves in the right place in life, of serenity, of feeling sheltered in one's frame of life. Most of the participants did not address directly pursuing health in their definition of a good life. On the side of powerful rationalistic and stern views of actively pursuing health, health coaches also pointed – if only peripherally - to competing views of a more relaxed and tolerant approach to health and to ambivalences in judging the societal pursuit of health. These are encouraging findings, in the sense that they reveal reflexive stances and critical positions that challenge the tenets of the dominant doctrine of health promotion.

Potvin and her colleagues (2005) argued that public health cannot live up to the democratic and emancipatory ideals proposed by the Ottawa Charter (1986) due to the inherent “limits of practice models that are based on dissemination of expert knowledge (...) which leave little room for local actors' knowledge in the face of standardized expert solutions” (Potvin et al., 2005, p. 594). Buchanan (2008) argued that rather than developing justificatory frameworks and principles for defending public health paternalism and the restriction of individual autonomy in health behavior modification, a focus “largely misguided,” the field of public health should be more invested in extending autonomy and human dignity through promoting social justice. I concur to these positions, and I propose that pursuing health should be anchored primarily in

general human interests and ideals, rather than molded along the requirements of a technocratic view of health promotion.

The main conclusion of this study is that public health needs to confront a series of difficult aspects, such as the question of what kind of health promotion it espouses, and on what ideological bases it does this, including its political ideology. Diverging ideologies appear to underpin coexisting theories of health production that have, as demonstrated here, a seriously unbalanced presence in the public sphere, with the severe underrepresentation of eco-social determinants of health in the public discussion. Also, the disciplines of public health would benefit from assessing more frequently and without complacency the overlooked contribution of their practices, including their discursive practices, to the governance of health. Public health would also contribute to its progressive mission by addressing frontally the discussion about the limits to the technocracy of health promotion, and about the ways in which its practices could be better calibrated toward a society where human interests are defined in humanistic terms rather than in technical instrumental and market terms.

4.1 RESEARCH LIMITATIONS

The main study caveat refers to the limited data used in the study, specifically to the limited number of individual interviews with health coaches. Additionally, all the participants were affiliated to a single organization and their approach to coaching was motivational interviewing only. Thus, no comparative analysis of findings from this specific group of participants and other groups of participants was possible. Further research involving health coaches in multiple

organizations as well as comparative studies of conceptions of health among diverse health profession groups would add important insights to the ones discussed here. Despite the limitations noted above, there are a number of considerations that support the relevance of study findings. First, the main findings from the interviews with health coaches converged with those identified in CDC health communication discourse. Second, the fundamental methodological and theoretical approach used here is qualitative critical interpretive. This orientation, combined with a methodological preference for depth rather than breadth in analyzing data, qualify the study as well suited for its assumed interest of understanding and interpreting the phenomena under consideration. The small number of interviews allowed a finely grained analysis of their contents, which may have been restricted in a larger data set; nuance and detail contributed importantly to the merit of study findings.

Third, it should be noted that this group of participants worked for a large, well established and reputable health care organization that is aligned to national trends in health coaching. These were described in my review of the literature about health coaching. The participants in the study were part of a specialized division and had received standardized training in motivational interview based coaching. The content of their job was similar to that listed by job descriptions from similar organizations identified during the background research phase. Thus, it is likely that rather than unique, the work approach, contents and organizational environment of this group of health coaches is typical of large entities within the health care industry.

Another aspect possibly threatening the relevance of findings refers to the fact that interview questions used by the researcher may have been framed in such a way as to elicit only a certain set of considerations from the participants, but not others. More specifically, it may be

suspected that the disjointed status of social determinants of health in the narrative of health employed by health coaches is a result of the uneven probing of this type of determinants as compared with behavioral and lifestyle factors. As described in detail in the methodological section, the interviews were loosely guided by a number of main questions. The interview guide presented in Appendix A was created to orient the discussions and to offer the researcher a set of probing questions had the flow of discussion proved unsatisfactory. In actuality, the interviews were dense and dynamic. The researcher favored an approach of probing aspects that surfaced in the elaborations of participants over that of applying strictly the interview guide. Additional clarifying questions covered aspects of both supra-individual and personal determinants.

Overall, main and probing questions offered the participants adequate space to express and elaborate positions on supra-individual determinants of health. The interviews proceeded based on general questions about health and achieving health that did not specify either individual or supra-individual determinants of health, nor specific health domains. Examples of characteristic questions are: what comes to mind when we say the word health? what are the things that make us healthy? The only direct question about a certain type of health referred to community health.

Finally, a concern could be raised that the specific assumptions of motivational interviewing may have confounded what was described to be a more general professional conception and ideology. Against the validity of this point of view speaks the convergence of findings from the CDC datasets examined here. Additionally, the majority of health coaches in this group were professionals with credentials and experience in nursing. Other participants had degrees in health sciences. It was considered that their professional views as well as their personal opinions derived from domains and sources of formation much broader and more

diverse than motivational interviewing. In light of these aspects, it is likely that the interviews elicited a professional ideology that may encompass and converge with some of the propositions of motivational interviewing, but is in no way contrived by these.

4.2 DIRECTIONS FOR FUTURE RESEARCH

Follow-up empirical research can address some of the limitations of this particular study and can add important perspectives to the ones presented here. For instance, future research can include more groups of health coaches from diverse organizations. Comparative perspectives between health coaches and other important categories such as clinicians or community/lay participants can be analyzed by designing a study with multiple comparison groups.

A study of the reception of health communication can build on the experience of navigating CDC.gov pages employed in the present research. One or multiple groups of participants may be asked to immerse themselves in browsing sessions of CDC materials and to discuss their responses to these.

A distinct line of follow-up research can focus on the ways in which health and the determinants of health are conceptualized and conveyed in the training of categories of health promotion, public health, and health care professionals.

Finally, a complementary study of how health promotion communication and social marketing discourse compares and interacts with health messages in the public sphere that are framed by commercial entities would offer a better appreciation of the specificity, cumulative effects and the implications of health discourses.

4.3 PRACTICAL IMPLICATIONS

A number of implications are of immediate applied interest. For instance, it is of critical importance for public health disciplines and professionals to reach a common language of health. In other words, it is critical for the field to share a unified, coherent and comprehensive understanding of health. One way to achieving this convergence of views on a satisfactory model of health production is to engage solid interdisciplinary bridges.

Another modality of action is to integrate a “universal” module on the comprehensive production of health in the education of those pursuing public health, health promotion and social service professions.

Also, the interviews with health coaches revealed that the regimens for the active, rational pursuit of health by individuals that are advocated by health promoters are considered hard to implement and sustain by clients, and by the participants themselves. This is an important signal for health promotion practice: “doing more” for the public – the common thrust of health professionals - may require not asking more individual rational controls of people, but precisely proposing alternative ways for better collective health: the enhancement of life conditions for all. Research should be devised to assess the burden of responsibility for health placed on individuals by the dominating doctrine of health promotion. This type of research could lead to a better calibration between health promotion discourse and the needs of the public.

Finally, health communication from official sources, such as the CDC, should offer widely available information about the social determinants of health. Rather than persuading the

public through advertisement techniques, CDC and similar agencies can offer a more plainly informative mode of communication about these determinants and can also emphasize the importance of public participation for improving the structural premises of health.

APPENDIX A

GUIDE INTERVIEW HEALTH COACHES

Introduction

- Purpose
- Convention
- Do you mind being taped? I'm doing this because I cannot take notes so fast and accurate
- Can withdraw

1. (Paper) When we say the word "health," what are the things that come to mind? Please take a minute to reflect and write down a list or a paragraph, whichever you prefer.
2. How would **you** define good health?
3. What are the most important things that make people healthy?
4. How do we know we are healthy?
5. What does a healthy lifestyle mean to you?
6. Let's talk a bit about this idea of achieving one's health? In your opinion, what does it mean 'achieving' one's health?
Can you think of examples of people who are really working on this?

As a health coach, how would you help people adopt healthy behaviors? What works and what doesn't?

How do you get people to change?

Are you successful?

What kind of person is really hard to change?

What kind of person is easy to change?

How tough, how forceful can you be with people?

7. In your experience, how do people control their health?
What about this idea of 'taking steps' toward controlling health? What is this about?
Do you know anybody unhealthy?
Can you think of someone who completely works on controlling his or her health?

In your experience – personal, professional – who is responsible for one's health? Give me an example of someone who completely doesn't understand health?
8. How do you think society looks at people who don't take care of themselves? What about health professionals?
9. There are many health messages and advertising around us, most often in the media, TV, websites, magazines... What is your overall impression of these messages? 8b. What do you think about the 'health talk' we hear in the media?
10. (Image Katie Couric) If you saw this image, yet at a very large scale, in an airport, what would be your reaction looking at it? What would be your reaction as a professional? What about your reaction as a private person?
11. (Brochure 'Women take care of your health) I am going to ask you to take a couple of minutes and look through this brochure, and mark the relevant information for you, personally.

What is your overall reaction (thoughts, emotions) going through this material – as a professional, as a private person?

Based on your experience, in what ways are people concerned with these aspects: screenings, lifestyle factors, etc. – a permanent concern, a periodic concern?

How concerned should people be with these things? How many more?

12. In your experience, what does 'community health' mean?
Do you think our community is healthy?
Have you ever been in an unhealthy community? How was that?

13. Finally, please take a minute to respond to a questionnaire, that doesn't serve to test your knowledge, but to serve as a basis of comparison between the various groups of participants in this study.

APPENDIX B

SEQUENTIAL LIST OF DESCRIPTIVE THEMES INTERVIEWS HEALTH COACHES

This list provides, in a sequential order, the descriptive themes that reflect the contents of each interview. On the left side of the page are themes as emerging in the interviews. On the right side of the pages there are notes of outstanding aspects, as well as considerations about emerging thematic patterns across the entire group of interviews. These are usually termed “across theme,” or “across.”

B.

