13 Social Patterning of Behaviour

Learning Objectives

In this chapter, you will learn to

- Understand why it is a mistake to regard health-related behaviour as freely chosen by the individual;
- Provide reasons as to why much of human behaviour is context-dependent;
- Appreciate that health-promotion initiatives that target individual behaviour will be of limited impact if contextual variables are ignored;
- Understand why the idea of "healthy lifestyles" is problematic, and therefore not a sound basis for health policy.

Chapter Overview

The chapter begins with an overview of the differences in lifestyles between more and less well-off individuals. Socio-economic status is associated with smoking, drinking, and exercising, and contributes to notable differences in "risky" behaviours. We ought to understand that health behaviours are socially patterned. The assumptions of health beliefs model and rational choice theories are simplistic in their understanding of human behaviour. Theories based in neuroscience and sociology demonstrate that our behaviour is not always (or exclusively) driven by our own free will. The author then considers how this approach can be applied to health promotion and public policy. By examining smoking and substance misuse, for example, we can see that health promotion and public policy in Canada need to consider a different approach. The discourse on healthy lifestyle is shaped by dominant agendas of upper social classes. The section ends with theoretical considerations that explore the links between population health and social justice.

Key Terms and Concepts

Agency an ability to make a choice about one's life (p. 306)

Behaviourist interventions interventions that seek to change individuals' behaviour (p. 306)

Brain plasticity a suggestion that brain has an ability to change throughout life (p. 312)

Enculturing brains an idea that history and other forms of socially patterned practice become encoded in the brains of people participating in each particular social formation (p. 312)

Free will capacity on the part of the person to choose (p. 306)

Fully informed consent a consent that is given after a health care provider offered detailed information about the proposed procedure and its risks and potential benefits (p. 309)

Habitus embodied habits and behaviours of individuals (p. 320).

Lifestyle a medley of practices embraced by a person as a statement of who he or she is (p. 318)

Methodologically individualist approach an approach that focuses on individual and individual's free will (p. 306)

Neural sculpting an ability of the brain to create new patterns of behaviours (p. 312)

Nudge theory the theory that suggests that the behaviour of individuals can be changed by subtle incentives or cues (p. 319)

Sin tax taxes imposed on products and services that are considered to be unhealthy (p. 309)

Social influence recognition that information available to individuals, and the content of their beliefs, may be modified by exogenous variables such as education, advertising, or information sharing within networks (p. 306)

Social patterning of behaviour a view that individual behaviour is associated with the population to which that individual belongs (p. 308)

Social structures relatively stable patterns of social relations (p. 308)

Study Questions

Scroll down for answers.

1. Summarize the link between socio-economic status and "risky" behaviours.

2. Summarize the health beliefs model.

3. Explain how rational behaviour can be understood using neuroscience.

4. Explain what Giddens means when he argues that human action is enstructured.

Critical Thinking Questions

Scroll down for answers.

1. Explain why we find a relationship between socio-economic status and unhealthy behaviours.

2. Explain and evaluate the theories focusing on individuals' rational behaviour. To what degree can these theories explain individuals' health choices?

3. Describe some of the implications of the recognition of patterning of behaviour by social variables for health promotion and public policy.

Annotated Multimedia Resources

1. Nudging our kids and families towards better eating
   https://www.youtube.com/watch?v=9WC8A1Lrq8M (8:32 min)
   This animated video by Dr. Mike Evans examines how we can make families eat better.

2. History of Nudge: Learn the power of nudge to win at behavioral change
   https://www.youtube.com/watch?v=jVTg3ZsNTTY (6:14 min)
   This short video explains nudging theory and looks at the contributions it made to the traditional psychology.

3. Agency–Structure Dualism: Critical Social
   https://www.youtube.com/watch?v=Y11rbS15cBY (2:34 min)
   This short video from the Open University examines the dualistic approach to agency and structure. The video encourages us to reconsider the dualism in our understanding of these two concepts.

4. It's Time to Focus on Health Prevention and Promotion
   https://www.youtube.com/watch?v=eOhv5gF987s (14:46 min)
   In this TEDX Talk, Dr. Derek Yach, a Chief Health Officer at the Vitality group who previous worked at WHO, claims that we need to rethink our approach to health promotion.

5. Powerful Possibilities for Making Prevention Better than Cure
   https://www.youtube.com/watch?v=mEPMRoBUAkA (11:22 min)
   In this TEDX Talk, Steven Tucker talks about the benefits of focusing on health prevention over focusing on curing the disease and explains how we can make it work.

6. An Introduction to Health Promotion and the Ottawa charter
   https://www.youtube.com/watch?v=G2quVLcJVBk (5:46 min)
   This short video summarizes the Ottawa Charter for health promotion and focuses on empowerment of individuals as a key strategy for improving population health.

7. How to Create Health Change That Lasts
   https://www.youtube.com/watch?v=iv8J3vh600w (12:00 min)
   This TEDX Talk examines how we can create a long-lasting change in our health behaviours.

8. The Paradox of Choice
   https://www.ted.com/talks/barry_schwartz_on_the_paradox_of_choice?referrer=playlist-how_we_make_choices (18:52 min)
   In this TED Talk, psychologist Barrie Schwartz claims that choice and freedom of choice do not make us happy.

