Young Cypriots’ consumer meanings of health-related behaviours

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Abstract

This study explores the complex ways that young Cypriots talk about consumer meanings associated with smoking, eating, drinking alcohol and exercise. This approach challenges the dominance of the orthodox (mainstream) Health Promotion research logic, which conceptualises these behaviours as health directed.

The research design captures the ways in which young people make sense of their health-related choices. The sample consists of 25 15 to 17 years-old living in the urban area of Nicosia. The principal features of the interviewing process were: open-ended; and one to one; to allow the respondents to talk about their everyday experiences which determine their behavioural choices. The data were analysed through the development of three categories, which aimed to reveal the consumer meanings associated with particular behaviours. These categories focus firstly, on embedded cultural traits (e.g. the quality of being ‘cool’), secondly, the role of these traits (e.g. used in projecting an image) and thirdly, reflections on the traits and their role in the context of their everyday lives. A central finding is that the consumer meanings of these practices amount to a vital resource through which young people play with their self- and life-style images, communicate and interact with peers.

This research highlights not only the validity but also the enhanced utility of understanding health-related behaviours in ways which depart from mono-directional and judgemental approaches within health promotion studies, which concentrate on the outcome to the exclusion of process. This research demonstrates the importance of taking full account of the ways in which young people make health-related choices as consumers, why those choices are meaningful to them and how the consequences of making those choices are understood. The significance of consumer culture in young people’s health-related choices is conceived not as a powerful meaning-making system which directs young people towards certain choices and excludes others, but as a phenomenon which activates young people to think about their choices in certain ‘consumer’ ways. This is a perspective which health promotion ought to both acknowledge and incorporate.
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Chapter 1

Introduction

Smoking, eating, drinking alcohol and exercise have this much in common. They are lifestyle activities. This, of course, begs the question, what does ‘lifestyle’ mean? It is an amorphous concept that has been interpreted in a variety of ways in different fields. This study is concerned with the approaches which have emerged in the areas of health promotion and consumer culture. Health promotion has arisen as a new system of health care focusing on the preventative rather than the curative (Bunton and Burrows, 1995), justified mainly on the grounds of the increased incidence of ‘lifestyle’ diseases (coronary heart disease (C.H.D), arteriosclerosis, cancer, etc.) as the major causes of premature death in the Western world (Conner and Norman, 1996; Ewles and Simnett, 1995). Consumer culture is seen as a more recent theoretical theme of consumption, emphasising the social and cultural aspect of the economic and utilitarian process (Chaney, 1996).

Within the area of health promotion, an umbrella term covering all interventions to promote good health (Naidoo and Wills, 1994), the notion of lifestyle constitutes an important component of preventative medicine, associated with health, and the degree to which people are ‘healthy’. It is generally recognised as being centred on four areas of personal behaviour: smoking; food intake; alcohol consumption and participation in physical exercise. Correspondingly, within the lifestyle field of health promotion, these four activities are classified as health-related behaviours and tend to be presented as the key elements in preventing disease or securing health. They are considered significant either as ‘health-impairing habits’ or ‘health-protective behaviours’ (Matarazzo, 1984 in Ogden, 1996). A ‘healthy lifestyle’ is thus promoted as a significant contributing factor to disease prevention, whereas an ‘unhealthy lifestyle’ is considered a risk factor, which may provoke the onset of disease.

As Gottlieb and Green (1984, p.104) stress, ‘these health practices may be health-related but they are not necessarily health directed’. Disconnecting these four
behaviours from the significance they have in the health promotion area we can also see them as 'consumer' activities, in the sense that they are charged with symbolic meanings through the marketing and advertising business (Lupton, 1995; Bunton and Burrows, 1995). The term ‘consumer’ in the present study is used in accordance within an orientation to consumer culture as a theoretical field, which focuses on the symbolic manifestation of commercial products and activities. When lifestyle is viewed through the domain of contemporary consumer culture it is more concerned with ways of expressing a ‘way of life’ (Miles, 1998), which, at the same time, connotes ‘a sense of the owner/consumer’ (Featherstone, 1991, p.83). Smoking, eating, drinking alcohol and exercise as consumer activities can be classified alongside other lifestyle activities such as choice of clothing or a particular car. They are also means through which an individual can express a way of living and thereby a sense of identity (Miles, 1998).

The way I have constructed the research project presented here is linked with both classifications of smoking, eating, drinking alcohol and exercise, as health-related behaviours and as consumer activities. My decision to explore these behaviours originated in their disease preventative role in health matters. If such a link among these four behaviours with health and prevention had not been the case, I would not have had any interest as a health promoter to explore them. My aspiration is to enrich health promotion ‘language’ to understand rather than devalue health-related behaviours. Nevertheless, I reject the notion of health and prevention as central conceptual frameworks in understanding young people’s meanings of health-related behaviours. I explore them as consumer activities by focusing on how these young people make sense of, and articulate, their ‘imagined’ cultural symbols of health-related behaviours with respect to their everyday lived experience. Health is seen as something potentially relevant rather than an inherent aspect affecting individuals’ meanings of these behaviours. Correspondingly, health-related behaviours are approached as commonalities of the participants’ everyday life rather than as behaviours which can prevent or cause diseases.

The scope of the study, therefore, is to be found in the juncture of the two fields: health promotion and cultural studies. It follows something of the overall orientation of
cultural studies\textsuperscript{1} – exploring how young people view these consumer activities as they are embedded in their everyday lives – within the area of health promotion. Each area informs and depends on the other. Yet, this is a thesis, which addresses the field of health promotion. The knowledge forms generated by the present study are intended to challenge, but also enrich the discursive\textsuperscript{2} practices in the health promotion area rather than the area of cultural studies. In this sense the present research project can be characterized as applied research since it can be broadly ‘distinguished from ‘basic’ or ‘theoretical’ research through its requirements to meet specific information needs and its potential for actionable outcomes’ (Ritchie and Spencer, 2000, p. 173). This project relies fundamentally on the conceptual framework of consumer culture in order to enrich the language of health promotion.

Specifically, the aim of the research is to explore through qualitative interviews how young people talk about the consumer meanings of smoking, eating, drinking alcohol and exercise in the context of their everyday lives. It has originated from my initial aspiration to listen to the voices of young people regarding health-related behaviour. Some of the main points regarding the empirical value for the area of health promotion in general and within the Cypriot context in particular are outlined below. These points are classified in two broad sub-headings. The first concerns the significance of the study regarding young people and the second with the Cypriot context.

1.1 Young people and health-related behaviours as consumer activities

‘Young people’ is a contested category. It is important to recognise that the designation is both relatively modern and its meaning can shift not only over time but also across culture (Barker, 2000). Yet, as McRobbie (1994) assumes, there are a sufficient number of shared age-specific experiences among young people which

\textsuperscript{1} The boundaries of cultural studies as a coherent, unified, academic discipline are difficult to define (Barker, 2000). Through a comprehensive review of concepts developed in the field of cultural studies, Barker (2000, p.34) defines cultural studies as an interdisciplinary field of inquiry which explores ‘the production and inculcation of maps of meaning’.

\textsuperscript{2} Discourse in this study reflects ‘a comprehensive framework of conceptualising (seeing) and practising (doing) health work’ (Katz and Peberdy, 1997, p.29). In this study the notion of discourse is used in order to refer to ‘a cluster (or formation) of ideas’ associated primarily with health promotion (see also Hall, 1997, p.6).
allows us to talk meaningful about youth without necessarily presenting youth as an essentialist category. Drawing on this argument, I discuss below the shared features of the category of young people as presented in the field of health promotion and consumer culture. My intention here is to support the empirical value of my study by concentrating on my choice of young people (aged 15-17). In particular, the points outlined in this section stress the invisibility of young people’s own concerns regarding the role of health-related behaviours as consumer activities with respect to their ‘everyday lived experience’. This is important since it highlights the empty space that my thesis intends to occupy.

‘Youth’ in the context of health promotion is regarded as a key time when many people experiment with behaviours that may be detrimental to their health (Pavis et al., 1998; Heaven, 1996; Hicks et al., 1988; Coleman, 1999). This position is often accompanied by the claim that many of the ‘unhealthy’ habits evident in young people can become established and are very difficult to change, and these may be precursors of patterns of illness in later years (Shucksmith and Hendry, 1998; Arnold, 1991). Giving a voice to young people regarding health and its related behaviours is critical for health promotion aspirations to ‘facilitate’ rather than to ‘coerce’ a healthy choice by providing people with empowering skills and support (Shucksmith and Hendry, 1998; Tones, 1997). This issue is concerned with the need for health promotion interventions to be grounded in what young people say and how they frame their actions in order to be responsive and relevant to their needs (Stockdale, 1998; Moore and Kindness, 1998). ‘Unless the individual sees some match between their self-definition and the attributes/behaviours portrayed, he/she will see interventions as irrelevant to them personally’ (Stockdale, 1998, p.34). Morrow (1999, 2001) also urges health education researchers to actively engage with young people’s views by drawing on recent legislative changes in the UK3 and the emergent sociology of childhood (James and Prout, 1997), which both acknowledge children as active participants in society and thus their perspectives can, and should be, elicited on issues that affect them.

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3 ‘The England and Wales Children Act 1989 represented a move from parental rights to parental responsibilities, and stipulated that courts shall have particular regard to ‘the ascertainable wishes and feelings of the child concerned (considered in the light of his [sic] age and understanding)’ (Section 1(3)(a)) (cited in Morrow, 1999, p. 297).
‘Young people’ also occupies an increased interest within the literature of consumer culture. The contemporary emergence of youth markets (Barker, 2000), which describe youth itself as a consumable item\(^4\) and young people as consumers (Miles, 2000) characterises contemporary consumer societies. This tendency is mostly associated with a general consensus that ‘youth’ amounts to an especially important period in a person’s life in as much as issues concerned with identity experiments through the use of the symbolic resources provided by cultural industries (Barker, 2000; Coleman, 1999; Miles, 1997, 1998; Willis, 1990; Mackay, 1997). The use of items of consumption such as clothing, footwear, popular music or sporting activities as a process of constructing a sense of identity or to establish a style appears to represent a very important aspect of young people’s lives (Barker, 2000; Bocock, 1993; Miles 1997).

Nevertheless, much work within the field of cultural studies regarding the experiential nature of consumption fails to engage with the perspectives of young people (Barker, 2000). This is due to the extensive use of ‘subculture\(^5\)’ as the main analytical concept, which denoted symbolic objects to be expressions of the underlying structural positions of youth groups (Barker, 2000). In more recent studies young people’s voices absorbed empirical interest, where consumption is viewed as an active not a passive process (e.g. Willis, 1990; McRobbie, 1994; Miles, 1997). In these studies, young people are attributed with an active, creative and symbolically productive relation to consumer commodities. Miles (1997, p.27) for instance, endorses this view in his study of young people’s relationship with consumer commodities by claiming that, ‘young consumers are arguably more adept at, and more willing to, experiment with their identities no matter what boundaries (whether they be class, gender or race) of identity may appear to constrain them’. Similarly, Nava (1992, p.173) notes, ‘many ads appear to utilize the codes that are most likely to appeal to that sector of the population with the most developed analytical skills – that is, the young’.

Smoking, eating, drinking alcohol and exercise have special features, particularly for young people, which support further my empirical orientation of exploring them as

\(^4\) Wyn and White (1997) refer to the inclusion of ‘youth’ within the consumer market by using the term ‘youth as a consumable item’.

\(^5\) See more in Barker’s (2000) review regarding ‘youth culture’ within the field of cultural studies.
consumer activities. Firstly, they are social activities in the sense that they are frequently practised collectively among young people in their leisure time. According to Hendry et al. (1993, p.2), leisure time for young people is a particularly significant time when ‘different lifestyles and forms of self-expression can be tried or exchanged through a process of socialisation with peers and adults outside the family’. Smoking, eating and drinking alcohol, as self-expressive activities, are practised in the places where young people go. Exercise again appears to be a collective activity, in the sense that it is practised in the gym or in athletic centres, accompanied in most cases by other young people. Secondly, these four behaviours as consumer items (such as buying a swim suit) or activities (such as going to the gym) entail a greater potentiality to be used as symbolic resources by young people since they are relatively cheap and accessible in comparison with other consumer commodities such as buying a mobile, a car and a house. They also have the advantage of being easy to modify or change as fashion dictates. The use of smoking, eating, drinking alcohol and exercise as symbolic activities which aim to fulfil some desired ends, such as creating a self-image, giving pleasure or gaining peer acceptance has been endorsed by Coleman (1999) in a recent review of adolescent health. In view of the symbolic manifestation of health-related behaviours, Coleman (1999) urges for centring the perspectives of young people in health services and in interventions for young people.

The points outlined above stress the importance of gaining access to the voices of young people regarding the role of health-related behaviours as consumer activities within the context of their everyday life. Yet, my literature review carried out in the area of health promotion indicated two main tendencies responsible for the absence of young people’s own concerns in much of the writing about their health-related behaviours. The initial point, discussed in chapter 2 concerns the judgemental way that young people’s voices concerning health-related behaviours are approached within the area of health promotion. Indeed, much empirical work fails to explore young people’s accounts of how these four behaviours are embedded within their everyday lives outside from the idea of health. The participants of the majority of these studies are encouraged to talk about the different aspects of their lives as health enhancing, or damaging, and the researchers approach their findings as rational or irrational with respect to ‘good’ health.
Second, there remains limited empirical work with respect to the consumer analysis of health-related behaviours (Bunton and Burrows, 1995). In addition, the consumer symbols inscribed in health-related behaviours are largely treated as reinforcing or limiting factors in favouring a healthy choice. As argued in chapter 3, a research project which focuses centrally on young people’s voices, regarding the consumer manifestations of health-related behaviours within the context of their everyday life, was seen as filling a crucial gap within the field of health promotion.