Health: actions and signifiers;

Individualization:..

Contradictions and paradoxes

Health and good life: the place in life to be healthy

Health and society: health conscious – contradictions

Moralization of health in society, stated

Health and media: “we” confuse the daylight

We/they

I’m asking about people, she answers at first singular

Health coaching practice

Illness

Control

No emphasis on change/willingness to change

I came up with a new question: what means healthy living?

N.

Health

Variation

Images/representations: the car; the wellness continuum

Domains

Associations and translations: pars for ...

Connotations: health and images of good life/the good life as source to health; others

Sources

Submergent issues

Responsibility and control (interpret: health, responsibility, control)

The logic of personal responsibility in poh, poh as moral enterprise applied to self

Choice and control

Change and control

Limitations to embracing control (qualifying circumstances)

Confidence and controls

Sustained and conscious scrutiny of one’s actions for poh: concern, awareness, daily surveillance?

Class stratum and control

The difficulty of the healthy norm, poh; struggle but not always

Limits to control

PERFORMING (the function of) HEALTH – health as social-moral performance

The healthy self/person; the other one

Construing the healthy person

Moral significances

Moral significance of healthy lifestyle; up-close ex of moralization – logic and sub-stance
Moral significances of poh vs illness

Distinctions in valuation: professional and societal

Defining Community health

The diagnosis of ‘health’ (whose expertise?)

Objectivity

Subjectivity

Both in N.’s case?

Expertise and life experience

Takes at ‘society’ and at society and health; society’s tricks/ from L.s: society’s distortions

Good life

Tensions and plain contradictions

Uses of Key examples

Use of laughter

From generic lists to personal experiences/takes

Healthy lifestyle, good life/lifestyle

L.

Health as INDIVIDUALIZED processes

Mental determination, attitude determination, conscious decision, conscious choice

The individual is the starting point in determining one’s health (‘even’ as she recognizes the limits of this, and the values of holism and balance)

HYBRID views:

Holism vs fragmented/technical

Individual rather than collective (things we limit ourselves; health coach certification)

Inside rather than outside

Superficial vs meaningful and profound

Work-life balance vs societal pressures for work, exertion

The Difficulty of maintaining healthy measures/lifestyle

Distortions: societal, media

“creating a culture of health and wellness” H coaches, H coaching industry, H coaching

Resisting lifestyle control – qualifications

Across interviews: gradient of moralizing health from outrightly judgmental to milder takes, to

normalized views, distinctions, yet not judgments, internalized takes....

PRIVATE-PUBLIC

Across interviews: the difficulty of engaging and/or maintaining healthy lifestyle, and being proactive about one's health.

E.

Health as individualized and internalized process

Determination and control

Personal(ized) project at a critical point in life

Health as measures of healthy living

Sources and influences on H

Money

Generational/family influences

Health as change

Resistance vs change in community and individuals alike
(unhealthy communities as collections of resistant types)

Across: H as change. Distinguishers:
resistance vs acceptance

Across and related: apologetic and
critical views of the 'official'
ideology of health

H as semantic takes

Across: Acknowledging (spontaneously) the new health consciousness (spontaneously)
Generational changes

Across: Construing the Achievement of Health

H is always improvable

H starts with perception

H it's up to the individual

H it's difficult to achieve and maintain

TENSIONS and CONTRADICTIONS

Control and conscious control/monitoring

Responsibility for health:

From H. as *my thing* to *societal pressures*

The diagnosis of health

Media and Health

Scare, confusion, creates concern and over-concern without providing solutions (people want a cure)

Why this emphasis in the media: good question, I don't know, money, ratings

V.

Mapping H

Forms, domains

Across: Recurring qualification: my take, my idea, my opinion, for me, my perspective

Diagnosis of H

Achievement

Linked to domains

Responsibility for H

Health as missed concept, or missed info?

Choice for health; choosing health

Choice leads to betterment; choice via awareness and motivation

Some resistant to-, some enrolling

THE Old and New School of health (new: managing one's health)

THE new health consciousness

Control-choice-responsibility

Responsible for making the best and taking advantage of what's available, of what's outthere

Across PATTERN: generally, h.coaches start by affirming fully the dominant version of construing health, i.e., plasticity, improvability, choice, control, responsibility, yet in their digressions or excursions in explaining other questions, they begin to substantiate, to various degrees and, progressively the limitations of this common view- sometimes accommodating even opposite views

The connection between good life-good world-people-nature-arrangements

Better life, better health

Societal pressures and distortions, including their relationship to the societal concern for health

the distortion and pressures of social arrangements: the concern of health in I. vs US

The new health consciousness

Generational developments and media
Pervasive public sphere influences – link to media

Media and health

A single voice in fact. A mixed bag, commercialized yet useful -
Some touches on the health reform core: the worthy vs un-worthy; should be shared
responsibility among all actors, and less concern for money
Commercialized yet useful.

Societal moralization of H

Professional moralization of H

Generational gradients: h. coaches about
health consciousness: me about h. coaches'
assuming the moralization of h.

Things that people really wanted to say,
usually triggered by the questionnaire at the
end.

G.

Mapping h.

Some release, some mix of categories

h. as perception

DX of h.

Perception

Change in behavior: Signifier of..

Connected to

Controlling h. intentionally

This means taking steps and equates controlling one's destiny

Connected to

The issue of responsibility

The old and new school

Connected to

The issue of achieving health

What it takes to change people

Change and choice

Resistance to

The difficulty of change

The good life

Health qualified differently by knocking on wood!!!

APPENDIX C

CDC PUBLIC DISPLAY ADS

Appendix C is comprised of various CDC public campaign images and can be viewed below:

Are you the picture of health?

“Colorectal cancer is the 2nd leading cancer killer. But it doesn’t have to be.”

Katie Couric, Co-Founder

EIF's National Colorectal Cancer Research Alliance

Colorectal cancer and precancerous polyps don't always cause symptoms. So you can look healthy and feel fine and not know there may be a problem. ■ Screening helps find polyps so they can be removed **before** they turn into colorectal cancer.

This is one cancer you can prevent! ■ Screening can also find colorectal cancer early, when treatment often leads to a cure. ■ If you're 50 or older, make sure you really are the picture of health. Get screened for colorectal cancer.



1-800-CDC-INFO (1-800-232-4636) • www.cdc.gov/screenforlife

Photo by Andrew Eccles



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention



This is personal.

My mother was the cornerstone of our family. When she was diagnosed with colon cancer, it was like the whole family got cancer. She died when she was only 56. Let my heartbreak be your wake-up call.

Terrence Howard, actor/musician

Photo: Andrew Macpherson

Colorectal cancer is the second leading cancer killer in the U.S., but it is largely preventable.

If you're 50 or older, please get screened. Screening finds precancerous polyps, so they can be removed before they turn into cancer. And screening finds colorectal cancer early, when treatment works best. If you're at increased risk—if you have a personal or family history of polyps or colorectal cancer, or you have inflammatory bowel disease—ask your doctor when to start screening. **Screening saves lives.**



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention



National Colorectal Cancer
RESEARCH ALLIANCE™
Entertainment Industry Foundation Program



1-800-CDC-INFO (1-800-232-4636) • www.cdc.gov/screenforlife

This is personal.

“My mother was the cornerstone of our family. When she was diagnosed with colon cancer, it was like the whole family got cancer. She died when she was only 56. Let my heartbreak be your wake-up call.”

Terrence Howard, actor/musician



Photo: Andrew Macpherson



Colorectal cancer is the second leading cancer killer in the U.S., but it is largely preventable. If you're 50 or older, please get screened. Screening finds precancerous polyps, so they can be removed before they turn into cancer. And screening finds colorectal cancer early, when treatment works best. If you're at increased risk—if you have a personal or family history of polyps or colorectal cancer, or you have inflammatory bowel disease—ask your doctor when to start screening. **Screening saves lives.**

1-800-CDC-INFO (1-800-232-4636) • www.cdc.gov/screenforlife



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention



**National Colorectal Cancer
RESEARCH ALLIANCE™**
Entertainment Industry Foundation Program



This is personal.

*My mother was the cornerstone of our family.
When she was diagnosed with colon cancer, it was like
the whole family got cancer. She died when she was
only 56. Let my heartbreak be your wake-up call.*

Terrence Howard, actor/musician



Photo: Andrew Macpherson



Colorectal cancer is the second leading cancer killer in the U.S., but it is largely preventable.

If you're 50 or older, please get screened. Screening finds precancerous polyps, so they can be removed before they turn into cancer. And screening finds colorectal cancer early, when treatment works best. If you're at increased risk—if you have a personal or family history of polyps or colorectal cancer, or you have inflammatory bowel disease—ask your doctor when to start screening. **Screening saves lives.**

1-800-CDC-INFO (1-800-232-4636) • www.cdc.gov/screenforlife



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention



**National Colorectal Cancer
RESEARCH ALLIANCE™**
Entertainment Industry Foundation Program



Colorectal Cancer Screening Saves Lives

Colorectal cancer is the 2nd leading cancer killer in the U.S.

But it can be prevented.

Screening helps find precancerous polyps so they can be removed before they turn into cancer.

Screening can also find colorectal cancer early, when treatment is most effective.

**If you're 50 or older—don't wait.
Talk to your doctor
and get screened.**



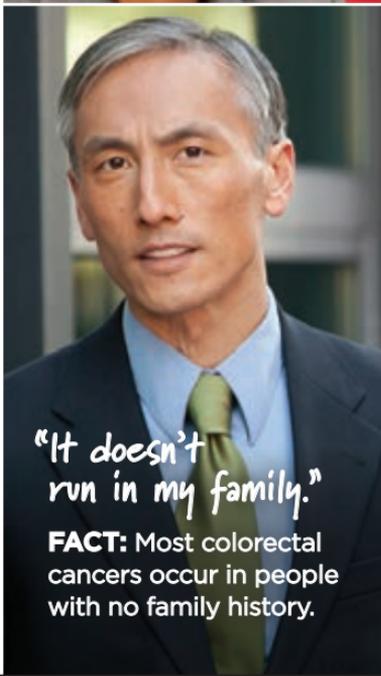
www.cdc.gov/screenforlife
1-800-CDC-INFO (1-800-232-4636)

**U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES**
Centers for Disease Control and Prevention



"I don't have symptoms."