Answers to Study Questions

1. Most "risky behaviour" is more common among less well-off people—people with lower incomes and less education—or among the socially marginalized. Important examples include smoking, leading a sedentary lifestyle, having multiple sexual partners, and engaging in a host of dangerous activities ranging from speeding, drinking and driving, driving without use of a seatbelt, illicit drug use, and binge drinking. There a few exceptions such as extreme sports, horse riding, boating, and skiing—all dangerous yet more common among affluent people. But risky recreation involves only a small minority and accounts overall for very little population-health impact. In contrast, smoking and inactivity, due to their prevalence, have enormous population-health implications. (p. 303)
2. Health Beliefs Model is a model of health behaviour that relies on four key variables: (1) self-perceived personal risk; (2) self-perceived severity of the outcomes associated with unhealthy behaviour; (3) self-perceived barriers to and costs of behavioural change; and (4) self-perceived benefits of making the behavioural change. (p. 307)
3. Neurology has undermined the traditional view of agency. As long ago as the 1980s, neuropsychologist Benjamin Libet questioned the existence of human free will based on a series of experiments showing (he thought) that the brain determines actions before the person has considered what they want to do and has become aware of that decision. Activity in the brain and in motor-neuron units precedes consciousness. Libet's findings do not imply that people are unable to choose their own actions, a conclusion he erroneously advanced, but suggest choice is far more constrained and unconscious than naïve models of human behaviour allow. Social psychologist John Bargh shows in his program of research that much of what we experience as "choice" is actually the brain's automatic interpretation of, and reaction to, stimuli arising from our context. (p. 311)
4. According to Giddens, human action is intentional and goal directed, but we arrive at our understandings of what is possible and how best to attain it through the social institution of language, our interactions with others, and our place in a variety of social institutions ranging from our families, our workplaces, to the broader social and economic structures of our society. In reality, we do not see free action on one hand and a range of determined outcomes arising from structural social forces on the other, but rather an interaction of agency and structure, individuals and their social contexts—"enstructuration." (p. 312)

Answers to Critical Thinking Questions

1. Behaviour like eating habits, physical activities, and smoking corresponds not only to an individual's income, education, and gender but also to the characteristics of his or her surroundings. Income, education, gender, and neighbourhood characteristics strongly condition individual behaviour. At the individual level, more education means greater health knowledge, better problem-solving and planning skills, and a stronger sense of personal efficacy. At the social level, more education means a job context that reinforces health promotion and discourages health-damaging behaviour, better social support, and a broader, richer social network. More income means more access to personal, as well as community, resources supportive of healthy choices. It also means living in a better, safer, well-resourced neighbourhood among other more affluent, better-educated people. Gender roles directly affect a broad range of activities and influence behavioural determinants, such as competitiveness. Stress, both during childhood and later in life due to workplace, neighbourhood, and other

social contextual factors, is strongly linked to adult smoking, compulsive eating, binge drinking, and drug abuse. (p. 305)

2. Recent research on what people actually choose has undermined models of agent rational choice. For example, in real life, people will choose outcomes that they conceive as being fairer even when, as result, they personally end up bearing additional costs or receiving lower benefits. The fact that people are not motivated to maximize benefits and minimize costs calls into question the naïve account of human behaviour that informs much health-promotion activity. A meaningful application of such findings comes from research on incentives. Doctors respond by providing more preventive services, such as blood-pressure monitoring, when financial incentives to do so are introduced into payment schemes. Incentives can have an effect, sometimes a very large one. But interestingly, incentives only seem to work if the thing incentivized is something the person wanted to do anyway and the incentive is quite large. Almost all current smokers would like either to quit or smoke less, thus smokers often welcome schemes that incentivize quitting, make continuing to smoke more costly or inconvenient, or remind people of the hazards associated with smoking. The same logic does not carry over to sugary or fatty snacks, fast food, or physical exercise. Small incentives, or incentives to do something the person is disinclined to do for whatever reason, are much less effective in altering behaviour. Incentives have perverse and unintended effects as well as the desired ones. In health-promotion work, this has generally been ignored because the implicit motivational models have been either too crude or simply wrong. For reasons such as these, we need to be wary of the effects of such popular measures as taxes on sugary drinks and fatty foods. (pp. 308–309)
3. The recognition of patterning of behaviour by social variables calls into question the common belief that people choose how they behave and that hence they are personally responsible for their behaviour. The assumption of personal responsibility leads to two common conclusions about people who are "acting badly" by, for example, smoking. They "misbehave" either because they do not know any better (the stupid hypothesis) or they misbehave because they are irresponsible (the feckless hypothesis). The social response takes the dual form of education about the harms of tobacco use and regulations such as smoking bans. But it turns out that virtually no one thinks smoking is harmless or that gaining a lot of weight is a good thing. People are not stupid, and it is paternalistic and offensive to contend that they are. Moreover, regulation against recklessness or irresponsibility raises some special problems. Regulation might produce the desired result with regard to simple actions that are easy to monitor, such as smoking or seatbelt use, but it is hard to see how prohibitions would work well elsewhere. How would we go about regulating eating behaviour or amounts of exercise for example? Moreover, the feckless hypothesis, contending that people are irresponsible or needlessly reckless, leads to coercion, which is then regarded by the target group as an assault on them. Working-class and Indigenous smokers reacted with understandable fury when middle-class policy-makers banned smoking in bingo halls. A hostile reaction is predictable when the target group regards the offending behaviour as part of what defines them—clubbing and pubbing among undergraduate students, for example. Health initiatives can thus be perceived as unwelcome, elitist intrusions into personal freedoms. Recognizing social patterning of behaviour would allow development of a more informed health promotion programs and public policies. (p. 313)