The empirical development of this study reflects both of these deficiencies examined within chapter 2 and 3. Firstly, this study focuses on the way of seeing the symbolic manifestations of these behaviours when they are viewed as everyday behaviours and not explicitly as health-related ones. Secondly, it does not use the consumer meanings of health-related behaviours as explanations of why young people do or do not follow certain health messages. It explores how young people make sense of the consumer meanings of health-related behaviours in their experience of social life rather than giving causal reasons for their actions or any structural reasons regarding their interpretations. Thus, while the social construction of youth through consumption forms the background of this present study, this area is not its primary empirical orientation. The research design and analysis reflect primarily my ambition to capture and record the spoken voices of young people regarding their everyday experience of health-related behaviours as consumer activities. The remainder of this chapter describes the Cypriot context, taking into account the scope of the study.

1.2 Cypriot context and health-related behaviours as consumer activities

The exploration of the consumer meanings of health-related behaviours within the Cypriot context also has its significant particularities. The recent ‘consumer’ development of the urban area of Nicosia and the invisibility of the young people’s self-concepts about their own lived experiences are the two key issues which frame the

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6 My observations in relation to recent socio-economic developments on the island are necessarily impressionistic. Few studies have either been conducted or published on the significant changes which I record here.
discussion below. Yet, it should be noted that health promotion and consumer culture in Cyprus is not all that distinct from the points made, in chapter 2 and 3 respectively, regarding mainly U.K.

Young people do not often (if at all) have the chance to raise their voice and articulate a position regarding their own ideas and experiences as these are related to health promotion and consumer culture. The pervasiveness of the common perception of youth as passive consumers, as more vulnerable, and more inclined to the different trends of fashion (Nava 1992) is an opinion, based on my personal experience, that also relates to Cypriot society. Along the same lines, the culture of compliance within the development of health education projects remains dominant in Cyprus and the empirical attempt to give voices to the young Cypriots who are marginalized is absent. Young people are often faceless, presented as merely numerical data, empty vessels to be filled up with health advice such as ‘don’t smoke, don’t dare to try drugs because you will become addicted, don’t drink, don’t eat that and eat the other’. While teachers’ perceptions of, and attitudes to issues relevant to the development of health education7 were explored (Fontana and Apostolidou, 2001), young people’s perspectives are still absent. In this light, T.V programmes with a critical perspective on young people’s health-related behaviours are very rare and in the everyday press one can read articles dealing a health in a static and monolithic way, for example discussing the problem of fat children as an artefact of the Cypriot culture.

Hence, it can be argued that the decision-makers are more than likely to be alienated from pupils’ everyday experiences and they do not seem to take into account changes, trends, new ideas or the contested messages that young people receive from school, parents, media etc. It is, therefore, particularly significant to carry out research which gives space to the voices of young people in Cyprus, a place where these perspectives, with respect to health or consumer matters have not been empirically explored. This study can be seen as a response towards the lack of recognition of young people’s versions of the reality of health-related choices in their everyday settings.

7The Ministry of Education in Cyprus published the first health education curriculum in 1992 in which Health Education was not a separate subject but integrated into the whole curriculum.
The empirical emphasis on the consumer meanings of health-related behaviours can be also justified as a significant area within the Cypriot context in general and particularly the urban area of Nicosia. At present Cyprus is regarded as a developing country, which is currently seeking to enter the European Union. Cyprus is a country which has been predominantly agricultural and in the last 30 years has experienced a vast economic and consumer development particularly, like in any other consumer societies, in its urban environment (Miles, 1998). The appearance of specially designed shopping centres, the introduction of food chains like Macdonald’s, Pizza Hut, Kenny Rogers (to name a few), the incorporation of multinational business, the access to new technologies like internet and the use of electronic mail and the multiplication of the products; are very recent features of the urban area of Nicosia. These consumer developments are described below.

The expansion of shopping centres has been characterized as an indicator of consumer culture within big cities (Nixon, 1997; Featherstone, 1991). Characteristically, the first shopping centre emerged in the urban area of Nicosia at the beginning of the 1990s. While at the beginning it was not successful – many shops closed down – a few years later the market centre of the town now consists of mainly big shopping centres. Different international clothing shops have appeared only in the last five years. For instance, taking a stroll down the main commercial high street of the town where many young people gather, you now find chains such as Next, Dorothy Perkins, Zara, Clarks, Exprit, Top Shop, River Island, Mango and so on. Moreover, some of the most expensive labels such as Dolce and Gabana, DKNY, Malboro Classic are sold in different shops. Cypriots frequently comment that one no longer needs to go abroad in order to shop for different clothing items - you can find them in Cyprus.

The commercial streets and the shopping malls have become significant autonomous spaces that young Cypriots spend their leisure time. The emergence of coffee shops, where people can enjoy themselves is also a very recent daily activity in the centre of the town. Shopping is not merely seen as a utilitarian activity – buying things that you need – but also as a cultural or social activity – having a coffee with your friends and talking about the latest fashions. Young people in particular spend much of their time ‘strolling’ (concept used by Featherstone, 1991) around shopping centres experiencing the stylistic and artistic display of consumer goods.
In terms of the food industry, major changes have occurred in the Cypriot context. Supermarkets have become much bigger and they provide a wider variety of each type of product. Small stores, which used to supply food in each neighbourhood, have closed and huge supermarket stores opened. You can now find each product in diverse varieties. For instance, the traditional Greek yoghurt has been multiplied in various types such as low fat, semi-skimmed, fruit yoghurt and so on. The take-away industry or fast food stores have also expanded in recent years. If you now open the ‘Yellow Pages’ for take-aways, you will find a great range of ‘western’ fast food chains such as ‘Big Boy’, ‘Pizza Hut’, ‘Pizza Express’ and ‘TG Fridays’. The first Macdonald’s in Nicosia’s urban area, for example, only opened in 1998 followed by a second one in December of 2001. The American food industries preceded the oriental ones. ‘Mr Lee’ was the first Chinese take-away, which opened only this year (2002), followed by a Thai take-away. Moreover, in Cyprus it is now possible to find restaurants from different part of the world such as Italy, China, Japan, France and so on. These types of food restaurants emerged alongside the more traditional Greek and fish taverns or kebab take-away shops that used to exist in considerable numbers. The vast majority of the customers of fast food stores are young people.

Along with these consumer developments being integrated so rapidly in Cyprus, new concepts and lifestyles interacted with a more traditional attitude towards life. These developments were not seen as an extension or a transformation of the Cypriot culture but rather as a Cypriot journey ‘to a destination variably called locally “modernity”, “Europe” or the “West” ’ (Argyrou, 1996, p.1). The differences between the ‘local’ and the ‘west’ is expressed through certain binaries that any Cypriot can identify: Macdonald’s versus traditional sandwich with Hallumi8 and tomato; Kentucky burger versus kebab (suvlaki); Coca-cola vs traditional lemonade; Nescafe vs. Turkish or Cypriot coffee; internet café vs. a more traditional cafeteria; fast food chains vs. kebab shops. On many occasions young people find themselves in defined camps where one side privileged fast food, popular music, westernised places like cosmopolitan ‘arty’ clubs and coffee shops, and those on the other side, who are more centred towards Greek values, national discourses, traditional music, traditional foods, tavernas, pulses, coffee shops with Greek names and home-made foods. Despite the use of these

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8 Hallumi is the traditional Cypriot cheese
binaries as a way of interpreting Cypriot culture, the struggle between the different forms of cultures is historically complex and can never be reduced to a simple opposition (Clark et al., 1976). It is thus preferable to see these cultural elements together, influenced by each other functioning together as markers of the Cypriot culture. At this point, it is worth mentioning the case of Pizza Hut in Cyprus, which serves Pizza made with ‘haloumi’ (Cypriot cheese) and Luntza (Cypriot smoked pork meat).

In this first chapter, I have clarified my rationales in exploring the concerns of young people regarding health-related behaviours as consumer activities. In the last section, I will discuss the outline of the study.

1.3 Outline of the research project

The rest of the thesis is divided into eight chapters. **Chapter 2** falls within the area of public health and elaborates on the way that the concept of health-related behaviours has been developed conceptually and empirically. It sets out the main argument of the thesis, via the idea of *health logic*, which prescribes the health-directed approaches within health promotion studies. It concludes by proposing an alternative viewpoint for understanding and researching health-related behaviour: a standpoint which ‘escapes’ from health issues, where the informants’ ways of seeing become central and the wider social setting is taken into account.

**Chapter 3** clarifies the central concepts of this study by exploring its relationship with consumer culture: ‘health-related behaviours as consumer activities’ and ‘consumer meanings’. I have expanded further the argument developed in chapter 2 regarding *health logic* by showing its effect on empirical projects which explore the consumer manifestations of health-related behaviours. In particular, I identified the absence of the concerns of young people regarding health-related behaviours as consumer activities within the context of their everyday lives. Correspondingly, I highlight the need for an empirical study which focuses on the consumer meanings of health-related
behaviours by making the perspectives of young people and their everyday lives central.

**Chapter 4** presents the research design employed in the study, including the method of collecting data through qualitative interviews and analysing it. The discussion here concentrates on the utility of the principal features with regard to the research agenda. In particular, I explain how these features allow me as a researcher to ‘escape’ from the *health logic* and record my participants’ reflections on the consumer traits and their role within a specific social setting.

The following three chapters concern the analysis of the interpretations of the participants regarding the consumer manifestation of health-related behaviours. The focus of the study on the participants’ ways of talking about the consumer manifestation of health-related behaviours led me to the development of three analytical categories, which represent different layers of the analysis.

**In chapter 5,** the first category of analysis focuses on the kinds of consumer traits that young people ascribe to health-related behaviours. I name the emerging categories as ‘symbolic’ since they are concerned with the type of consumer traits (e.g. the quality of being ‘cool’) that are inscribed in health-related behaviours.

**In chapter 6,** the second category concentrates on the consequences of those traits in everyday lives of young people. In particular, I sketch out the ways in which the participants talked about the *role* of health-related behaviours as consumer activities within the context of their everyday lives (Role Categories).

**In chapter 7** the third category explores the way young people come to understand themselves as subjects who adopt a particular standpoint with respect to the symbolic and role categories (Reflective categories). The circle of the research project is completed with **chapter 8** which summarises the research findings and their implications for the field of health promotion. I also discuss the limitations of the present study and give suggestions for future empirical studies.
Chapter 2

Health-related behaviours and Health logic

2.1 Introduction

The aim of this chapter is to provide a picture of the field - health promotion - from which my research originated. The chapter sets out the main thesis - that the underlying health logic prescribes the judgemental way that health-related behaviours are determined conceptually and empirically within the area of health promotion. From this proposition my thesis argues for a different viewpoint of health-related behaviours by centring on young people’s everyday lives and escaping from the binary divisions created by the health logic, such as healthy/unhealthy, or the role of the enhancing or obstructing social context.

The chapter is divided in two main sections. In the first section, I discuss the particularities of the way that the health-related behaviours notion is used with particular respect to smoking, eating, drinking alcohol and exercise as activities, which have a cause-effect and preventative relationship with health. I then elaborate further the view of health-related behaviours as preventative activities with respect to two different perspectives – the biomedical and the social (section 2.2.1). Through this process, I outline health promotion and health education - key fields for the study - in relation to health-related behaviours (section 2.2.2).

Overall, the first two sections can be seen as the principal framework where the main argument of the study is developed. Demonstrating the background of ideas that exist behind health-related behaviours, in the context of health promotion, contributes to our understanding of how the health framework can directly and indirectly frame the way that these behaviours are understood. The two following sections discuss the underlying logic of health-related behaviours conceptually (section 2.3.1) and empirically (section 2.3.2). The chapter concludes by asserting the need to use a
framework, which is not directed by a health rationality, in order to explore the way that young people talk about the role of smoking, eating, drinking alcohol and exercise in their everyday lives.

2.2 Health-related behaviours

2.2.1 Smoking, eating, drinking alcohol and exercise as health-related behaviours

‘Health-related behaviour’, ‘unhealthy behaviour’, ‘health-enhancing behaviour’, ‘health-damaging behaviour’, ‘health maintaining behaviour’ and other similar terms are scattered throughout World Health Organisation (WHO) documents, health education reports and the daily press (Research Unit in Health and Behaviour Change, 1995). At one level of analysis, ‘health behaviours are regarded as behaviours which are related to the health status of the individual’ (Ogden, 1996 p.11). Yet, such a broad definition of the term raises a number of questions, including: What is health? What do we mean by behaviour? Who defines the relationship between health and behaviour? And consequently, what is ‘health-related behaviours’? Each question can receive a variety of answers⁹. Moreover, a number of activities or perhaps any sort of activity can be included in such a classification, considering the fact that ‘health is subject to wide individual, social and cultural interpretation’ (Katz and Peberdy, 1997 p.23).