FACT: Colorectal cancer doesn't always cause symptoms, especially early on.



*"It doesn't
run in my family."*

FACT: Most colorectal cancers occur in people with no family history.

*"Why Should I
Get Screened?"*



"But that test..."

FACT: There are several kinds of screening tests for colorectal cancer.

You may **not** **not**

be **ready** to have a baby,

ready

but your body's been preparing for years.



FOLIC ACID NOW

So your body's ready when you are.



You have lots to do before motherhood. But make sure to take folic acid today — and every day. Whether you get it in a pill by itself, in a multivitamin, or in foods like breakfast cereals, breads and pastas, this essential B vitamin helps prevent some serious birth defects in babies. 1-800-232-4636 (CDC-INFO)





Folic acid is part of my healthy lifestyle!

I take 400 micrograms (mcg) of folic acid every day as part of my healthy daily routine. If I decide to have a baby in the future, I want my body to be as healthy as it can be.

Folic acid is a B vitamin that helps prevent some birth defects of the baby's brain and spine. By taking 400 mcg of folic acid every day, I can help prevent those serious birth defects.

You can start getting ready today! Talk with your doctor about taking 400 mcg of folic acid. There are two easy ways to be sure to get enough folic acid each day:

1. Take a vitamin that has folic acid in it every day. Most multivitamins sold in the United States have the amount of folic acid women need each day. Women can also choose to take a small pill (supplement) that has only folic acid in it each day.
or
2. Eat a bowl of breakfast cereal that has 100% of the daily value of folic acid every day. Not every cereal has this amount. Check the label on the side of the box, and look for one that has "100%" next to folic acid.

www.cdc.gov/ncbddd/folicacid

National Center on Birth Defects and Developmental Disabilities
Division of Birth Defects and Developmental Disabilities





Folic acid is part of my healthy lifestyle!

I take 400 micrograms (mcg) of folic acid every day as part of my daily routine. Just like eating nutritious food, drinking plenty of water and exercising is important for my health, taking folic acid every day can help me get my body ready for when I decide to have a baby.

Folic acid is a B vitamin that helps prevent some birth defects of the baby's brain and spine.

You can help prevent serious birth defects of your baby's brain and spine. Talk with your doctor about taking 400 mcg of folic acid.

There are two easy ways to be sure to get enough folic acid each day:

1. Take a vitamin that has folic acid in it every day. Most multivitamins sold in the United States have the amount of folic acid women need each day. Women can also choose to take a small pill (supplement) that has only folic acid in it each day.
or
2. Eat a bowl of breakfast cereal that has 100% of the daily value of folic acid every day. Not every cereal has this amount. Check the label on the side of the box, and look for one that has "100%" next to folic acid.

www.cdc.gov/ncbddd/folicacid

National Center on Birth Defects and Developmental Disabilities
Division of Birth Defects and Developmental Disabilities





Folic acid is part of my healthy lifestyle!

I take 400 micrograms (mcg) of folic acid every day as part of my healthy daily routine. If I decide to have a baby in the future, I want my body to be as healthy as it can be.

Folic acid is a B vitamin that helps prevent some birth defects of the baby's brain and spine. By taking 400 mcg of folic acid every day, I can help prevent those serious birth defects.

You can start getting ready today! Talk with your doctor about taking 400 mcg of folic acid. There are two easy ways to be sure to get enough folic acid each day:

1. Take a vitamin that has folic acid in it every day. Most multivitamins sold in the United States have the amount of folic acid women need each day. Women can also choose to take a small pill (supplement) that has only folic acid in it each day.
or
2. Eat a bowl of breakfast cereal that has 100% of the daily value of folic acid every day. Not every cereal has this amount. Check the label on the side of the box, and look for one that has "100%" next to folic acid.

www.cdc.gov/ncbddd/folicacid

National Center on Birth Defects and Developmental Disabilities
Division of Birth Defects and Developmental Disabilities



B Before you know you're pregnant...



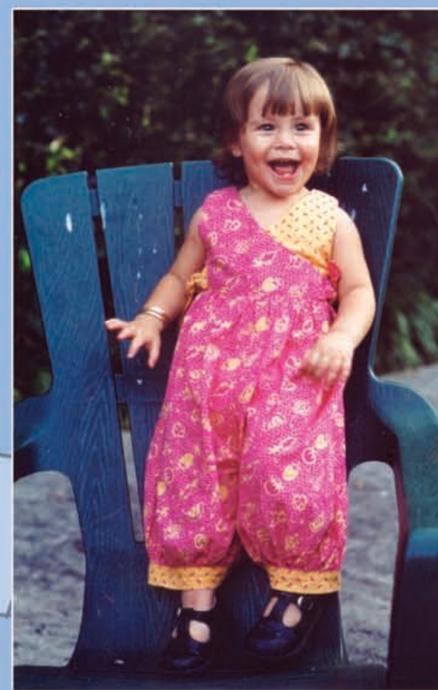
One of the strongest instincts of life is to protect your baby. But you don't have to wait until you see your baby for the first time. You can start taking care of your baby today before you become pregnant.



Folic Acid

The B vitamin folic acid can help prevent some serious birth defects of the baby's brain and spine.

That is why it is so important to take folic acid... even if you're not planning to have a baby yet. Unplanned pregnancies happen every day. You can get folic acid in a multivitamin and in some enriched foods such as breakfast cereals. Getting enough folic acid requires a small effort, but it can make a big difference.



Information: 1-800-232-4636 (CDC-INFO)
www.cdc.gov/ncbddd/folicacid

Every Woman,
Every Day!





Here's what happened...

My story may help you.

"I knew something wasn't right. I had a little bloating and some lower back pain. But what really worried me was the bleeding between periods. It wasn't normal for me.

It turned out I had ovarian and uterine cancers. Getting diagnosed and treated wasn't easy. But now my doctor and I are optimistic about my future.

Please listen to your body. If something doesn't feel normal for two weeks or longer, see your doctor."

– Jennie M., Washington, D.C.

Gynecologic cancer includes cervical, ovarian, uterine, vaginal, and vulvar cancers. Signs and symptoms are not the same for everybody...so get the facts. **Get the Inside Knowledge. Get the facts about gynecologic cancer.**



www.cdc.gov/cancer/knowledge

1-800-CDC-INFO



This is personal.

My mother was the cornerstone of our family. When she was diagnosed with colon cancer, it was like the whole family got cancer. She died when she was only 56. Let my heartbreak be your wake-up call.

Terrence Howard, actor/musician

Photo: Andrew Macpherson

Colorectal cancer is the second leading cancer killer in the U.S., but it is largely preventable.

If you're 50 or older, please get screened. Screening finds precancerous polyps, so they can be removed before they turn into cancer. And screening finds colorectal cancer early, when treatment works best. If you're at increased risk—if you have a personal or family history of polyps or colorectal cancer, or you have inflammatory bowel disease—ask your doctor when to start screening. **Screening saves lives.**



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention



National Colorectal Cancer
RESEARCH ALLIANCE™
Entertainment Industry Foundation Program



1-800-CDC-INFO (1-800-232-4636) • www.cdc.gov/screenforlife

Preconception Health and Health Care

My Reproductive Life Plan

Thinking about your goals for having or not having children and how to achieve those goals is called a *reproductive life plan*. There are many kinds of reproductive life plans. Your plan will depend on your personal goals and dreams.

How to Make a Plan

First, think about your goals for school, for your job or career, and for other important things in your life. Then, think about how having children fits in with those goals.

If you do want to have children one day, think about when and under what conditions you want to become pregnant. This can help ensure that you and your partner are healthy and ready when you choose to have a baby. If you do not want to have children (now or ever), think about how you will prevent pregnancy and what steps you can take to be as healthy as possible.

Try to include as many details as possible in your plan. Some people find it helpful to write their plan down on a piece of paper or in a journal. Be sure to talk with your health care professionals. Doctors and counselors can help you make your plan and achieve your goals.

Questions to Get Started

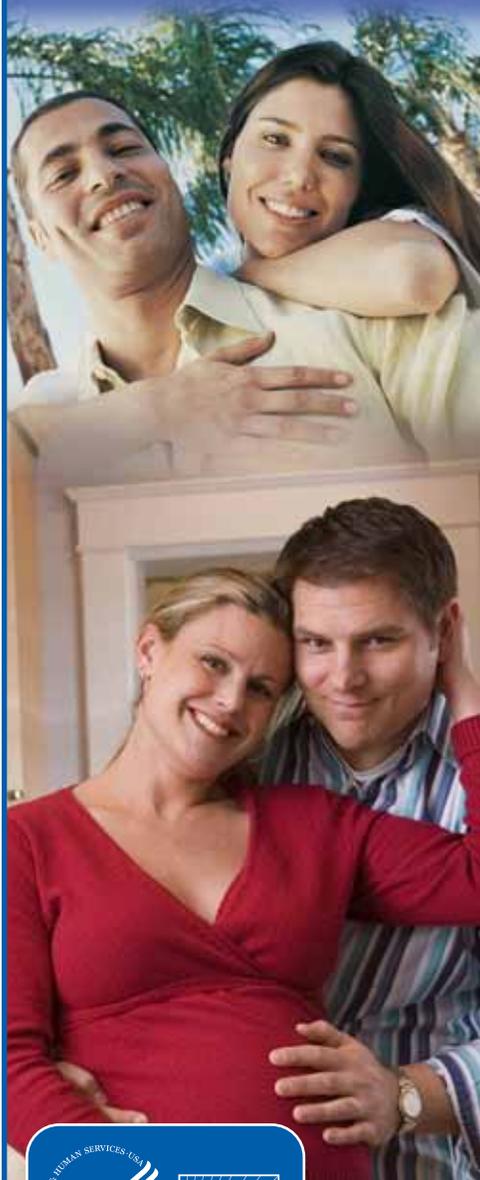
When making a reproductive life plan, the following questions might be helpful. These are probably not all of the questions that you will want to ask yourself, but they will help you to get started.

If you **DO NOT** want to have children, you might ask yourself:

- How do I plan to prevent pregnancy? Am I sure that I or my partner will be able to use the method chosen without any problems?
- What will I do if I or my partner becomes pregnant by accident?
- What steps can I take to be as healthy as possible?
- What medical conditions (such as diabetes, obesity, and high blood pressure) or other concerns (such as smoking, drinking alcohol, and using drugs) do I need to talk about with my doctor?
- Is it possible I could ever change my mind and want to have children one day?

If you **DO** want to have children one day:

- How old do I want to be when I start and when I stop having children?
- How many children do I want to have?
- How many years do I want between my children?
- What method do I plan to use to prevent pregnancy until I'm ready to have children? Am I sure that I or my partner will be able to use this method without any problems?
- What, if anything, do I want to change about my health, relationships, home, school, work, finances, or other parts of my life to get ready to have children?
- What steps can I take to be as healthy as possible, even if I'm not ready to have children yet?
- What medical conditions (such as diabetes, obesity, and high blood pressure) or other concerns (such as smoking, drinking alcohol, and using drugs) do I need to talk about with my doctor?



Examples of Plans

Following are some examples of reproductive life plans:

- I've decided that I don't want to have any children. I will find a good birth control method. Even though I don't want to have children, I will talk to my doctor about how I can be healthier.
- I'm not ready to have children now because I want to finish school first. I'll make sure I use effective birth control and protect myself from sexually transmitted diseases every time I have sex. Some day, I think I'd like to have two or three children about 2 years apart. Before I get pregnant, I will talk to my doctor about losing weight and eating healthy.
- I want to have children when I've saved some money. My partner has diabetes so, when it's time, I'll encourage her to see her doctor to make sure her body is ready for pregnancy. In the meantime, we're taking really good care of ourselves just for us.
- I might want to have children one day, but I'm not sure right now. For now I'm not going to have sex. Even though I'm not ready to have kids yet, I'm going to talk with my doctor about how I can be as healthy as possible.
- I am in a good relationship and I'm pretty healthy. I want to stop using birth control and try to get pregnant. I'm going to talk to my doctor to find out what I can do to have a healthy pregnancy.
- I've had two kids, and they were only a year apart. Both times, it just happened. I want to have another kid before I turn 36, but I want to wait at least 2 years. I'll talk to my doctor about birth control. This time, I'm going to make sure I get pregnant only when I want to.
- I'm going to let pregnancy just happen whenever it happens. Because I don't know when that will be, I'm making sure that I'm in the best health now, just in case!
- My partner and I are ready to have a child, but we'll need to use a sperm bank or fertility service to get pregnant. I'll make sure I'm in good health and financially stable before we use those services.

Take Action

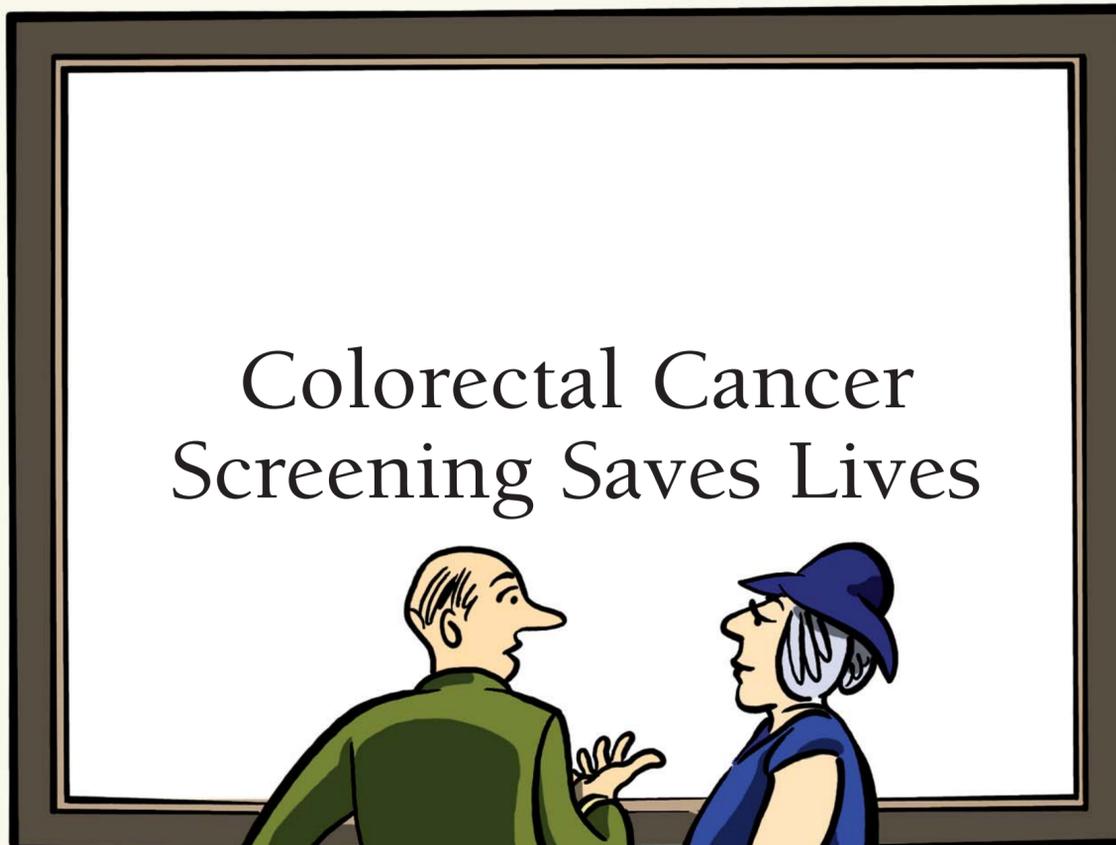
Once you have a plan, take action. For example, if you've decided to use condoms to prevent pregnancy, be sure to use them every time you have sex. Or, if you've decided to quit smoking, follow through and get help if needed.

Keep in mind that your plan doesn't have to be set in stone. Life is unpredictable! So, make a plan today, give it some thought each year, and expect to make changes along the way.

For more information please visit: www.cdc.gov/preconception

This Reproductive Life Plan was developed in partnership with Merry-K Moos, RN, FNP, MPH, FAAN, Department of Obstetrics and Gynecology, University of North Carolina at Chapel Hill and is based on her webinar, "Reproductive Life Plans" (February 25, 2010) available at <http://www.beforeandbeyond.org/?page=cme-modules>.





Colorectal Cancer Screening Saves Lives



“Now THAT I understand.”

If you're over 50, get tested for colorectal cancer.



Polyps and colorectal cancer don't always cause symptoms. That's why screening is so important... screening helps find precancerous polyps, so they can be removed before they turn into cancer.

See your doctor and get screened.



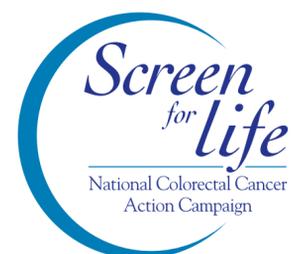


What do these busy people have in common?

They all got tested for colorectal cancer.
If they have time, so do you.

Screening saves lives. Screening tests help find precancerous polyps
so they can be removed **before** they turn into cancer.

If you're over 50, take time to see your doctor and get screened.



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention



1-800-CDC-INFO (1-800-232-4636) • www.cdc.gov/screenforlife

Are You the Picture of Health?

“You might look and feel fine, but you need to get the inside story. Colorectal cancer often has no symptoms, so please get tested. I did.”

*Katie Couric, Co-Founder
EIF's National Colorectal Cancer Research Alliance*

Screening can detect precancerous polyps so they can be removed **before** they turn into colorectal cancer.

If you're 50 or older, talk to your doctor and get screened.

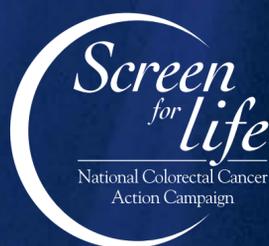


Photo by Hilmar

Call: 1-800-CDC-INFO • Visit: www.cdc.gov/screenforlife



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention



This is personal.

“My mother was the cornerstone of our family. When she was diagnosed with colon cancer, it was like the whole family got cancer. She died when she was only 56. Let my heartbreak be your wake-up call.”

Terrence Howard, actor/musician



Photo: Andrew Macpherson

Colorectal cancer is the second leading cancer killer in the U.S., but it is largely preventable. If you're 50 or older, please get screened. Screening finds precancerous polyps, so they can be removed before they turn into cancer. And screening finds colorectal cancer early, when treatment works best. If you're at increased risk—if you have a personal or family history of polyps or colorectal cancer, or you have inflammatory bowel disease—ask your doctor when to start screening. **Screening saves lives.**



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention



**National Colorectal Cancer
RESEARCH ALLIANCE™**
Entertainment Industry Foundation Program



1-800-CDC-INFO (1-800-232-4636) • www.cdc.gov/screenforlife

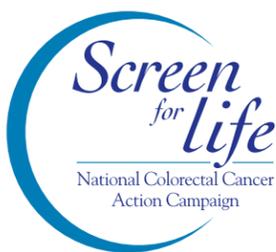
“Why Should I Get Screened?”

Colorectal Cancer Screening Saves Lives

Colorectal cancer is the 2nd leading cancer killer in the U.S.

But it can be prevented. Screening helps find precancerous polyps so they can be removed before they turn into cancer. Screening can also find colorectal cancer early, when treatment is most effective.