This research project originates from the classification of smoking, eating, drinking alcohol and exercise as health-related behaviours. Therefore, I chose to define the concept of health-related behaviours and answer the above-mentioned questions in the light of the classification of these four behaviours. In this case, we have four specific behaviours grouped as health-related ones by the implication that they have some

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⁹ The various explanations of health and disease correspond to different possible ways of defining the human behaviours that can influence the health status of the individual. For instance, during industrialization and urbanization the environment was perceived as the major reason for disease occurrence throughout Europe (Stacey, 1988; Beaglehol and Bonita, 1997; Lupton, 1995; Donaldson and Donaldson 1993). Correspondingly, health-related behaviours concerned the individual’s actions against contamination by a ‘polluted’ environment such as avoiding overcrowded, polluted, urban areas, living in the countryside with fresh air and caring about your personal hygiene. Later, when diseases were ‘caught’ and analysed within the body via the dissection of the corpse and the use of the microscope (Donaldson and Donaldson, 1993) health-related behaviours were concerned with medical instructions that patients were obligated to follow.
relationship with health. Their relationship with health is primarily concerned with their biomedical link separately or in combination with the growth and aetiology of diseases (Research Unit in Health and Behaviour Change, 1995). This perspective, as the main background of the notion that health-related behaviours, corresponds to ‘the minimalist biomedical view where health is the absence of diseases’ (Dines and Cribb, 1993, p.20).

Historically, the popularity of the concept of health-related behaviours is strongly associated with the epidemiological transition, from acute and infectious disease to chronic and multi-factorial disorders as leading causes of morbidity and mortality (Davison, Frankel and Smith, 1997; Glanz et al., 1997). The relation between smoking and lung cancer, which was discovered since the late 1940s in the United States and Britain, appeared to be significant in establishing the biomedical paradigm in health-related behaviours (Beaglehole and Bonita, 1997 p.97). Abel et al. (2000) also identifies in the USA the initial growing empirical interest in the effects of particular behaviours such as smoking, excessive alcohol consumption, physical inactivity and overweight on mortality and morbidity.

Epidemiological studies - the underlying discipline of the biomedical perspective on health-related behaviours (Research Unit in Health and Behaviour Change, 1995) - test the hypothesis that certain behaviour or behaviours may be beneficial or harmful in causing or preventing the onset of a disease. Epidemiological studies are understood as identifying ‘the distribution and determinants of health-related states and events in groups and populations’ (Abramson, 1997, p.143). They encompass ‘a strong positivistic model of cause and effect’ (Research Unit in Health and Behaviour Change, 1995 p.6) studying ‘factors’ underlying various chronic and acute disease

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10 The hypothesis that certain behaviours may have a causal relationship with health was developed by different theories and observations, before the formal use of epidemiological studies. One of the central, initial theories of disease causation was the ‘humoral theory’, focused on the balance of ‘the six non-naturals: diet, evacuation, exercise, air, sleep and the passions’. It was believed that individuals should regulate them in order to ensure good health (Porter, 1992, p.99; Risse, 1992, p.171 in Lupton, 1995). Based on his observations and recording of facts, Hypocrates also gave advice in relation to exercise and diet. Donaldson and Donaldson (1993, p.108) quote one of his aphorisms ‘those naturally very fat are more liable to sudden death than the thin’. Lastly, the role of vitamin C has been one of the initial classic findings supporting the biomedical link between disease and individual behaviour. James Lind, informed by an investigation implemented with sailors (1747), identified a causal relation between lack of vitamin C and scurvy (Donaldson and Donaldson, 1993).
processes. Many of these so-called ‘factors’ are seen as behavioural (e.g. smoking behaviour, eating behaviour, drinking behaviour), which are predicated upon a notion of causality. The onset of disease is primarily supported by medical studies which explain, via their research design, an anatomical or physiological abnormality caused by ‘unhealthy’ behaviours.

The development of risk scales constitutes the primary feature of the biomedical perspective on health-related behaviours. The concept of risk is ‘used in the form of aggregate probabilities by epidemiologists to identify lifestyle factors’ (Nettleton, 1995, p.37). Risk scales demonstrate proportionally a simple linear connection between the incidence of disease and a particular kind of human behaviour (Anderson et al., 1988; Ogden, 1996). The popularity of smoking, eating, drinking alcohol and lack of exercise may partly be related to their precise placement on a quantified continuum of risk probabilities; something unlikely with other personal factors such as stress, which are incalculable.

The biomedical perspective takes a highly ‘mechanistic’ view of health-related behaviour. Human behaviour is seen as a possible ‘measure’, ‘indicator’, ‘cause’ ‘factor’ or ‘prevention’ of the development of ill-health and thus, as beneficial or harmful to the health status of the individual. In addition, the probabilistic way of presenting health-related behaviours on risk scales places everybody at risk. The boundaries between health and illness are increasingly less clear. Both states of being have become inextricably linked within a great continuum of a disease. Thus, under the biomedical perspective the concept of health-related behaviours concerns the healthy population since as Armstrong (1993, p.65) comments, ‘health has become a temporal trajectory containing the seeds of illness’.

Yet, a number of problems that are of major importance here were identified regarding the default use of the notion of causation with respect to behavioural factors. ‘The difficulty, conceptually has been to try to fit such ‘factors’ in to a deterministic epidemiological model where it is almost impossible to make a sound case that these factors are determinants of disease rather than outcomes of other more basic sociocultural processes. In fact, one could argue that such behaviours are themselves mediating or buffering factors involved in complex social processes’ (Research Unit in Health and Behaviour Change, 1995, p.6).

‘Mechanistic’: a concept used by Curtis and Taket (1996) concerning the biomedical discourse of disease.
In the light of the biomedical perspective, the classification of smoking, eating, drinking alcohol and exercise as ‘health-related’ behaviours is distinctive in two respects. The first feature is concerned with the conception of these types of risks as ‘human made’ (Nettleton, 1995, p.38) or as ‘self-imposed’ (Ashton and Seymour, 1988, p.22) and of individuals as being ‘quasi-producers of their health status’ (Macdonald and Bunton, 1992, p.8). Second, and as corollary with the above, individuals are seen as capable of actively securing their health through their behaviours. These features are mainly concerned with the idea of health as individual prevention, that individuals can cause disease or secure health via their behaviours.

While it is undoubtedly true that a biomedical perspective led to a diagnosis of health-related behaviours as a health problem, it cannot offer an adequate explanation of why certain categories of people think and behave the way they do (Macdonald and Bunton, 1992; Research Unit in Health and Behaviour Change, 1995). As a result, a social science perspective has emerged, largely since World War II, into the concept as a necessary one (Research Unit in Health and Behaviour Change, 1995). It seeks to understand and analyse why health-related behaviours are occurring and how they are embedded in the social context in people’s lives (Macdonald and Bunton, 1992; Abel et al., 2000). Psychology and sociology emerged as the main social sciences which developed the so-called social perspective on health-related behaviours (Research Unit in Health and Behaviour Change, 1995). Psychology has attempted to explain behaviour and the mechanisms of change through the development of a number of behavioural change models (Bennett and Hodgson, 1992). Sociology has argued for the influence of social structure and behaviour and produced a critique of the biomedical perspective, which overlooks how health and illness fit into the experience of everyday life (Research Unit in Health and Behaviour Change, 1995; Nettleton, 1995; Thorogood, 1992a).

The development of the social perspective on smoking, eating, drinking alcohol and exercise is distinctive in two respects. The first feature is concerned with the fact that these four behaviours are closely related to everyday social activities, in the sense that people can engage with them outside of the health context. These behaviours differ, for example, from health checks in the sense that they are part of the daily lived experience of the individuals. They may be associated with health risk but they also
have ‘a routine character, a habitual aspect, which places them somewhat outside full consciousness’ (Research Unit in Health and Behaviour Change, 1995, p.7). Second, and as a corollary with the above, ‘behaviour seen as irrational in biomedical terms may be a perfectly valid response when understood from the viewpoint of the individual, or groups, concerned’ (Research Unit in Health and Behaviour Change, 1995, p.42). In contrast to the normative approaches of health-related behaviours implicit in the biomedical model, the social perspective incorporates the everyday and the social character of these four behaviours.

In this light, the biomedical and the social perspective of health-related behaviours should not be seen as competing but rather as complementing or overlapping with each other. Both perspectives have a significant role to contribute to the construction of health-related behaviours as preventative human practices. The biomedical perspective on health-related behaviours focuses exclusively on the relationship between individuals’ behaviours and their health status. The social perspective does not abandon a biomedical perspective but adds to it a greater concern for recognising the broader social framework within which these behaviours arise. Yet, while theory and research stemming from the social sciences led to a widening of conceptualisation in the field of health-related behaviour, this has not been achieved out of the step of the biomedical perspective. The argument here is that by having the biomedical perspective as the underlying background for studying the fields of smoking, eating, drinking alcohol and exercise, ‘ways of seeing’ how these behaviours fit in people’s everyday life remained largely untouched. This issue, which constitutes the main argument of the thesis, is further discussed through empirical and conceptual examples in section 2.3. Before that, I will illustrate the use of both perspectives in the field of health-related behaviours in public health.

2.2.2 Health-related behaviours and public health

Health-related behaviours, as a concept and a field, originated and developed through and across the different institutions of public health. Public health ‘represents an organised response to the protection and promotion of human health and encompasses a concern with environment, disease control, the provision of health care, health
education and health promotion’ (Research Unit in Health and Behaviour Change, 1995, p.xvii). It incorporates wide-ranging activities, which share ‘the same utilitarian objective to accomplish a continuing good health status for all’ (Lupton, 1995, p.2). Health-related behaviours as a field, belong to a specific phase of public health, which relies on preventative medicine (Ashton and Seymour, 1988). It has been characterized as one of the most important shifts of the twentieth century\(^ {13}\) in the target of public health care ‘from the symptoms of an individual patient to the social and behavioural characteristics of the person’ (Nettleton, 1997, p.316). The overall target, with respect to the field of health-related behaviour has crystallised into the importance of the ‘healthy lifestyle’, which has developed as the central concern of health promotion and health education (Glanz et al., 1997). In the present section, I elaborate how the biomedical and the social perspective on health-related behaviours informed the development of the field as a target in the area of public health.

The preventative model of health education (Tones and Tilford, 1994, p.12), also called ‘conventional’ health education, is fundamentally located within the biomedical perspective. From within this orientation, health educators worked within a narrow view of health: ‘good health is equated with the avoidance of health damaging behaviours’ (Calnan, 1994 cited in Katz and Peberdy, 1997 p.18). Correspondingly, the emphasis is on ‘the need for “patient compliance” in changing behaviours’ (Katz and Peberdy, 1997 p.18). The strategies of conventional health education informed by epidemiology – as the major discipline of the biomedical perspective - approach the individual behaviour as the key to prevention of health problems by attempting to stop people developing dangerous or risky behaviours (Davison et al., 1997).

In the light of conventional health education, individuals are expected to evaluate their risks of succumbing to disease and to take responsible decisions (Seedhouse, 1997). People’s failure to control their daily behaviours is justified by a lack of knowledge concerning the potential harm associated with certain aspects of everyday behaviour. Characteristically, health notions have been dominant in the construction of widely

\(^ {13}\) Although health-related behaviours were mainly neglected in the seventeenth and eighteenth centuries, ‘individuals were encouraged via a series of publications, to adopt a regime directed at strengthening the body’s constitution, giving advice on the type of food it was best to consume, the frequency of exercise that should be taken and so on’ (Lupton, 1995, p.20). See also footnote 10, p.24.
used Behaviour Change models such as the Health Belief model (Rosenstock, 1966; Becker, 1974) and the theory of Planned Behaviour (Ajzen, 1985). These models rely on a simple cause-and-effect logic and disregard the broader social context of these behaviours. They seem to overestimate the importance of people’s health-related notions in their actions. Accordingly, in the frame of conventional health education, individuals who suffer from ‘lifestyle’ diseases or fail to cooperate with health educators are projected as victims of their own ignorance, or inabilities to modify their lifestyles (Naidoo, 1986; Katz and Peberdy, 1997).

Health Promotion – a term of more recent origin than health education (Glanz et al., 1997, p.8) - is viewed as a new phase of public health, which moved in the 1970s from health ‘education’, to health ‘promotion’ or differently to the ‘new’ public health (Beattie, 1993 et al.; Naidoo and Wills, 1994; Donaldson and Donaldson, 1993). As opposed to ‘conventional health education’, with its premise based on personal prevention, health promotion additionally emphasises social and environmental influences on health patterns (Lupton 1995; Ashton and Seymour, 1988). The underlying position of health promotion is that ‘the health of individuals or social groups is the outcome of complex and interacting, material-structural and behavioural-cultural factors’ (Katz and Peberdy, 1997 p.33). As Thorogood (1992a, p.51) states ‘the evidence for also taking a structural level approach for intervention is incontrovertible and it is this which has lain behind the transition of health education into health promotion’.

Accordingly, the proposed working definition of health promotion was to combine environmental improvements – ‘a structuralist approach’, with behaviour changes – ‘a lifestyle approach’, in order to reduce morbidity and premature death (Macdonald and Bunton, 1992). ‘Health promotion is about increasing people’s control over their own health, and that this goal is to be attained by addressing the twin supporting themes or pillars of lifestyle and structuralist approaches’ (Thorogood, 1992a, p.48). What is argued in both definitions of health promotion is not that ‘the lifestyle approach has been abandoned but rather that to be effective in increasing individuals’ or communities’ potential for health the two must be addressed together’ (Thorogood, 1992a p.51-52). Thus, during the 1970s and 1980s the field of health education was defined in a broader way: ‘Health education includes not only instructional activities
and other strategies to change individual health behaviour but also organizational efforts, policy directives, economic support, environmental activities and community level programmes’ (Glanz et al., 1997, p.7-8).

In this context, the bio-medical perspective has been found too restrictive for the purposes of health promotion, which aims to incorporate not only lifestyle changes but also structural effects upon these changes (Bunton and Macdonald, 1992 p.2). This corresponds to the environmental approach of health promotion as expressed in the Ottawa Charter for Health Promotion (1986) as ‘creating environments conducive to health, in which people are better able to take care of themselves’ (Epp, 1986). Correspondingly, the definition of health, which is evident in the context of health promotion, is broader than the polar opposite of ‘absence of disease’. As Curtis and Taket (1996) point out the socio-ecological perspective is reflected in the definition of health according to the pronouncement of the World Health Organisation. ‘Health is a state of complete physical, mental and social well-being’ a state, which can be attained, not only through individual change but also through political, social and economic one’ (Katz and Peberdy, 1997, p.6).

The consideration of lifestyle and structural effects upon the health status of the individual is reflected in the main strategies or ideas which were developed in health promotion regarding health-related behaviours. Firstly, health-related behaviours ceased to be regarded as the only solutions in preventing diseases. Secondly, healthy choices are not perceived as matters of relevant knowledge but as markers of environmental, social and cultural conditions of the individual (Thorogood, 1992a). Accordingly, the strategies of health promotion aim at facilitating healthy choices, these are not free choices but are themselves circumscribed by material conditions (Thorogood, 1992a). WHO (1993, p.236) argues with respect to the lifestyle intervention and taking into account the personal and social forces that ‘the public should be informed of the merits and demerits of the various options open to them and resources should be made available to make the option chosen possible’.

Recognising that health-related choices are situated largely beyond the control of the individual leads us to the third feature of health-related behaviours - that they are not seen as solely matters of individual responsibility. Respectively, developments in
health promotion have suggested that this information-giving approach is a necessary, but not a sufficient condition, for change. Behaviour change as a matter of personal knowledge and thus responsibility was seen as inadequate and ‘unfair’ for the role of individuals in health matters (Tones, 2001). The development of health promotion is typically represented as a reaction against both the excessive responsibility which is placed on individuals concerning their health-related choices and the victim-blaming approach of health education (Lupton, 1995; Donaldson and Donaldson, 1993).

2.3 Health logic

In the preceding section, I provided a picture of the way that the term health-related behaviours is conceptualised with respect to the biomedical and social perspectives (Research Unit in Health and Behaviour Change, 1995) and as allied to health education and health promotion. It is important to emphasise that health promotion does not abandon the biomedical perspective on health-related behaviours but adds to it a greater concern for recognising the broader social context within which health-related behaviours arise. As discussed above, health promotion, which is seen as a ‘new’ view of health-related behaviours, does not overlook the social and cultural issues relevant to these behaviours. In the rest of this chapter, I develop the main argument of the thesis, which is concerned with the constraints of this ‘new’ approach - associated primarily with health promotion – to health-related behaviours. For this purpose, I developed the term health logic to reflect the discursive logic employed within the field of health promotion, which is fundamentally linked with the biomedical classification of these behaviours as health-related. In particular, I demonstrate the biomedical cause-effect logic as it is embedded in the social perspective of health-related behaviours.

The use of the term health logic in this study aims to highlight the judgemental way that smoking, eating, drinking alcohol and exercise are approached within the field of health promotion. Smoking, eating, drinking alcohol and exercise are classified as health enhancing or damaging in the sense that they can cause or prevent disease. The problem - which is central for the development of the present study – is concerned
with the utilisation of health enhancing or damaging classifications for the social and cultural issues relevant to these practices. These issues are classified more or less through the same logic: as enhancing or damaging to health, as positive or negative factors. While such classifications can be rationalised under the field of health promotion, which aims at the promotion of healthy choice, they can be relatively disruptive in understanding other roles of these behaviours in the everyday social settings.

The main argument of the thesis is directed towards the ‘judgemental’ way that health-related behaviours, as everyday practices, are understood. By the term ‘everyday activities’, I refer to their existence, in particular, in social and cultural manifestations outside of the health context which are also relevant and significant in young people’s lives. The contrast between ‘everyday’ and ‘health-related’ behaviours does not have as its aim the rejection of one in favour of the other. These four behaviours – smoking, eating, drinking alcohol and exercise – can be classified both as health-related in the sense that they can enhance or damage health – or as ‘everyday’ activities since they are practised by people as they go about their day-to-day lives. Yet, the term here functions as a ‘counterconcept\(^\text{14}\)’ which aims to highlight the ‘ordinary’, the ‘popular’, the ‘daily’ character of these four behaviours, by contrasting with the institutional (public health) classification of these behaviours as health-related. ‘Everyday’ as opposed to ‘health-related’ is a contrast that ought to receive special attention within the area of health promotion where the health logic intervenes in the way that these four behaviours are explored and consequently theorised.

My intention in the following sections is to show, through conceptual (section 2.3.1) and empirical (section 2.3.2) examples, how health logic intervenes in the way that health-related behaviours are understood as everyday practices in the field of health promotion. In doing so, I justify my empirical and theoretical orientation which aims to escape from the health logic in exploring smoking, eating, drinking alcohol and exercise.

\(^{14}\) Everyday life as a counterconcept is used by Gouldner (1975, p.421) meaning that ‘it gives expression to a critique of a certain kind of life’ (Cited in Featherstone, 1997, p.58).
2.3.1 Health logic and conceptual approaches to health-related behaviours

The notions ‘lifestyle’, ‘choice’ and ‘empowerment’ which are considered central to the philosophy and practice of health promotion (Sidell et al., 1997), rely fundamentally on the recognition of the social and cultural dimension of health-related behaviours. After I elaborate the main arguments concerning this recognition for each term, I discuss the conceptual intervention of the health logic. Specifically, I discuss the vision of socio-cultural issues relevant to these four behaviours as variables with a range of positive or negative health implications. In effect, the significance of the cultural and social manifestation of these behaviours as everyday life activities independent of their health consequences is either omitted or presented as a positive or negative contributory factor.

2.3.1.1 Lifestyle

Lifestyle is a much-used concept employed within the area of health. It is considered central in the development of a socially based model of health in the theory and practice of health promotion (Backett and Davison, 1995). It is used as a broader term compared to the notion of health-related behaviours because it additionally recognises the social and cultural factors to health matters (Backett and Davison, 1995). The use of the concept lifestyle, rather than risk behaviour, facilitates the acknowledgement of the broader social impact upon personal behaviour choices.

The extensive use of the notion lifestyle originates from the relationship between health and people’s daily practices and social circumstances. Nevertheless, it can be argued that the interdependency between the health status of the individual and lifestyle activities formulates the way that the broader social conditions are approached within the field of health promotion. Two comments from the World Health Organisation are indicative of the way that social conditions are handled within the area of health. The first concerns the definition of ‘lifestyle’ and the second that of ‘lifestyle approach’.

‘Lifestyles are patterns of (behavioural) choices made from the alternatives that are available to people according to their socio-
economic circumstances and to the ease with which they are able to choose certain ones over others.' (WHO, 1993, p.230)

‘Successful intervention, therefore, must first accept that the social forces already at work in influencing health for the better are of paramount importance. This means that ways must be found of strengthening the influence of factors conducive to healthy lifestyle.’ (WHO, 1993 p.236).

The above statements aim to enhance the conceptual understanding and the consequences of the notion of lifestyle, not only as a set of daily behaviours, but also as an incorporation of the socio-cultural dimension of these behaviours. In both statements, ‘lifestyle’ does not refer merely to risk behaviours but also to the interplay of social circumstances and behaviours. Nevertheless, the inclusion of the socio-cultural perspective is identified primarily as an impact upon the behavioural choice. Socio-economic conditions are used as positive or negative explanatory factors for the final choice. The social setting is primarily perceived both as a constraining or a supporting factor, and consequently the ‘lifestyle’ approach will either strengthen or weaken it. Although such an emphasis can demonstrate how the behaviour of the individual is constrained or enhanced within social circumstances, it does not shed light on how the choices fit in the everyday experiences of people.

### 2.3.1.2 Choice

‘The essence of health promotion is choice’ (WHO, 1993 p.236), meaning that health promoters should foster ‘informed’ health choices rather than attempting persuasion or coercion (Tones, 2001). The preferred substitution of the notion of ‘behaviour change’ by ‘choice’ within the field of health promotion aims at protecting ‘free will’ and at the same time preventing the ‘blaming’ from people who do not follow the healthy choice. It challenges the over-emphasis on modifying individual behaviour in a vacuum, unrelated to the socio-cultural and economic influences on people’s lives (Sidell et al., 1997). In particular, ‘making healthy choices the easy choice’ a 1980s phrase of health promotion, is associated with the recognition that the healthy choice is not equally available to all people and the resulting need to create supportive environments so that individuals have more opportunities to choose a healthier ‘lifestyle’ (Sidell et al., 1997; Katz and Peberdy, 1997; WHO, 1993).
While the rhetoric of ‘making healthy choices the easier choices’ has drawn attention to the broad social influences on lifestyles, the argument here concerns the recognition of the judgemental way – labelled in this study health logic - that choices and related broader social issues are conceptualised. Both choices and related social issues are classified as positive or negative in relation to the health status of the individual. Choice within the field of health promotion reflects a ‘rational’ one which is accompanied with ‘possession of the information, the clarified norms and values, and the decision-making skills, and with socio-cultural barriers removed’ (Thorogood 1992a p.61).

In this light, certain groups of individuals are assumed more open to health than others, a phenomenon that reinforces social divisions and thereby contributes to classifications of structurally advantaged and disadvantaged groups in terms of health-related behaviours (Nettleton and Bunton, 1995). This type of classifications has the effect of correspondingly pathologising or celebrating certain characteristics of individuals. As Lupton (1995, p.131) comments, ‘like many other contemporary institutions and agencies, public health and health promotional discourses and practices that privilege a certain type of subject, a subject who is self-regulated, “health”-conscious, middle class, rational, civilized’. These kinds of judgemental divisions of choices and individuals’ situations are strong ‘common sense’ arguments within the context of health promotion. If health promotion were to truly accept all choices as equally valid, the role of health promotion would be reduced to promoting access to, and decision-making about services, and the dominance of the rational, medico-scientific paradigm would be challenged (Thorogood, 1992a).

Therefore, it could be argued that the central concern within the health promotion is the cause-effect relationship between social life and health choices. However, this approach which fails to identify the role of health-related choices in the daily experiences of an individual. Rather, as appeared in a discussion document of health promotion, ‘The predominant way of life in society is central to health promotion since it fosters personal behavioural patterns that are either beneficial or determinant to
Thus, social life is largely treated as reinforcing or limiting resource for ‘healthy’ or ‘unhealthy’ choices.

2.3.1.3 Empowerment

Empowerment is a central notion in the philosophy and practice of health promotion (Tones, 1997, 2001; Weare 1992,). It reflects the primary concern of health promotion to help people to exercise at least some degree of control over the determinants of health and illness rooted in their material, social, economic and cultural circumstances (Tones, 2001). According to the ideological perspective of WHO, as summarised by Tones (1997, 2001), empowerment is achieved through the establishment of a healthy public policy and the reinforcement of individuals’ personal competencies and capacities. Individual empowerment – as self-empowerment - and community empowerment - as an active participating community - are regarded as two interrelated strategies which work in a form of partnership in order to facilitate healthy choices by creating the conditions necessary for them.

As with the preceding examples (‘lifestyle’ and ‘choice’), the development of the notion of empowerment within the field of health promotion is accompanied by the recognition of the determinants of health that reside in the physical, cultural and socio-economic environment in which people live. It is apparent however, that the social life of the individual is perceived either as a set of reinforcing or limiting factors towards the achievement of health status. Likewise, the socio-cultural framework of health-related behaviours is seen either as reinforcing or limiting. On the one hand, there are strong ‘common sense’ arguments, as outlined through the concept of empowerment, which favour a judgemental way of perceiving people’s lives. On the other hand, the judgemental vision of social life can constrain our understanding of how health-related behaviours are embedded in the everyday experiences of people.

In parallel, the notion of empowerment, in the context of health promotion, concerns primarily the potential capacities that an individual may develop in order to overcome environmental constraints related to a healthy option. The extent to which individuals

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or communities possess or can develop empowering skills has been critically questioned (Nettleton and Bunton, 1995). Yet, within the field of health promotion, the absence of a healthy choice is primarily associated with the absence of empowerment. The possibility of an individual having empowering skills with respect to his/her choice and still arriving at the unhealthy choice is missing. This is due to the health background of the notion of empowerment as it is used in the field of health promotion. This is the underlying main reason according to Shucksmith and Hendry (1998), that individuals’ own experiences and views of empowerment are rarely incorporated in health promotion interventions.

2.3.2 Health logic and empirical approaches to health-related behaviours

In the preceding section, I explored the prevalence of the health logic upon three key concepts of health promotion: lifestyle, choice, and empowerment. In particular, I discussed how health logic obscures the ways in which smoking, eating, drinking alcohol and exercise fit in the everyday life of the individuals. I will now expand the same argument by showing how the health logic is reflected in empirical research.