If you're 50 or older—don't wait. Talk to your doctor and get screened.



www.cdc.gov/screenforlife
1-800-CDC-INFO (1-800-232-4636)

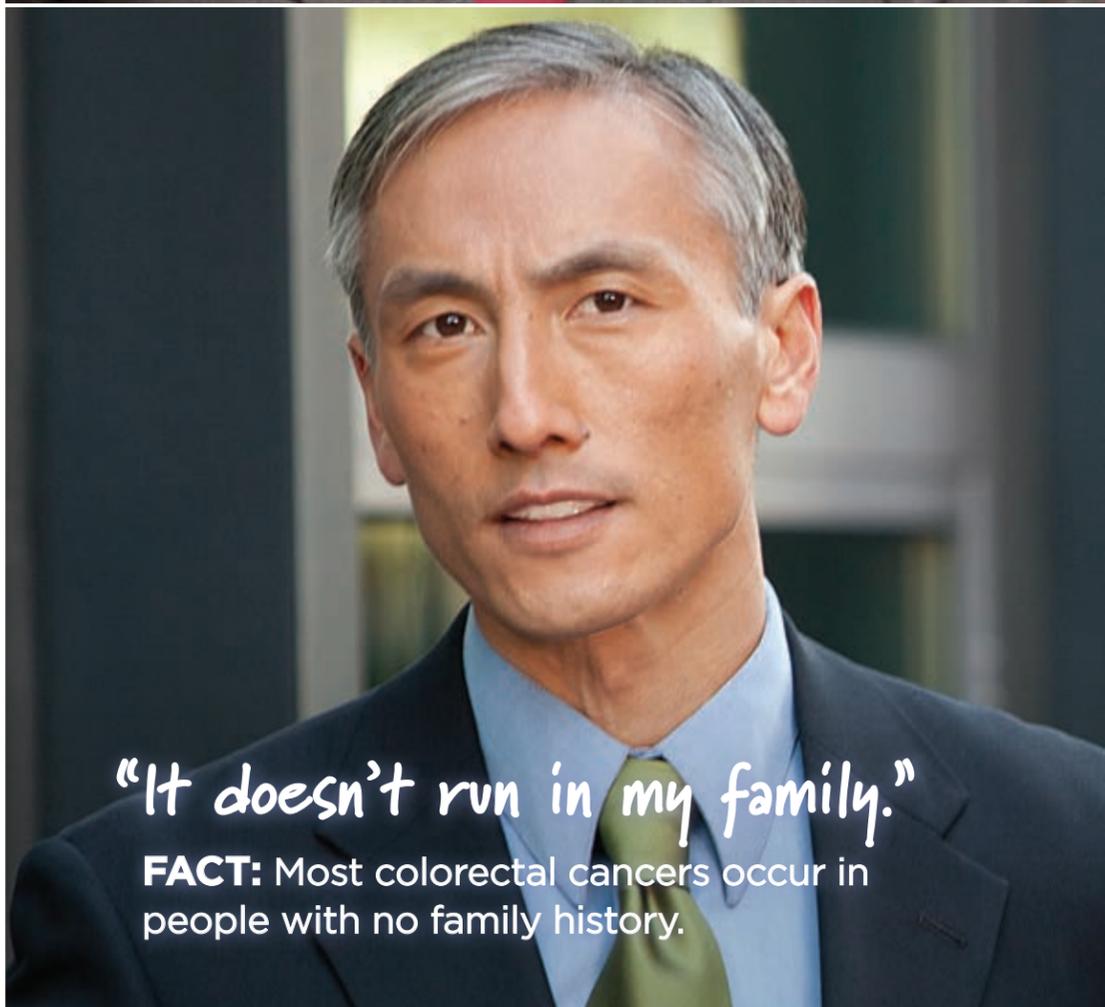


U.S. Department of Health and Human Services
Centers for Disease Control and Prevention



“I don't have symptoms.”

FACT: Colorectal cancer doesn't always cause symptoms, especially early on.



“It doesn't run in my family.”

FACT: Most colorectal cancers occur in people with no family history.



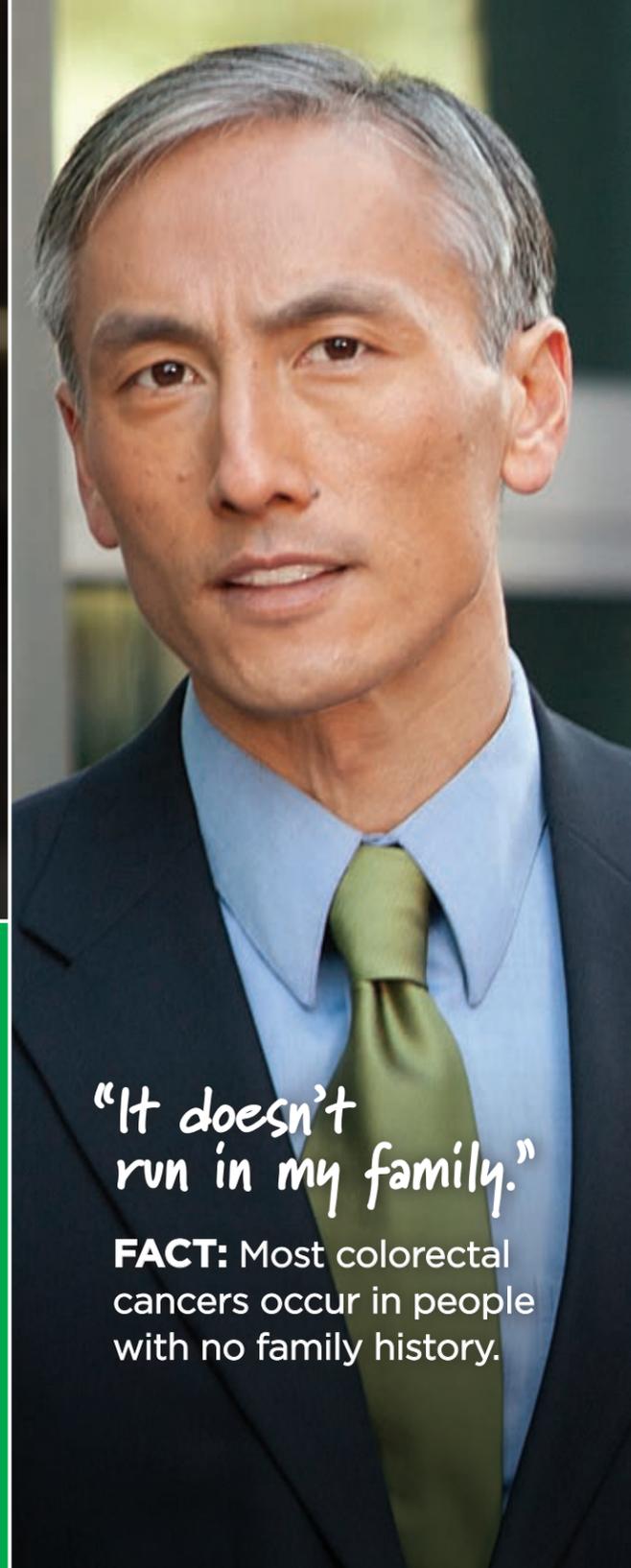
“But that test...”

FACT: There are several kinds of screening tests for colorectal cancer.



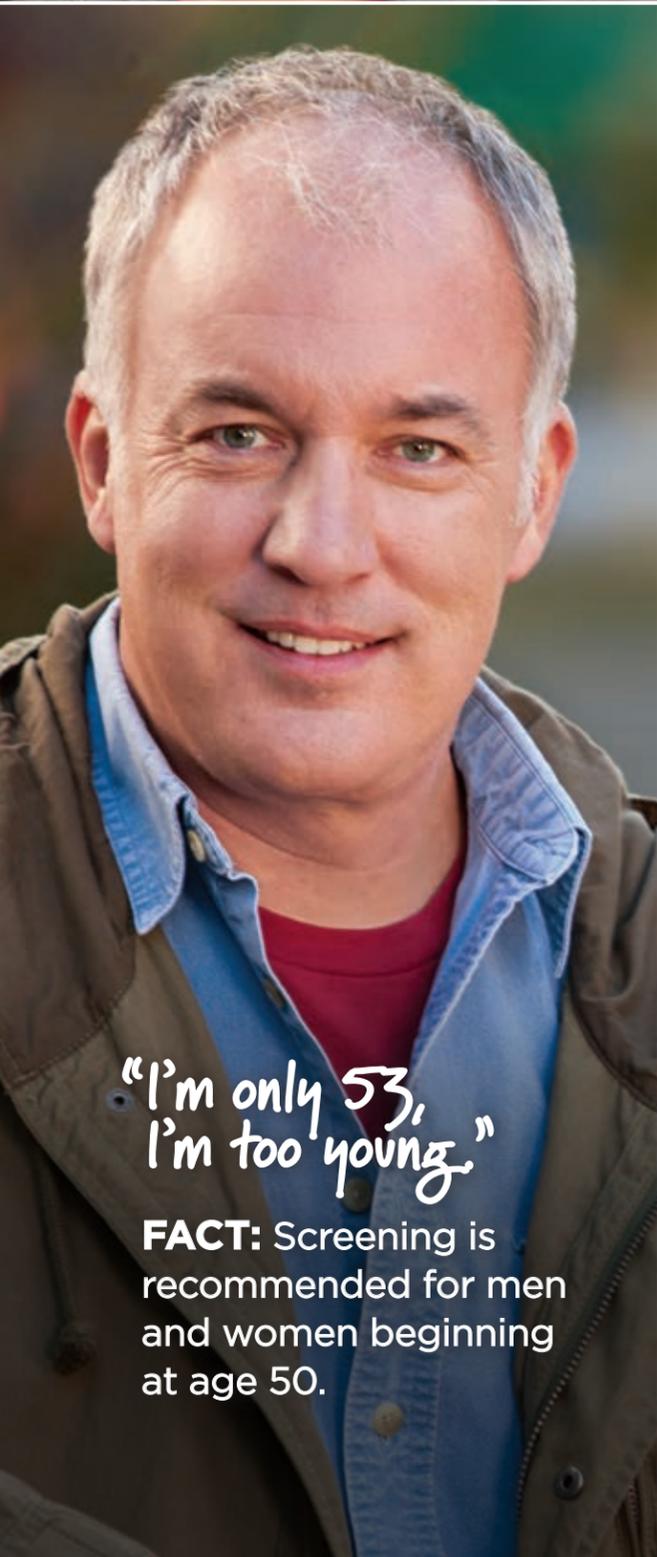
"I don't have symptoms."