After a careful examination of much published work, concerning young people’s health-related behaviours, I identified three main groups of research projects, which I have classified in terms of their health-related behavioural goals. These are:

a) Measuring frequencies of health-related behaviours
b) Identifying patterns of health-related behaviours
c) Focusing on young people’s accounts of health-related behaviours

This review of research does not focus on current research findings derived for each group. Rather, for each group I have given examples which reveal their intricate

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16 Here, I refer to studies, which were sought by systematic searching of key journals (such as Health Education Journal and Social Science and Medicine) or literature reviews such as (Health Education Authority, 1997 and Wright, 1999).
17 Here, I exclude biomedical and epidemiological studies, which aim to show the benefit or harm of each health-related behaviours (such as Grundy and Denke, 1990). The reason is that they are more concerned with a medical perspective on health-related behaviours.
coupling between their health background and their findings. Methodological comments are only made in order to exemplify the nature of the findings in each research group. My intention is not to criticise any group of research projects as insufficient in relation to their own expectations. These studies collect information according to their own objectives. Accordingly, a formal logic is inherent in the chosen methodologies, which cannot be faulted with respect to the researchers’ objectives.

A novel feature of the review is that it attempts a critical appraisal of how these studies approach smoking, eating, drinking alcohol and exercising: as health-related or as ‘everyday activities’. The hegemonic role of health is particularly illustrative if someone considers the findings of these studies independently from their health purposes. The third group is elaborated on more deeply since it is related with this study: exploring how young people make sense of their everyday experiences with health-related behaviours.

2.3.2.1 Measuring frequencies
The first research group includes research projects, which aim at estimating the ‘current’ prevalence of smoking, exercising, eating food (healthy or unhealthy) among a sample of young people (such as Goddard, 1997; Rudat et al., 1992a, 1992b; Markham et al., 2001). The following are types of information which are used to determine the frequency of a particular behaviour among a population group: who, when, how often and how much does someone smoke, drink alcohol, eat ‘healthy’ or ‘unhealthy’ food and exercise? The majority of these studies implement surveys using either closed questionnaires or structured interviews. These studies mainly vary in relation to size, content, sample and the number of times that they are conducted; features which determine the kind of information that is given regarding the prevalence of health-related behaviours among young people.

The prevalence of the health logic in this type of research can be conceptualised when someone considers the role of health in these measurements. These behaviours are not measured simply because they are daily human activities but primarily because they

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18 See relevant discussion concerning the distinction between ‘everyday’ and ‘health-related’ activities, section 2.3 (p.32).
are related to the health status of the individuals (Donaldson and Donaldson 1993). Kohli and Hanlon (1997) summarise the value of such indicators based on 15 surveys of young people’s behaviour undertaken in Scotland during 1986-95. All given reasons are associated with the promotion of good health: ‘to provide local data’; ‘to provide baseline data for the board’; ‘for planning purposes’; ‘to raise awareness of health and lifestyle issues’; ‘to monitor health promotion programmes’; ‘to provide data for the setting and monitoring of local health targets’; and ‘to evaluate health promotion’ (Kohli and Hanlon, 1997 p.77).

The above-mentioned reasons, given by Kohli and Hanlon (1997), for measuring the frequencies of health-related behaviours, emerged in the report of other researchers. For instance, Rudat (1992b, p.1) justifies the Health Education Authority’s (HEA) interest in conducting a survey on health-related behaviours among young people in order ‘to gain a picture of the behaviour of young adults which has, to a greater or lesser extent, some bearing on their current and future health’. Similarly, Power (1995, p.42) who describes the ‘prevailing’ (at the time of investigation) trends in diet, physical activity, smoking and alcohol consumption among British children, introduced his study as follows: ‘Many serious diseases in later life are thought to be preventable by improving lifestyles’. Lifestyles and risk factor prevalence were also used as monitors of any continuity or change (Lintonen et al., 2000; Turtle et al., 1997; Balding 1994, 1995, 1996 and Balding et al., 1997), or of any progress towards national health targets (e.g. OPCS 1995). In other cases, these four activities were also measured as indicators of the success of a health education project. Boaz et al. (1998), utilize health surveys of children’s diets in order to assess the effectiveness of a ‘five-a-day’ fruit and vegetable pack for primary school children.

The findings gained from surveys carried out within the health promotion field do not raise questions about the role of these behaviours within the daily lives of young people. Rather, the frequency findings concerning health-related behaviours are justified as significant only for health-related purposes. It is in this context that the perception of individuals and practices they engage in, take on a judgemental character. Individuals are classified as healthy or unhealthy, as compliers or deviants, and as improvable or non-improvable.
Nevertheless, one may view these frequencies as indicators of social phenomena or the role of these behaviours in people's lives other than for health reasons. Johansson et al. (1999) uses a number of variations (such as age, education, socio-economic status, income, location of residence, smoking, exercise and attention to healthy diet) to arrive at complex comparative conclusions. For example, men aged 16-29, with low education, living in rural areas, paying little attention to a healthy diet, reach the lowest indicator regarding fruit and vegetable intake. These variables enabled the researcher to arrive at detailed descriptions of the prevalence of health-related behaviours among the sample. Nevertheless, these indicators show also a daily habit - fruit intake - which occurs less often among a specific group of people. From outside the health discourse, the prevalence of these practices could have been seen as indicators of the habits of this specific group of people, rather than as identifying a possible target group for health promotion intervention.

2.3.2.2 Identifying patterns

The second research group includes studies which aim at identifying patterns between a group feature (e.g. gender, age) and the corresponding prevalence of health-related behaviours (such as Milligan et al., 1997; Lintonen et al., 2000). One side of a relationship concerns patterns relevant to actual behaviour. These patterns may relate directly to behaviour e.g. how much alcohol is consumed on weekends or indirectly to a decision-making area of behaviour i.e. do you like exercising. The other part of the relationship consists of a number of variable sets, which I classify in two broad categories: personal (such as age, class, gender, personal belief); and environmental variables (such as parental influence, culture and media). Health-related patterns are mainly studied through surveys which collect numerical data for each part of the relationship (e.g. age and alcohol consumption) and measure statistically the strength of the relationship of one set of facts to another. Qualitative research projects, which are limited in this group, focus on describing how a pattern (such as gender and smoking) operates within the everyday life of individuals (Devine, et al., 1998).

Health logic is manifested here if someone considers the underlying reasons which support this type of research orientation. The identification of patterns between a health-related behaviour and personal or environmental variables gained great interest among health researchers, mainly because the revealed patterns can indicate factors
which determine the tendency of a group to follow, or fail to follow healthy choices (Pill, 1991). In effect, personal and environmental variables are likely to be presented as ‘factors’, ‘determinants’ or ‘predictors’ of people’s health-related choices entailing an evaluative character - as enabling or constraining, positive or negative. In the following concluding remarks of the health-related researchers, I highlight in bold how the environment and personal conditions are approached as indicators of a ‘healthy choice’.

- ‘A person’s life-course transitions and trajectories (persistent thoughts, feelings, strategies, and actions over lifespan) are fundamental influences on the development of his or her personal system for making food choices’ (Devine et al., 1998, p.361).
- ‘Although the individual’s level of socioeconomic characteristic was not as strongly related to health behaviour as the small area factors, a low level of education predicted smoking and alcohol use and among girls, decreased physical activity’ (Karvonen and Rimpela, 1997).
- ‘Boyfriends and friends have been found to have a particularly strong influence on girls’ motivation for taking part in physical activity’ (Orme, 1991).

The ‘causal’ impressionootnote{While it is not always clear whether researchers claim a cause-effect pattern, their findings tend to be presented as causal factors rather than as simple descriptions of people’s health choices.} 9 embedded in the revealed relationships with health-related behaviours is ‘logical’ if one considers the underlying health promotion aspirations to explain the healthy or the unhealthy choice. Correspondingly, the emphasis is on the positive and negative impact of the revealed pattern upon the adoption of a ‘healthy’ choice, a phenomenon which overlooks the relationship between these factors and people’s social lives.

The above point is illustrated when someone considers how a revealed pattern is interpreted within a health and sociological research project. In the case of sociological studies the underlying intention is to explain a social phenomenon, whereas a health
researcher seeks to explain positive or negative movement towards or away from a healthy choice. In order to clarify the boundaries between health and sociological studies, I quote how two health researchers interpret the relationship between church attendance and smoking, alcohol consumption. In their results Gottlieb and Green (1984, p.98) state:

‘church attendance was characteristic of men and women non-smokers and was negatively related to monthly volume of alcohol for both sexes... This suggests a reduction in substance abuse resulting from religious teaching’.

The significance of the above findings, as health-related ones, concerns the capacity of church attendance to promote healthier choices in terms of smoking and drinking alcohol. By contrast, a sociological or an anthropological study may use the relationship between church attendance, smoking and alcohol consumption in an analysis of social networking or socio-economic background of people who attend church, issues relevant to the way that health-related behaviours fit in a social setting.

Lastly, it is very important for the present research project to highlight the cause-effect logic applied to people's accounts regarding health-related behaviours in the 'identifying patterns' group of health-related research. Young people's concerns about health-related behaviours are examined as a possible contributing factor in their health-related choices. Manfredi et al., (1997), for instance implemented a survey and face-to-face interviews in order to assess health beliefs and the perceived utilities of smoking. Sun et al., (1998) also rationalize their research interest in youths' perceptions of cigarette smoking as possible contributing factors on their decision to smoke. Similarly, Thrush et al., (1997, p.69), who study children's social representations of smoking conclude their study as follows:

‘The more we can discover about children’s social representations of smoking, and the processes which underpin them, the more we are likely to be able to use this knowledge to predict smoking uptake and to design more effective intervention programmes’. [Bold –emphasis by the author]

Correspondingly, the lack of strong evidence, which connects people's statements of belief, intention or attitude with health-related behaviours, is seen as problematic within the present research group, which focuses on the 'strength' of this relationship (Norman, 1986; Pill, 1991). The significance of exploring people’s accounts for their
own sake - independently with the degree of the incidence of health-related behaviours - within the field of health promotion, is discussed in the following section.

2.3.2.3 Focusing on people’s accounts of health-related behaviours

This group covers research that investigates what and how young people think and talk about health-related behaviours. Here I do not refer to studies in which people’s accounts are at the forefront in identifying patterns, connecting the incidence of health-related behaviours with personal and/or environmental factors. People’s concerns regarding health-related issues occupy the central focus of this group. The focus here is on the attempt to capture the meanings employed by young people: the effectiveness of health promotion intervention²⁰ (Moore and Kindness, 1998, Aggleton, 1996, Nettleton, 1995; Curtis and Taket, 1996; Shucksmith and Hendry, 1998); the comparison between ‘lay’ and ‘professional’ views (Nettleton, 1995; Pill, 1991; Williams and Moon 1987); and the role of the social context upon the expressed ideas (Amos et al., 1998; Devine et al., 1999; Cornwell 1984) are all found as the main justifying reasons for exploring young people’s meanings.

In conducting an explicit content review, I realised the malleability of the generated beliefs. As pointed out by Curtis and Taket (1996, p.44), the type of accounts gained from each study is ‘crucially dependent on the details of the particular context concerned’. Two main types seem to stand out in relation to the above criterion: research projects which approach these four behaviours as ‘health related’; and those which study them as ‘everyday practices’. In the light of these two groups, I also clarify the empty space that this project attempts to fulfil exploring young people’s accounts of smoking, eating, drinking alcohol and exercise as ‘everyday’ activities.

The above distinction is significant for the main argument of the thesis concerning the role of a health logic in the way that the accounts of young people are generated. The point here concerns how research participants are encouraged to talk about smoking, eating, drinking alcohol and exercise. That is not to claim that research projects which approach these behaviours within a health oriented framework cannot ‘inform’ us how

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²⁰ The role of young people’s voices regarding health promotion interventions is discussed in section 1.1, p.13.
young people make sense of their own experiences. Rather the argument here is to emphasise the conceptual framework within which the participants’ accounts of these behaviours are generated. Nevertheless, what seem to be missing in these studies is the recognition that young people’s beliefs are influenced by the context and ‘should be viewed as dynamic rather than static’ (Curtis and Taket, 1996, p.35).

2.3.2.3.1 Smoking, eating, drinking alcohol and exercise as health-related behaviours
In the first section, I show through examples (such as presentation, interview questions, aim of the study) how a health-related framework formulates explicitly or implicitly the content of young people’s accounts of smoking, exercise, eating and drinking alcohol. The notion of health as an overarching conceptual framework is a potentially useful one within which young people are asked to construct their own ideas regarding smoking, eating, drinking alcohol and exercise. Nevertheless, it should be recognised that, in this case young people’s ideas concerning health-related behaviours are explored as ‘cultures of health’; an idea developed by Aggleton (1996) which encompasses the ways in which different groups of young people make sense of health-related issues.

Firstly, the presentation of a study can be critical in defining the context within which young people’s accounts are obtained. Research participants are likely to be informed about issues concerning the research such as origins, economic sponsors, stimulating factors, research purposes and aspirations. For instance, the word ‘health’ is included in the title of questionnaires given to young people: Turtle et al.’s (1997) questionnaire is entitled ‘Young People’s Health and Lifestyle 1995 Questionnaire’ and Balding’s (1996) questionnaire is entitled ‘Health-related Behaviour’. In addition, Balding’s questionnaire informs research participants of its health-related background ‘Schools Health Education Unit’. These presentations apparently demonstrate a health framework in which young people’s ideas are employed.

Interest in young people’s meanings invested in smoking, eating, drinking alcohol and exercise is frequently revealed as a component rather than as an exclusive objective of a research project. In most cases, young people’s ideas are collected as part of a
broader interest in health issues such as how health, illness or disease is defined (Watson, 1993; Brannen et al., 1994; Pill 1991; Helman, 1984; Foster and Anderson, 1978); how individuals can protect or sustain their health; how they can avoid the onset of disease (Pill and Stott, 1986; Backett 1990); and how certain behaviours can be harmful (such as alcohol consumption, Plant et al., 1990). It is in this context that health matters inevitably are manifested in young people’s responses about smoking, eating, drinking alcohol and exercise.

A selection of examples shows how both researchers and participants refer to these four behaviours only because of their health quality. Backett (1992), who investigated how health and illness are conceptualised within socio-cultural settings in Edinburgh and South Wales, also discuss young people’s meanings regarding alcohol consumption. Consequently, young people are unlikely to talk about alcohol consumption as a social activity since the overarching goal of the study is to collect meanings concerning health and illness. Pill and Stott (1986) use specifically the question ‘what are the three most important things you do to protect your health’ in order to collect ideas held by British working class women in relation to these behaviours. Consequently, Pill and Stott (1986) present their findings mainly by classifying the suggested behaviours in relation to their health qualities given by their respondents; food and nutrition were the most frequently mentioned health-related behaviour, followed by exercise and physical activity, sleep, rest and relaxation. Similar health-related types of findings have been reproduced in Backett’s (1990) study since the open question was ‘what are the ingredients of good health?’ I therefore challenge Backett’s remark concerning participants’ responses: ‘health concerns were treated as integral aspects of daily life’ (Backett, 1990, p.34). Rather, I understand the dominance of the issue of healthiness in children’s drawings concerning food and physical activity as a matter of a response to the first round opening question.

Another way of imposing health as an underlying conceptual framework within studies which aim to search ‘health-related ideas’ is by asking research participants to give reasons for their healthy or unhealthy choices rather than simply describe them. A health-related logic is transferred on to individuals’ responses since they are constrained to construct explanations why they or others adopt or reject health-related
behaviours. Asking someone to justify why he/she smokes, drinks alcohol, exercises or eats certain foods instead of others, closes up the possibility of other sorts of accounts. The implicit or explicit need for ‘excusing’, or ‘giving good reasons for’ health-related behaviours, excludes analogies, differences and shifts regarding health-related choices. For instance, in Bain and McKie’s (1998) study, participants were asked to comment upon their expectations, fears and concerns regarding behavioural change in smoking; areas which do not leave space for the research participants to construct other sorts of understandings of smoking. The disclosure of social life as multiple factors may prevent both the researchers and participants from dealing with the processes by which beliefs are shaped within the social context. For example, it is unlikely that either researcher or participants will explore issues of how gender may shape the way that young people experience these behaviours, when the focus is located on the cause-effect relationship between gender and health-related behaviour.

2.3.2.3.2 Smoking, eating, drinking alcohol and exercise as ‘everyday activities’

The preceding section illustrated how health as a revealed background framework influences the way young people talk about health-related behaviours. Here I discuss a sample of studies, which purposefully seek to escape from the health logic by focusing on young people’s daily life and how they construct their beliefs within this context. This empirical orientation is accompanied with the recognition that ‘behaviours, which may affect health almost invariably carry social meanings other than those which pertain to health’ (Nettleton 1995, p.37). One may distinguish these studies since they use certain techniques in order to direct research participants to talk about these four behaviours within the context of everyday life.

In conducting this research review, I found only a very limited number of projects within the field of health promotion which explore smoking, eating, drinking alcohol and exercise within a broader view of everyday life. The lack of this empirical direction has been acknowledged by a number of health advocates. Moore and Kindness (1998) for instance raised the lack of research about the ‘cultures’ of children and young people and how they view the crossroads between different aspects of their lives and their health-related behaviours. Young people’s conceptions of health-related behaviours are largely unexplored in relation to self-conceptions of their lifestyles,
identities and social networks (Moore and Kindness, 1998; Shucksmith and Hendry, 1998). In the light of this tendency, Wright (1999, p.xiii) declares that there is very limited knowledge ‘about the way young people themselves define, prioritise, organise or interpret information about alcohol, in order to make sense of their social worlds’. Similarly, Allbutt et al. (1995) have acknowledged the lack of information on what young people themselves think about smoking and the social contexts within which smoking or non-smoking is promoted.

Health researchers should therefore seek to enhance their insight to health issues by grasping the aims, purposes, intentions and meanings of the individuals and not merely by identifying broad trends or by demonstrating causal factors associated with behaviours (Buchanan, 1998; Shucksmith and Hendry, 1998; Pavis and Cunningham-Burley, 1999; Morrow, 2001). Otherwise, as Nettleton (1995, p.37) argues, ‘to emphasise these lifestyle factors in isolation from their social context is, given what we know about lay health beliefs somewhat artificial’. Shucksmith and Hendry (1998) adopt similar position by raising the need to explore young people’s own accounts of how specific health-related behaviours are embedded in more general youth cultures. It is required therefore, for health researchers to use certain techniques in order to encourage young people to generate their own agendas, regarding the way that health-related behaviours are embedded in their social lives (Shucksmith and Hendry, 1998). The present research project aims partly to fill this research gap concerning young people’s ideas about health-related behaviours by exploring them as everyday practices. Yet, it focuses on the consumer meanings of health-related behaviours from the vantage of young people, a direction which is elaborated in the next chapter.

In the remaining part of this section, I exemplify some methodological techniques that researchers have applied in order to capture meanings that young people have attached to these four behaviours emphasizing their ‘everyday’ rather than their health aspect. Some of these techniques were used in my research project (see p.104-105). My intention here is to highlight the conceptual framework within which young people are encouraged to talk about smoking, eating, drinking alcohol and exercise. I begin with issues concerning the presentation which is offered to the research participants. In most cases young people are asked to participate in a research project which deals with issues relating to young people’s everyday lives such as their current interests.
Shucksmith and Hendry (1998, p.20) for instance, introduced their research project as one generally concerned with exploring ‘young people’s thoughts on issues which concern them’. Similarly in Michell and Amos’ (1997) study, the researcher introduced herself as someone with a broad interest in teenage lifestyles. Likewise, Allbutt et al. (1995) presented the project as an investigation into what young people did and what their interests were. They also purposefully avoided making smoking behaviour the initial focus of the interview.

Apart from the presentation which is offered to the research participants, a number of other research techniques have been employed by health researchers in order to collect young people’s meanings on these four behaviours as social ‘everyday’ activities rather than as health-related ones. Pavis et al. (1998) located these behaviours in a concrete social setting during the interview procedure. Allbutt et al. (1995) constructed open interviews about their subjects’ own lives and experiences and let smoking emerge as a topic suggested by the interviewee rather than by the interviewer. A topic guide used to promote discussion included three social areas: social meanings, social activities and images of smoking. Similarly Devine et al. (1999) allowed their subjects to talk broadly about food choices in general without constraining them in specific health-related themes in order to understand how ethnicity was interpreted, expressed and enacted through food choices. Amos et al. (1998) constructed a questionnaire in which subjects had to rate smoking and non-smoking pictures, taken from youth and style magazines, their self, ideals and socially desirable images. In this way, Amos et al. (1998) managed to locate smoking behaviour in conjunction with ‘contemporary’ cultural trends. In this study, the focus was placed on the perceived social images connected with smoking behaviour. A ‘healthy’ image was only one of the suggested attributes of the photographs.

The research participants’ accounts differ when researchers approach health-related behaviours as everyday activities rather than as health-related ones. For instance, young people who participated in Shucksmith and Hendry’s (1998) research project expressed rarely any health concerns regarding food and nutrition. Instead, their concerns about their food intake were rather linked to issues of weight and its association with their personal and physical appearance and attractiveness. In Pavis et al.’s (1997, p.311) qualitative study, the reasons which the young interviewees gave
regarding alcohol consumption concerned their daily lives – ‘peer influence/pressure, social facilitation, mood alteration, and to cope with personal difficulties and/or to relieve stress’. The fact that the respondents’ accounts were concerned with the way they experienced alcohol drinking in their daily lives could be justified methodologically. The interview questions aimed to retrieve their meanings attached to their health behaviour in specific social settings: ‘Tell me about a typical night out’ or ‘would you just drink in pubs or...’ (Pavis et al., 1997 p.316). Michell and Amos (1997) describe how young people perceive their smoking experiences in relation to peer group structure and gender. Their reports were about how smoking behaviour was experienced in different peer groups and how it was shaped by gender. They indicate, for instance, how smoking was used as a symbol of a gendered identity. Pavis et al. (1998) captured individuals’ descriptions concerning their subjective experience within different social locations. Young respondents described how smoking was used in their daily life in order to gain access to groups they admire.

The examples given above illuminate the fact that participants’ descriptions or evaluations of health-related behaviours are informed by social attributes and not necessarily by biomedical relevance to health. Young people’s accounts centred on their perceived social attributes (such as social images, social identities, social morals or norms) which are then used in order to describe people’s day-to-day experience in relation to these behaviours. Many of these perceived concerns of young people are reflections of wider cultural images (Shucksmith and Hendry, 1998). The present research project, which used some of the techniques elaborated in this section generated similar concerns to the studies of this group of health-related research. What is, however, distinctive of this study is its concentration on young people’s symbolic attributes connected with smoking, eating, drinking alcohol and exercise; an empirical direction which is informed by consumer theories as outlined in the following chapter.

2.4 Conclusion

The chapter began with a review of the classification of smoking, eating, drinking alcohol and exercise as health-related behaviours through the biomedical and social
perspective and as allied to health education and health promotion. The biomedical perspective, which is informed primarily by epidemiological studies, reveals health or illness casual consequences associated with health-related behaviours. The social perspective aims to sensitise health advocates regarding the role of the social, material, economic and cultural determinants related to health-related behaviours. Health promotion, as a critical term in public health, argues for the need of ‘engineering’ knowledge gained from the social perspective, in order to make the healthy choice the easy choice. Yet, the strong biomedical origins of the development of the social perspective – employed primarily by the field of health promotion – is reflected in the way these behaviours and related social context are handled.

In the second part of the chapter through the notion health logic, I exemplified how ‘health’ is embedded conceptually and empirically in the way that health-related behaviours are approached. As it is ‘logically’ expected, these four behaviours and their broader social manifestations are conceptually and empirically framed in a straightforward association with the ultimate goal of the field to promote good health. On the basis of these three key concepts, ‘lifestyle’, ‘choice’, and ‘empowerment’, employed within the field of health promotion, I discussed how the broader social dimensions of these behaviours are largely treated as reinforcing or limiting factors to the accomplishment of a healthy lifestyle. Likewise, the majority of health-related research projects aim at measuring the prevalence or uncovering patterns related to the personal adoption (or rejection) of ‘healthy’ behaviour. Hence, social and cultural aspects associated with health-related behaviours were largely treated as reinforcing or limiting factors to the health compliance of the individuals.

The pitfall regarding health logic is that it plays down young people’s voices and their social setting, and over-emphasises the social influences upon the final choice. It is in this context that the place of health-related behaviours within the context of young people’s broader lives and cultures is either dismissed or presented as positive or negative influential factors towards the healthy choice (Backett, Davison and Mullen, 1994; Pavis and Cunningham-Burley, 1999). In a similar ‘fashion’, the meanings employed by young people remain essentially unexplored within the area of health promotion, notably in favour of using them as evidence of their compliance or not, with the healthy choice. Only a limited number of studies explored young people’s ways of
seeing day-to-day experiences with smoking, eating, drinking alcohol and exercise without locating them implicitly or explicitly within a health framework. In effect, we still know remarkably little about the ‘cultures’ of children and young people and how these behaviours integrate within their everyday lives (Moore and Kindness, 1998). Therefore, what is needed is a framework that takes account of young people’s perspectives regarding the role of these behaviours within the context of everyday life, rather than concentrating on their health relevance.

Although the health promotion field aims at incorporating the social and cultural manifestation of these behaviours, it is still primarily the health context which influences the way that the roles of these behaviours in people’s daily lives are understood and explored. This recognition, as developed in the present chapter, was fundamental for the construction of the present research project. Firstly, it has originated as an empirical attempt to address young people’s own agendas regarding health-related behaviours. Secondly, it is equipped with a set of practical solutions regarding the exploration of smoking, eating, drinking alcohol and exercise, not explicitly as health-related but rather as ‘everyday activities’. In the next chapter I discuss the use ‘consumer culture’ as a framework in which smoking, eating drinking alcohol and exercise can be viewed as daily activities which can have other roles in young people’s lives without ‘forcing’ me to judge them in terms of their health relevance.
Chapter 3

Health-related behaviours and consumer culture

3.1 Introduction

In the preceding chapter, I elaborated on the prevailing orthodoxies regarding the concept of health-related behaviours within the field of public health. In particular, I highlighted the empirical tendency within the field of health which favours to approach the social life of individuals as an influential positive or negative factor. As it was argued, such a strongly value-laden approach seems unlikely to tell us very much about how young people make sense of health-related behaviours within the context of their everyday lives. In this chapter, I propose an alternative viewpoint of health-related behaviours - a standpoint centring on young people’s own concerns about their everyday experience with health-related behaviours as consumer activities.