FACT: Colorectal cancer doesn't always cause symptoms, especially early on.



"It doesn't run in my family."

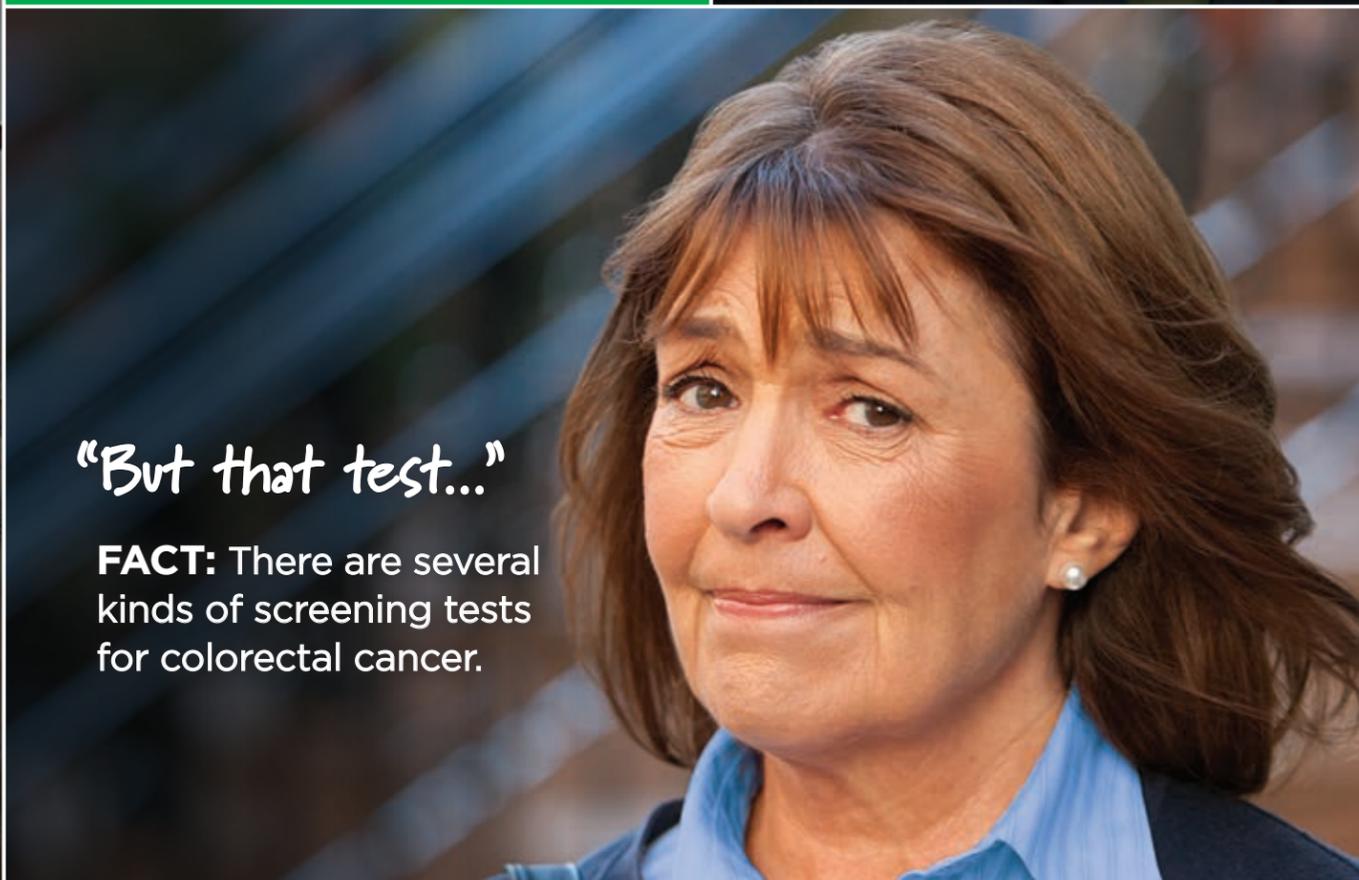
FACT: Most colorectal cancers occur in people with no family history.



"I'm only 53, I'm too young."

FACT: Screening is recommended for men and women beginning at age 50.

"Why Should I Get Screened?"

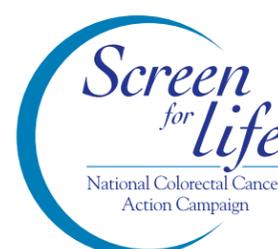


"But that test..."

FACT: There are several kinds of screening tests for colorectal cancer.

Screening Saves Lives

Colorectal cancer is the 2nd leading cancer killer in the U.S. But it can be prevented. Screening helps find precancerous polyps so they can be removed before they turn into cancer. Screening can also find colorectal cancer early, when treatment is most effective. **If you're 50 or older — don't wait. Talk to your doctor and get screened.**



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

www.cdc.gov/screenforlife
1-800-CDC-INFO (1-800-232-4636)

TRUE *or* FALSE?

Colorectal cancer is the 2nd leading cancer killer.

TRUE

FALSE

Both men and women get colorectal cancer.

TRUE

FALSE

Colorectal cancer often starts with no symptoms.

TRUE

FALSE

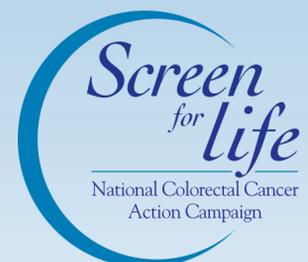
You can stop this cancer before it starts.

TRUE

FALSE

Testing for colorectal cancer can save your life.

Screening tests can find precancerous polyps so they can be removed before they turn into cancer. Screening can also find colorectal cancer early, when treatment is most effective. Talk to your doctor and Screen for Life.



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention



1-800-CDC-INFO (1-800-232-4636) • www.cdc.gov/screenforlife

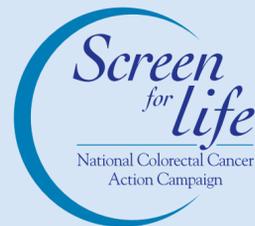
Are you the picture of health?

**“Colorectal cancer is the 2nd leading cancer killer.
But it doesn’t have to be.”**

*Katie Couric, Co-Founder
EIF’s National Colorectal Cancer Research Alliance*

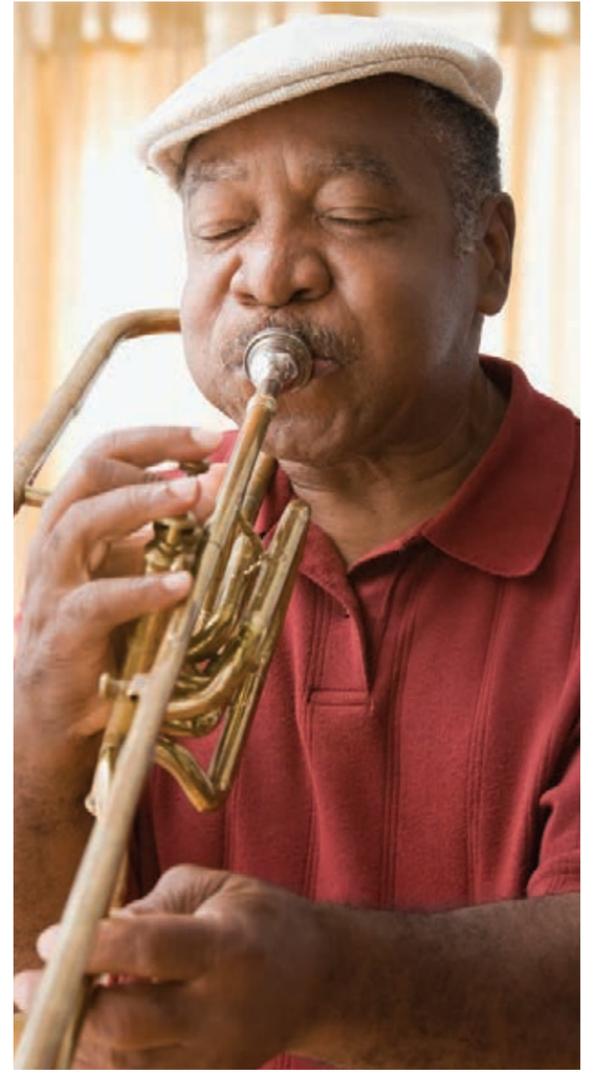
Colorectal cancer and precancerous polyps don’t always cause symptoms. So you can look healthy and feel fine and not know there may be a problem. ■ Screening helps find polyps so they can be removed **before** they turn into colorectal cancer. This is one cancer you can prevent! ■ Screening can also find colorectal cancer early, when treatment often leads to a cure. ■ If you’re 50 or older, make sure you really are the picture of health. Get screened for colorectal cancer.

1-800-CDC-INFO (1-800-232-4636) • www.cdc.gov/screenforlife



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention

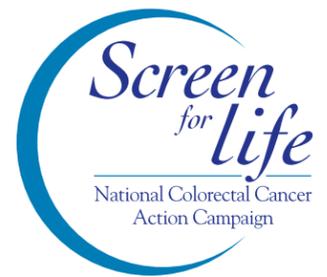




Colorectal cancer is the 2nd leading cancer killer in the U.S. But it doesn't have to be.

Getting screened for colorectal cancer beginning at age 50 helps **prevent** the disease. Screening finds precancerous polyps so they can be removed **before** they turn into cancer. Screening also finds colorectal cancer early, when treatment can be most effective.

This is one cancer you can prevent! If you're 50 or older, get screened for colorectal cancer. **Screening Saves Lives.**



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention



1-800-CDC-INFO (1-800-232-4636) • www.cdc.gov/screenforlife



Show your love.

Your future is filled with many possibilities and choices. The demands of everyday life are great. It's important to show yourself some love so that you'll be ready to take on the world.

What can you do?

- Choose behaviors like eating a healthy diet, being physically active and taking folic acid every day.
- Stop smoking, using street drugs, and drinking excessive amounts of alcohol.
- Get screened and tested for possible medical problems like infections or diabetes.
- Talk with your doctor about how to best manage your medical conditions.
- Make sure your vaccinations are up-to-date.
- Get mentally healthy.
- Get regular checkups at least once a year.
- Use an effective method of contraception correctly and consistently to prevent pregnancy.

For more information on how to improve your health now, talk with your doctor and visit www.cdc.gov/showyourlove.

Your Body Will Thank You For It!



Centers for Disease
Control and Prevention
National Center on Birth Defects
and Developmental Disabilities

1-800-CDC-INFO



Show your love.

Your future is filled with many possibilities and choices. The demands of everyday life are great. It's important to show yourself some love so that you'll be ready to take on the world.

What can you do?

- Choose behaviors like eating a healthy diet, being physically active and taking folic acid every day.
- Stop smoking, using street drugs, and drinking excessive amounts of alcohol.
- Get screened and tested for possible medical problems like infections or diabetes.
- Talk with your doctor about how to best manage your medical conditions.
- Make sure your vaccinations are up-to-date.
- Get mentally healthy.
- Get regular checkups at least once a year.
- Use an effective method of contraception correctly and consistently to prevent pregnancy.

For more information on how to improve your health now, talk with your doctor and visit www.cdc.gov/showyourlove.

Your Body Will Thank You For It!

Show
Your
Love  Preconception
Health



Centers for Disease
Control and Prevention
National Center on Birth Defects
and Developmental Disabilities

1-800-CDC-INFO

Show your love.

You're ready to get pregnant. It's time to nurture and love yourself by planning and preparing your body for pregnancy. Take these steps to improve your preconception health.

What is preconception health?

- Preconception health refers to a woman's health during the years she can have a baby.
- A woman's health before she gets pregnant can affect the health of her baby.

What can you do?

- Choose behaviors like eating a healthy diet, being physically active and taking folic acid every day.
- Stop drinking alcohol, smoking, and using street drugs.
- Get screened and tested for possible medical problems like infections or diabetes.
- Talk with your doctor about how to best manage your medical conditions and medicines with pregnancy in mind.
- Make sure your vaccinations are up-to-date.
- Get mentally healthy.
- Get regular checkups at least once a year.

For more information on how to improve your health now, talk with your doctor and visit www.cdc.gov/showyourlove.

Your Baby Will Thank You For It!



Centers for Disease
Control and Prevention
National Center on Birth Defects
and Developmental Disabilities



1-800-CDC-INFO

Show your love.

You're ready to get pregnant. It's time to nurture and love yourself by planning and preparing your body for pregnancy. Take these steps to improve your preconception health.

What is preconception health?

- Preconception health refers to a woman's health during the years she can have a baby.
- A woman's health before she gets pregnant can affect the health of her baby.

What can you do?

- Choose behaviors like eating a healthy diet, being physically active and taking folic acid every day.
- Stop drinking alcohol, smoking, and using street drugs.
- Get screened and tested for possible medical problems like infections or diabetes.
- Talk with your doctor about how to best manage your medical conditions and medicines with pregnancy in mind.
- Make sure your vaccinations are up-to-date.
- Get mentally healthy.
- Get regular checkups at least once a year.

For more information on how to improve your health now, talk with your doctor and visit www.cdc.gov/showyourlove.

Your Baby Will Thank You For It!

Show
Your
Love  Preconception
Love Health



Centers for Disease
Control and Prevention
National Center on Birth Defects
and Developmental Disabilities

1-800-CDC-INFO



Show your love.

You're ready to get pregnant. It's time to nurture and love yourself by planning and preparing your body for pregnancy. Take these steps to improve your preconception health.

What is preconception health?

- Preconception health refers to a woman's health during the years she can have a baby.
- A woman's health before she gets pregnant can affect the health of her baby.

What can you do?

- Choose behaviors like eating a healthy diet, being physically active and taking folic acid every day.
- Stop drinking alcohol, smoking, and using street drugs.
- Get screened and tested for possible medical problems like infections or diabetes.
- Talk with your doctor about how to best manage your medical conditions and medicines with pregnancy in mind.

For more information on how to improve your health now, talk with your doctor and visit www.cdc.gov/showyourlove.

Your Baby Will Thank You For It!

Show
Your
Love  Preconception
Health



Centers for Disease
Control and Prevention
National Center on Birth Defects
and Developmental Disabilities

1-800-CDC-INFO

BIBLIOGRAPHY

- Bakhtin, M. (1981). *The Dialogic Imagination: Four Essays*. Edited and translated by Brian Holquist. Translated by Caryl Emerson. University of Texas Press Slavic Series.
- Begley, S. (2012, November 13). Clinton says his foundation to tackle health disparities. *Reuters*. Retrieved from <http://www.reuters.com/article/2012/11/13/us-usa-health-clinton-idUSBRE8AC0KH20121113>
- Bennett, H.D., Coleman, E.A., Parry, C., Bodenheimer, T. Chen. E.H. (2010). Health coaching for patients with chronic illness. *Family Practice Management*, 17(5), 24-29.
- Berry, E. (2008). Health plans push for more health coaching. *American Medical News*, 51(28), 11.
- Bodenheimer, T., Laing, B.Y. (2007). The teamlet model of primary care. *Annals of Family Medicine*, 55, 457-461.
- Brandt, A.M., & Rozin, P. (Eds). (1997). *Morality and Health*. Routledge.
- Buchanan, D.R. (2008). Autonomy, paternalism and justice: ethical priorities for public health. *American Journal of Public Health*, 98, 1, 15-21.
- Butterworth, S., Linden, A., McClay, W., Leo, M.C. (2006). Effect of motivational interviewing- based health coaching on employees' physical and mental health status. *Journal of Occupational Health Psychology*, 11(4), 358-365.
- Butterworth, S., Linden, A., McClay, W. (2007). Health coaching as an intervention in health management Programs. *Disease Management & Health Outcomes*, 15, 299-307.
- Clarke, A.E., Shim, J.K, mamo, L., Fosket, J.R., Fishman, J.R. (2003). Biomedicalization: technoscientific transformations of health, illness and U.S. biomedicine. *American Sociological Review*, 68, p. 161-194.
- Conrad, P. (2007). *The Medicalization of society. On the transformation of human conditions into treatable disorders*. Baltimore: the Johns Hopkins University Press.

- Crawford, R. (2006). Health as a meaningful social practice. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, 10(4), pp. 401-420.
- Delanty, G. (2009). The foundations of social theory. In B.S. Turner, (Ed.), *The New Blackwell Companion to Social Theory*, Wiley-Blackwell, pp.19-38.
- Dubos, R. (1984). *Mirage of Health: Utopias, Progress and Biological Change*. Rutgers University Press.
- Dumit, J. (2002). Drugs for life. *Molecular Interventions*, 2, 3, p. 124-127.
- Eagleton, T. (1994). *Ideology*. London, New York: Longman.
- Feenberg, A. (1991). The technocracy thesis revisited: on "The Critique of Power." *Inquiry*, 37, pp.85-102.
- Fetterman, D.M. (2009). *Ethnography: Step-by-step*. Third Edition, Sage Publications Inc.
- Foucault, M. (1973). *The Birth of the Clinic; An Archeology of Medical Perception*. Translated from the French by A.M. Sheridan Smith. Pantheon Books: New York.
- Foucault, M. (1984). The politics of health in the eighteenth century. In P. Rabionw (Ed.), *The Foucault Reader*. New York: Pantheon Boods, pp. 273 – 289.
- Gee, J.P. (1999). *Introduction to discourse analysis: Theory and method*. London, New York: Routledge.
- Gee, J.P. (2010). *How to do discourse analysis: A toolkit*. London, New York: Routledge.
- Glanz, K., Rimer, B. & Viswanath, K. (Eds.) (2008). *Health Behavior and Health Education: Theory, Research and Practice*. Jossey Bass, A Wiley Imprint.
- Goffman, E. (1979). *Gender Advertisements*. New York: Harper & Row.
- Greenberg, J., Newcomer, R., Tidwell, L., Mullan, J., Malone, J., Hollan, S.K. (2005). Community-based health coaching, exercise, and health service utilization. *Journal of Aging and Health*, 17(6), 697-716.
- Gulino Schaub, B., Luck, S., Dossey, B. (2012). Integrative Health Coaching for Health and Wellness. In *Alternative and Complementary Therapies*, Mary Ann Liebert Inc., 10(1), 14-20.
- Habermas, J. (1984). *The Theory of Communicative Action. Volume One: Reason and the rationalization of society*. London: Heinemann.
- Habermas, J. (1987). *The Theory of Communicative Action. Volume Two: Life world and system: a critique of functionalist reason*. Cambridge: Polity Press.