The present chapter has two objectives. Firstly, I review the role of ‘consumer culture’ as a supportive theoretical framework for the aim of the study. In particular, I would like to clarify two of my key concepts ‘health-related behaviours as consumer activities’ (section 3.3) and ‘consumer meanings’ (section 3.6). Secondly, I outline the distinctive position of this research study regarding the use of ‘consumer culture’ as a theoretical framework which is concerned with its emphasis on how the participants talk about the everyday consequences of the symbolic dimension of health-related behaviours.

This chapter consists of five main sections. In the first, I clarify the notion of consumer culture as a theoretical field, highlighting the role of consumption as a cultural rather than a material phenomenon (section 3.2). Giving briefly the conceptual framework of consumer culture I elaborate what I mean by labelling health-related behaviours as consumer activities (section 3.3). I then review two different orientations concerning the way that the forms of consumption are explored within the field of consumer culture (section 3.4), and their application within the field of health promotion.
(section 3.5). Through this presentation I identify the distinct position of the present study, focusing on the everyday consequences of the symbolic meanings of health-related behaviours via the perspectives of young people. Finally (section 3.6), I elaborate in further detail the direction that this present study adopts.

3.2 Defining consumer culture

‘Consumption appears to be rooted in the satisfaction of purely natural, biological and physical needs’ (Bocock, 1992, p.121). Literally, it is seen as a process dictated by human biology which aims to satisfy these basic needs by means of food, liquid, medicine, warm clothing, means of transportation and so on. It is, however, perhaps impossible to understand consumption, from the way in which millions of people now shop for and consume goods and services without realising that the material object being sold is never enough (Bocock, 1992; Williams, 1993). Consumption is a social and cultural activity which constitutes a fundamental channel of communication through the exchange of social meanings (Featherstone, 1991). This crucial cultural quality of consumption constitutes the basis of the development of consumer culture which emphasizes the social and cultural aspect of the economic and utilitarian process - a more recent theoretical theme of consumption (Chaney, 1996; McCracken, 1988). Accordingly, consumer society as a distinctive form of advanced capitalism signifies not just the expansion of the quantity of goods, but also the increasing penetration of the meanings associated with consumption into the culture of everyday life (Nava, 1992).

The prevailing idea within the field of consumer culture is the potential of goods to be consumed not only for their material use but also because of their cultural quality (Bocock, 1993). The comparative relationship between material and cultural needs emerged frequently as a profile of ‘consumer culture’; a phenomenon which is indicated in the following statements. Consumption is seen ‘as a process governed by the play of symbols, not by the satisfaction of material needs’ (Bocock, 1993, p.75). ‘Becoming a consumer is a process which depends upon cultural symbols, and is not merely a mechanical or biological response to signs’ (Bocock, 1993, p.85). The main argument here is that the choice of consumer products or activities is associated with
the satisfaction of cultural needs or desires and not only with material ones. Within this framework, terms like ‘cultural needs’ or ‘cultural desires’ highlight the relative weakness or even obliteriation (Baudrillard, 1995) of the material value of objects within the process of consumption. Consumption moves away from the essential satisfaction of material needs to the more abstract and less instrumental - cultural ones.

The following discussion concentrates on the relationship between consumption and culture; this constitutes the key prevailing theme, which formulates ‘consumer culture’ as a modern cultural phenomenon (McCracken, 1988). The idea of ‘culture’ as a key component of consumer culture has usually been used in the area of consumption in a somewhat different and more specialised way than in other social fields. I found the combination of two prevailing definitions of culture – as a ‘shared stock of meanings’ (Hall, 1997) and as ‘a distinctive way of life’ (Williams, 1961; Hall, 1997) - to be the most relevant in respect of how the concept is used within the area of consumption.

According to Hall (1997, p.2), culture reflects ‘the production and the exchange of meanings – the giving and taking of meanings – between the members of a society or group’. The emphasis here is on communication, achieved through the shared stock of meanings or values, and the relative knowledge of the cultural repertoires prevailing among the members of a group. Meanings become part of a culture only if they are interpreted in roughly the same ways and as such can be communicated among members within the same cultural context (Hall, 1997). Du Gay et al. (1997) associated this definition of culture with the idea of ‘collective representation’, which reflects the shared understandings binding individuals together in society. In this sense culture depends on its participants ‘making sense’ of the world in broadly similar ways. Nevertheless, culture should not be perceived as a strictly unitary frame of interpretations, as Hall (1997, p.2) argued, ‘there is a great diversity of meanings about any topic, and more than one way of interpreting or representing it’.

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21 Culture is a divergent and complex concept in its various applications. ‘This is so partly because of its intricate historical development, in several European languages, but mainly because it has now come to be used for important concepts in several distinct and incompatible systems of thought’ (Williams, 1983b, p.87).
With reference to the above definition, the relationship between culture and consumption is associated with the crucial role of consumer goods to ‘operate as symbols, which stand for or represent (i.e. symbolize) the meanings we wish to communicate’ (Hall, 1997, p.5). Consumer activities have the capacity to function as symbols; representing thus ‘our concepts, ideas and feelings, in such a way as to enable others to “read” decode or interpret their meanings in roughly the same way that we do’ (Hall, 1997, p.5). Culture involves consumer activity, not simply as an economic activity, but as a signifying practice (Barker, 2000) which carries symbols that can be meaningfully interpreted, used and communicated in daily life by people who share, in a broad sense, the same cultural codes. Accordingly, ‘consumer culture’ as a theoretical framework is based on the idea that the consumption of goods is perceived as part of ‘a system of symbolic exchange’ (Lury, 1996, p.14).

The second association between culture and consumption is documented from the perspective of culture as a distinctive ‘way of life’. Du Gay et al. (1997) considered the social definition of culture to be probably the most relevant with the circulation of meanings through consumer products. Culture is defined as a ‘description of a particular way of life which expresses certain meanings and values not only in the art and learning but also in institutions and ordinary behaviour’ (Williams, 1961, p.57). As Hall (1997, p.2) has stated ‘in recent years and in more “social science” context, the word culture is used to refer to whatever is distinctive about the “way of life” of a people, community, nation or social group’; however, what is significant in the ‘modern’ use of culture is its associations (Hall, 1997). A ‘distinctive way of life’ is expressed not only through art, publications, or music but also through ‘the everyday lives of the majority of ordinary people’ (Hall, 1997, p.2), or as Williams (1961, p.57) stated, through ‘ordinary behaviour’.

Consumption, seen as a mediator which can construct or articulate boundaries and distinctions between different groups of people, constitutes a key issue for the development of the consumer culture as a theoretical field. Lifestyle, in the context of consumer culture, ‘is a concept which has come to refer to people’s styles of living which in turn, are shaped by their patterns of consumption’ (Nettleton, 1995, p.37).
Historically, Veblen (1899, 1912) was one of the first to stress the cultural significance of consumption for social groups in their effort to demonstrate their social status to others (Lee, 2000). Similarly, the work of Simmel (1903) and Weber (1915 and 1970) focused on demonstrating that consumption (clothing, furniture, foods and drinks) is linked with a specific style of living, thought to be appropriate to a specific status group (Bocock, 1992). Until the 1950s the symbolic element of consumption was concerned with separating groups of people into socio-economic categories.

By contrast, during the 1980s and 1990s, a critical mass of consumption studies built up which emphasised the active role of consumers to experience and construct various forms of cultural identities and lifestyles (Sarup, 1996b; Barker, 2000; Miles, 2000). In this context, the meaning-oriented activities of consumers of expressing themselves through the modes of consumption, which Barker (2000) defined as style, surfaced. In parallel, many market researchers devised new categorisations by lifestyle rather than by class or income level (Mackay, 1997). These categories signified consumer styles such as the ‘working class’, ‘youth’, ‘males’, ‘Hippies’ and ‘Punks’ (examples given by Bocock, 1992). Likewise, Featherstone (1991) claims that ‘an active stylisation of life’ is cultivated in contemporary consumer culture: the new heroes of consumer culture are those whose life can be viewed as a project, utilising goods, practices and experiences, which flow within consumer culture. The aesthetic value of commodities and consumer practices, generated through the contemporary commercial migration of arts into industrial design, is closely tied up with the importance of style as an expression of a lifestyle (Featherstone, 1991; McCracken, 1988).

So far I have elaborated the relationship between consumption and culture, with reference to two conceptions of culture: as a ‘shared stock of meanings’ (Hall, 1997); and as ‘a distinctive way of life’ (Williams, 1961; Hall, 1997). Yet, it should be noted here that the nature of the relationship between consumption and culture is premised on a complex interdependence of goods and cultures (McCracken, 1988). Their relationship is concerned with issues regarding the place of consumption within a culture: does consumption simply convey cultures? Or does it also reproduce culture

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22 ‘The Theory of the Leisure Class was originally published in 1899, with a revised edition in 1912’ (Lee, 2000, p.47)
(Hearn and Roseneil, 1999)? I do not discuss further the interrelationship between consumption and culture, since it is beyond the scope of this research study. I conclude the discussion of this relationship by referring to the post-modern conceptions of consumption through which I give some further clarifications regarding the use of consumer culture as a theoretical framework of this research study.

The post-modern conceptions of consumption are premised on the idea that the sign-value or symbolic qualities of consumer products or services are more significant than their use value (Miles, 1998). As Mackay (1997, p.5) summarises: 'these writers root their analysis in the notions that culture is becoming increasingly fragmented, and the symbolic is of increasing significance – such that any underlying substance is obliterated'. For example, Baudrillard (1988) argues that consumers do not purchase items in order to express an already existing sense of identity. His work is characterized as postmodern in the sense that he explores the ways in which the sphere of the symbolic is not produced, or directly determined, by structural positions in the economic system (Bocock, 1993). Correspondingly, these writers argued against the idea that certain styles of life are in accord with certain fixed status groups. Featherstone (1991) states:

'We are moving towards a society without fixed status groups in which the adoption of styles of life (manifest in choice of clothes, leisure activities, consumer goods, bodily dispositions) which are fixed to specific groups have been surpassed' (Featherstone, 1991, p.55).

The proliferation of images decreases the possibility of correlating consumer goods, not to certain fixed social groups, but rather to various 'styles' and 'lifestyles'. This is a movement for Featherstone (1991, p.83) towards a postmodern consumer culture in which 'the end of the social as a significant reference point' proclaims the victory of culture and signifying practices.

Summing up, 'consumer culture' as a theoretical field is concerned with the use of health-related behaviours as signifying practices of cultural meanings. Although, I concentrate primarily on the cultural meanings attached to health-related behaviours, I prefer, however, the term 'consumer culture' rather than post-modernity as an analytical tool. This is because the latter implicitly raises historical questions concerning social life and suggests that the consumer formations of lifestyles and identities override other forms of identifications such as work, gender and social class.
The empirical construction of this research study is not concerned with the extent to which consumption constructs identities or whether there is or there is not a historical shift. For this reason I prefer the terms ‘self-images’ or ‘self-expressions’ rather than identities since the latter declares a more fixed attribute. I concentrate on how the participants of the study perceive or ‘get a feeling’ of health-related behaviours as a ‘lifestyle’ arena, which in turn provides a sense of who they are. The next section defines health-related behaviours as consumer activities in the light of the relationship between consumption and culture, as discussed above.

3.3 Health-related behaviours as consumer activities

The term of ‘health-related behaviours as consumer activities’ in this study aims to highlight the capacity of smoking, eating, drinking alcohol and exercise to be consumed as cultural products or activities and not only as health-related options according to the risk element (Bunton and Burrows, 1995). Bunton, Nettleton and Burrows (1995) list a number of contemporary health-related commodities which are charged with symbolic meanings, such as food, drinks, exercise machines and videos, membership of sports and health clubs, walking boots, running shoes, shampoo and so on. Different types of alcoholic drinks (Barr, 1995; Gough and Edwards, 1998), fast food chains (Lupton, 1996; Warde, 2000), sports or fitness industry (Miles, 1998; Glassner, 1989) and smoking campaigns (Amos, 1992; Gray et al., 1996) were studied as opportunities for the consumers to play with them as cultural products. I demonstrate below, using examples from empirical studies which concentrated on the cultural manifestation of smoking, eating, drinking alcohol and exercise.

Firstly, participation in sporting activities is not necessarily related to the desire for a physically healthy body but may represent a desire to reject or engage with other cultural ideas such as masculinity and youth, (Hargreaves, 1986), or patriarchy (Willis, 1991). It is interesting to note, that in the research project of Rantala and Lehtonen (2001), exercise is classified as a cultural practice along with recreational shopping and art making. In this study, common ‘self-relations’ were identified - such as ‘the ideal of being a self-responsible agent’ - and are found in all these three practices (Rantala and Lehtonen, 2001, p.66). Likewise, food can be consumed not only as a
bodily resource (Falk, 1994); Lupton (1996) demonstrated how different eating choices receive different cultural values such as eating a Big Mac compared with dining at an expensive restaurant. In terms of the symbolic role of alcohol consumption, strong associations were found, for instance between beer and masculinity (Gough and Edwards, 1998; Barr, 1995). In addition, an important social function, as a mechanism for determining and communicating group membership and exclusion, was attributed to alcohol consumption (Douglas 1987; Heath, 1987). Finally, the images of smoking generated within a consumption-oriented society such as ‘tough’, ‘sexy’ and ‘cool’ were associated with the development of smoking habits among young people (Gray et al., 1997; Allbutt et al., 1995; Amos et al., 1997).