- Health coaches critical to making health care more patient-centered. (2011). *Managed Care Weekly Digest*, April 2011.
- Health coaches: improving employee well-being (and containing costs). (2010). *Industrial Safety Hygiene News*, 44.4 (April).
- Heinen, S. & Sommer, R. (2009). *Narratology in the age of cross-disciplinary narrative research*. Berlin: Walter de Gruyter.
- Herman, D., Jahn, M. & Ryan, M-L. (2005). *The Routledge Encyclopedia of Narrative Theory*. London, New York: Routledge.
- Hess, D., Dossey, B., Southard, M.E., Luck, S., Gulino Schaub, B., Bark, L. (2012). Draft: Professional nurse coach role: defining scope of practice and competencies. First Edition, Retrieved from http://www.ncchwc.org/files/DRAFT_2812_27_11_29_Professional_Nurse_Coach_Rol_Defining_Scope_of_Practice_and_Compencies_.pdf
- Holquist, M. (2002). *Dialogism: Bakhtin and his world*. London, New York: Routledge, 2nd ed.
- Huffman, M. (2007). Health coaching: a new and exciting technique to enhance patient self-management and improve outcomes. *Home Healthcare Nurse*, 25(4), 271-274.
- Huffman, M. (2009). A fresh, new approach to improve quality outcomes and compliance for patients with chronic conditions. *Home Healthcare Nurse: The Journal for the Home Care and Hospice Professional*, 27(8), 490-496.
- Huffman, M. (2012). Health coaching trends for 2012. *Healthcare Intelligence Network Podcast*. Podcast retrieved from <http://www.nshcoa.com/site/>
- Kevinmd, G. (2009). What is a health coach and what are they doing. Retrieved from <http://www.kevinmd.com/blog/2009/03/what-is-health-coach-and-why-are-they.html>
- Kim, S.H. (2012). Max Weber. In *The Stanford Encyclopedia of Philosophy*, Retrieved at <http://plato.stanford.edu/entries/weber/>
- Kickbusch, I. (2010). Health governance: The health society. In: McQueen, D.V. and Kickbusch, eds. *Modernity and Health*. Springer, 146-161.
- Kress, G. & van Leeuwen, T. (2006). *Reading Images: The grammar of visual design*. 2nd Ed. London, New York: Routledge.
- Leveille, S.G., Phelan, E.A, Davis, C., Logerfo, M., Logerfo, J.P. (2004). Preventing disability through community-based health coaching. *Journal of the American Geriatrics Society*, 52(2), 328-329.

- Linden, A., Butterworth, S.W, Prochaska, J.O. (2010). Motivational interviewing-based health coaching as a chronic care intervention. *Journal of Evaluation in Clinical Practice*, 16(1), 166-174.
- Lupton, D. (1995). *The imperative of health: public health and the regulated body*. Sage Publications, Ltd.
- Martinez, J., Ro, M., Villa, N.W., Powell, W., Knickman, R. (2011). Transforming the delivery of care in post-health reform era: what role will community health workers play? *American Journal of Public Health*, 101(12), e1-e5.
- Margolius, D., Bodenheimer, T., Bennett, H., Wong, V., Padilla, G., Thom, D.H. (2012). Health coaching to improve hypertension treatment in a low-income, minority population. *Annals of Family Medicine*, 10, 199-205.
- Mason, J. (2002). *Qualitative Researching*. Second Edition, Thousand Oaks, CA: Sage Publications
- Merril, R.M., Aldana, S.G, Bowden, D.E. (2010). Employee weight management through health coaching. *Eating and Weight Disorders – Studies on Anorexia, Bulimia and Obesity*. 15(1-2), e52-e59.
- McCall, N., Cromwell, J. (2011). Results of the medicare health support disease-management pilot program. *N Engl J Med*, 365, 1704-1712.
- Morris, P. (Ed.) (2009). *The Bakhtin Reader: Selected writing of Bakhtin, Medvedev and Voloshinov*. Bloomsbury Academic.
- National Prevention Council, National Prevention Strategy. (2011). U.S. Department of Health and Human Services, Office of the Surgeon General, Washington, D.C., Retrieved from <http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf> and <http://www.hhs.gov/news/reports/nationalprevention2010report.pdf>, .
- National Strategy for Quality Improvement in Health Care. (2011). U.S. Department of Health and Human Services, Washington, D.C.. Retrieved from <http://www.healthcare.gov/law/resources/reports/quality03212011a.html>
- O'Connor, A.M., Stacey, D., Legare, F. (2008). Coaching to support patients in making decisions. *BMJ*, 336(7638), 228-229.
- Olsen, J.M., Nesbitt, B.J. (2010). Health coaching to improve healthy lifestyle behaviors: an integrative review. *American Journal of Health Promotion*, 25(1), e1-e12.
- Pallarito, K. (2008). Health coaches tackle both risks and goals; programs, expertise, and cost vary greatly. *Business Insurance*, 42.16, 14.

- Palmer, S., Tubbs, I., Whybrow, A. (2003). Health coaching to facilitate the promotion of health behavior and achievement of health-related goals. *International Journal of Health Promotion & Education*, 41(3), 91-93.
- Palmer, S. (2004). Health coaching: a developing field within health education. *Health Education Journal*, 63(2), 189-191.
- Petersen, A, & Lupton, D. (1997). *The new public health: Health and self in the age of risk*. Sage Publications, Ltd.
- Potvin, L., Chabot, P. (2002). Splendour and misery of epidemiology for evaluation of health promotion. *Revista Brasileira de Epidemiologia*, 5 (Suppl. 1), pp. 91-103.
- Potvin, L., Gendron, S., Bilodeau, A., Chabot, P. (2005). Integrating social theory into public health practice. *American Journal of Public Health*, 95, 4, pp.591-595.
- Potvin, L., & Balbo, L. (2010). From a theory group to a theory book. In: McQueen, D.V. and Kickbusch, I. eds. *Modernity and Health*. Springer, pp. 6-20.
- Race, K. (2012). 'Frequent sipping': Bottled water, the will to health and the subject of hydration, *Body & Society*, 18, 3-4, pp. 72-98.
- Richardson, B. (2000). Recent concepts of narrative and the narratives of narrative theory. *Style*, 34(2), p. 169.
- Rose, N. & Novas, C. (2005). Biological Citizenship. In A. Ong and S. Collier (Eds.) *Global Assemblages: Technology, politics and ethics as anthropological problems*. Malden, MA: Blackwell
- Rollnick, S., Miller, W. R. & Butler, C. C. (2008) *Motivational Interviewing in Health Care: Helping Patients Change Behavior*. New York: Guilford Press
- Rubak S, Sandbaek A, Lauritzen T, Christensen B. (2005). Motivational interviewing: a systematic review and meta-analysis. *British Journal of General Practice*, 55, 305-12.
- Scambler, G. (2001). Introduction: unfolding themes of an incomplete project. In G.Scambler (Ed.), *Habermas, Critical Theory and Health*. Routledge, London and New York, pp. 1-25.
- Scheper-Hughes, N., & Lock, M. (1987). The mindful body: a prolegomenon to future work in medical anthropology. *Medical Anthropology Quarterly*, 1(1), pp. 6-41.
- Schoeff, M. (2006). UPS employees get advice from health coaches. *Workforce Management*, 85.16, 14.

- Serlin, D., Bu, L., Cartwright, L. & Cooter, R. (2011). *Imagining Illness: Public health and visual culture*. University of Minnesota Press.
- Szabo, J. (2007). Health coaches win big by driving down costs: one-on-one training lets patients manage their illnesses and avoid hospital stays. *H&HN Hospitals & Health Networks*, 81(2), 28.
- Tesh, S.N. (1988). *Hidden Arguments: Political Ideology and Disease Prevention Policy*. New Brunswick: Rutgers University Press.
- Thomson Healthcare Company, (2011). Expand occupational health role to that of a health coach. *Occupational Health Management*
- U.S. Department of Health & Human Services. (2010). *Healthy People 2020: Improving the Health of Americans*. Retrieved from <http://www.healthypeople.gov/2020/default.aspx>
- U.S. Department of Labor. Occupational Outlook Handbook. Retrieved from <http://www.bls.gov/ooh/Community-and-Social-Service/Health-educators.htm>
- Van Leeuwen, T. & Jewitt, C. (2001). *Handbook of Visual Discourse Analysis*. Sage Publications Ltd.
- Van Ryn, M., Heaney, C. A. (1997). Developing effective helping relationships in health education practice. *Health Education & Behavior*, 24, 683–702.
- Wetzel, T.G. (2012). Health coaching: hospitals update their playbooks to make patients active members of the care team. *H & HN Hospitals & Health Networks*, 85.5 (May, 2011), 20-24.
- Wodak, R. (2006). Critical discourse analysis. In C. Seale, D. Silverman, J.F. Gubrium, G.Gobo (Eds.). *Qualitative Research Practice: Concise paperback edition*. Sage Publications Ltd, pp. 185-203.
- Wodak, R., & Meyer, M. (Eds.) (2009). *Methods of Critical Discourse Analysis*. Second Edition, Sage Publications.
- Wolcott, H.F. (1994). *Transforming Qualitative Data: Description, analysis, and interpretation*. Thousand Oaks, CA: Sage Publications.
- Wolcott, H.F. (2004). *The Art of Fieldwork*. AltaMira Press. Second Edition.
- Wolever, R.Q., Dreusicke, M., Fikkan, J., Hawkins, T.V., Yeung, S., Wakefield, J., Duda, L., Fowers, P., Cook, C., Skinner, E. (2010). Integrative health coaching for patients with type 2 diabetes: a randomized control trial. *The Diabetes Educator*, 36, 629-639.

Wolever, R.Q., Caldwell, K.L, Wakefield, J.P., Little, K.J., Gresko, J., Shaw, A., Duda, L.V., Kosey, J.M., Gaudet, T. (2011). Integrative health coaching: an organizational case study. *Explore – The Journal of Science and Healing*, 7(1), 30-36.

World Health Organization. (1986). Ottawa Charter for Health Promotion. Retrieved from <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/>

World Health Organization. (2005). The Bangkok Charter for Health Promotion in a Globalized World. Retrieved from http://www.who.int/healthpromotion/conferences/6gchp/bangkok_charter/en/