These examples demonstrated that health-related commodities or activities can be consumed not only as health resources but also because of the cultural meanings that surround them. Parallel consumer sectors do not only approach health as a medically defined state of well-being, but also as a cultural product which can be desirable for consumers. Bunton, Nettleton and Burrows (1995) suggest two opposed directions for utilising the concept of health as a cultural value within the market. First, the original use value of a number of commodities, which were perceived as irrelevant to health matters, has now been transformed into one increasingly articulated in terms of ‘health’. They exemplify, for instance, the ‘greening’ of household cleaning products, the shift from decorative to health-enhancing cosmetics and various forms of leisure. Second, the original health-related use value of certain activities such as bodybuilding has been transformed to take on much wider social and cultural meanings. As Glassner (1989) reveals in his study, images of health are akin to body images promulgated by the slimming, cosmetic and fitness industries. There is a potent combination between the health educationalist appeal for individuals to assume increasingly self-awareness for their health, and body ‘maintenance’, with the consumer culture’s proliferation of stylised images of the body which emphasise the importance of appearance, energy, fitness and the ‘look’ (Lupton, 1994; Featherstone, M., et al. 1991).

Along with the cultural manifestation of health-related behaviours, the commercialisation of healthy lifestyles results in the expansion of health-related choices. One of the ways in which the market manages to expand the category of health-related products is through exploiting the idea of risk minimisation as evolved
in the health promotion discourses (Nettleton and Bunton, 1995). A health-related choice in the commercial sector is not always based on clear-cut categories of something being healthy or unhealthy but can be based on the art of choosing products, which may maximize or minimize health. For instance, choosing milk from the dairy products section can be an extremely complicated process: full-fat milk, semi-fat milk, skimmed milk, organic milk, goat’s milk, soya milk, 2% fat milk and so forth. Even the traditional ‘unhealthy’ choices are presented in the market as ‘healthy ones’ such as cakes in the form of low fat cakes or a packet of biscuits labelled as follows: ‘contain 25% less fat than the normal Tesco custard cream biscuits’. The increased quantity of health-related behaviours can also be understood through the integration of consumer values regarding beauty and fitness, with health messages about body maintenance; the expanding selection of fitness goods and services, new diet foods, vitamin products and new magazines such as Men’s Health and fitness are prime examples. These products, which are sold for the pursuit of fitness and beauty could also be classified as health-related commodities (Nettleton, 1995; Lupton, 1996).

Health-related behaviours as consumer activities inevitably have an effect on the field of health promotion in view of the fact that its own emergence is located within contemporary consumer culture (Bunton and Burrows, 1995). Consumption developments in health promotion approach good health as ‘an elective state, which could be achieved and enhanced by a range of consumer activities which directed the individuals towards being more healthy’ (Yen 1995, p.24). According to Yen (1995) an approach in which users and providers are encouraged to adopt a ‘pick and mix’ approach is consistent with a rhetoric of consumer empowerment and involvement – principles of the ‘new public health’ that were laid out in the Alma Ata Declaration (WHO, 1978). As explained by Tones (1997, p.33)

‘The empowerment strategy helps to resolve an important dilemma in health promotion: The need, on the one hand, to prevent disease and safeguard public health while, on the other hand, respecting individual freedom of choice – including the freedom to adopt an “unhealthy” lifestyle’.

23 Another example of how the idea of risk minimization has been developed within consumer societies are the campaigns for sex risks and sexual health: where the early messages for sexual protection was ‘safe sex’, it gradually modified to ‘safer sex’.
This is important taking into consideration the revealed conflict between consumer sectors and health promotion strategies. The former aims at expanding people’s choices while the latter at directing or limiting them under a health criterion (see also section 8.5, p.237).

The consumer status of health-related products or activities has received relatively little empirical attention compared with other types of directions, as shown in section 2.3.2. This research study can be classified among these studies (e.g. Sulkunen 1998; Denscombe 2001a, 2001b; Gray et al., 1996) which concentrate their energies on exploring the symbolic dimension of health-related behaviours. Nevertheless, exploring health-related behaviours as consumer activities does not correspond to a unique approach. Clearly, a study might follow many directions according to its purposes. The remaining sections of this chapter discuss the distinctive empirical orientation of this research project: to study how young Cypriots talked about health-related behaviours as consumer activities within the context of their everyday lives.

### 3.4 Researching consumer activities

This section aims to clarify my empirical orientation and highlight its significance within the field of health promotion. For this purpose, I classify approaches generated within the field of consumer culture regarding the study of consumer activities in two main categories (sections 3.4.1 and 3.4.2). These are ‘consumers’ compliance’ – focusing on the consumer choice as a structural outcome - and ‘consumers’ perspective’ – concentrating on the consumers’ experience of consumer meanings in their everyday lives. The criterion chosen for this classification concerns the point of emphasis when analysing the symbolic dimension of consumer products and activities. For each approach I highlight their main focal points through a selection of theoretical and empirical studies. Briefly, ‘consumers’ compliance’ approach focuses on the degree of compliance of the final consumer choice and the ‘consumers’ perspective’ approach on people’s ways of perceiving their experiences of consumption in their everyday lives.
In the next section (section, 3.5), I discuss the applicability of these two approaches within the field of health promotion. The former - consumers’ compliance approach – received more empirical attention within the field of health promotion compared with the latter - consumers’ perspective approach. I discuss the increased popularity of the consumers’ compliance as an outcome of the health logic\textsuperscript{24} embedded within the field of health promotion. It supplies health promotion with valuable theoretical and empirical competence to identify consumer determinants of the healthy choice in people’s lives. Given this framework, I identify the distinctive position of this research project which chooses to follow the consumers’ perspective approach. As the discussion below indicates, exploring the concerns of young people regarding the symbolic meanings of health related behaviours within the context of their lives – a direction which characterises the consumer perspective approach – is a rather neglected area within the field of health promotion. It can be, however, a fruitful empirical resource for the aspiration of health promotion to support the empowerment competence of its target population.

3.4.1 Consumers’ compliance

This section refers to theoretical or empirical studies which concentrate their energies on estimating how far a consumer choice is an outcome of at least a degree of structural compliance. I use the term ‘compliance’ in order to highlight the focus of these approaches on revealing ‘objective structures’ defining the consumer choice. Consumer symbols here are theorised as products of some form of underlying structure, which is external to, and determining for, individuals. In parallel, people’s consumer choices, preferences and meanings are mainly understood as outcomes of structures which lie outside of the intention of actors and constrain them (Baker, 2000). The concept of compliance is extremely relevant in order to compare this study with other health promotion studies which also deal with the consumer manifestation of health-related behaviours. It captures their empirical focus on the causal reasons for an individual to follow a health-related choice (see section 3.5.1).

\textsuperscript{24} See relevant discussion in section 2.3 (p. 31-32).
The emphasis on explaining the choice of the consumers as the expression of deep structures, appeared in the body of work which is concerned with structuralism,\(^{25}\) (Bocock, 1993) and is demonstrated in the consumer perspective often known as 'mass culture critique', 'the traditional view' (Mackay, 1997), or 'masses and manipulation' (discussed in Nava, 1992). The prevailing ideas in these texts are that individuals are passive victims of advertisers and are easily duped by the work of the producer who constantly seek greater profit (Nava, 1992; Mackay, 1997; Featherstone, 1991). Consumers are seen as passive recipients of symbols which entail a structural purpose. They are portrayed as 'manipulated, mindless dupes rather than active and creative being' (Mackay, 1997, p.3). The work of the Frankfurt School and cultural theorists of the 1950s and 1960s, are considered as representations of this perspective (Nava, 1992; Mackay, 1997). Marcuse (1964, p.5) typifies this approach:

'We may distinguish both true and false needs... Most of the prevailing needs to relax, to have fun, to behave and consume in accordance with advertisements, to love and hate what others love and hate, belong to this category of false needs'.

Here, consumers' needs or desires are considered as being inauthentic since they are generated by marketing and advertising strategies. The point here is the constraining patterns of consumption through culture and social life.

A rather different approach, which focuses on the relationship between agency and structure, has more recently pre-occupied a number of theorists in the area of consumer culture (Giddens, 1976, 1984, 1991; Miles, 1997; Bourdieu, 1984). What distinguishes this body of work from the 'traditional' structural approaches is the determination of the consumer choice as an outcome of a dynamic relationship between structure and agency. Bourdieu's work does not attribute to consumers a profoundly passive role but it still concentrates on the patterning of consumption as a relative outcome of positions in a structure. Nevertheless, the emphasis of this body of work remains primarily on theorising the final choice as a form of some degree of compliance. The 'habitus' (and related terms) of Bourdieu (1990) amounts to one of the most accomplished approaches to structure and agency within the area of consumption.

\(^{25}\) Theorists of consumer culture who are concerned with 'structuralism emphasise the role that signs and symbols play in the structures of consumer societies' (Bocock, 1993, p.2).
Through the use of the notion 'habitus', Bourdieu (1990) aims to explain people's everyday lives by bridging together structure and agency. 'Nor does he accept that practice can be understood solely in terms of individual decision-making, on the one hand, or as determined by supra-individual "structures"...' (Jenkins, 1992, p.74). Nevertheless, as Bocock (1993) argues, Bourdieu does not abandon the existence of structures such as social class and gender, which affect people's everyday practices independently of the subject's consciousness. Habitus 'refers to the underlying pattern of unconscious preferences, classificatory schemes and taken-for-granted choices which differ between groups and distinguish one from the other' (Bunton and Burrows, 1995, p.213). It is inculcated from early childhood through interaction with the social environment and allows individuals a mechanism for structuring their experiences (Miles, 1998). Habitus, in other words, is understood as the everyday knowledge that reflects the routine experience in a particular culture; therefore, lifestyle is 'a system of classified and classifying practices' (Bourdieu, 1990). As such, lifestyles offer distinctions to certain groups of individuals and give rise to individuals' differences and similarities.

In the context of consumer culture, Bourdieu’s (1984) analysis of lifestyle draws attention to the capacity of consumer goods to act as markers of social difference or distinction. Specifically, his empirical work was based on an analysis of different patterns of consumption, which distinguish social groups according to their status and social class in a given society. 'Taste' in cultural goods is seen as one of the signifiers which may also function as an important marker of social difference or distinction (Jenkins, 1992). Taste like 'habitus' is not a free floating and randomly classifying choice. It is defined from the individuals' embodied forms of capital\textsuperscript{26} (Bocock, 1993). An individual's embodied status is experienced, and also experiences through a 'pre-defined' selection of consumer goods (Lee, 1993). Therefore, taste does not only classify people's preferences but it also classifies the classifier (Bourdieu, 1984). In that sense, Bourdieu (1984) argues that consumption, even though it might reproduce

\textsuperscript{26} Capital is understood as a form of power accumulated and embodied by the individual from an early age quite unconsciously, there are four forms of capitals (Jenkins 1992) and these are 'economic capital', 'cultural capital', 'social capital' and 'symbolic capital'. These forms of capitals operate in an existing field as goods or resources (relation with others, significant others, clothes, cars, works of art).
hierarchies between different groups, is a process of communication, an act of decoding signs and meanings.

Overall, these scholars – presented in this section - approach the symbolic element of consumer activities as products of a relative external reality, which cannot always be consciously captured by individuals. This is the reason, as Bocock (1993, p.59) suggests, that leads structuralists to treat texts which they seek to analyse ‘objectively, that is as texts within a structure, but not as authored pieces whose meaning was to be grasped by trying to work out what the intentions of the author might have been’. The texts for structural analysis are explored as representing underlying deep structures beyond conscious awareness and thus impossible to be subjectively grasped or authored\(^\text{27}\). Accordingly, there is a preference for using quantitative statistical methodology, which can provide evidence of who consumes what: an approach, which raises primarily issues concerning social differentiation (Du Gay et al., 1997). Nevertheless, this exploration of consumer activities, also bears interpretative costs.

In particular, as a number of critics have argued, one of the major problems of the structural methodology is its ‘anti-humanistic’ approach ‘by decentring of human agents from the heart of inquiry’ (Barker, 2000, p.16) and thereby failing to tell us about how these products are used in the practices of everyday life (Du Gay et al., 1997). For instance De Certeau (1984, p.35) has argued, that the survey approach adopted by Bourdieu, can only count ‘what is used, not the ways of using... the latter become invisible in the universe of codification’. Along the same lines, Du Gay et al. (1997, p.84) states, ‘Such a strongly “objectivized” view, with its antipathy towards any notion of human agency, seems unlikely to tell us very much about what people make or do with material cultural artefacts’. What is missing here is any exploration of the practices of consumption from the perspective of the consumer: a neglected area from the structural forms of analysing consumer choice (Nava, 1992).

Du Gay et al. (1997) associate the absence of the consumers’ perspective with the concealment of the role of practices of consumption in the production of meanings. An

\(^{27}\) For instance, Barthes (1972) who applied structural methods associates wine with ‘Frenchness’ without supplying any empirical evidence with which to substantiate his argument.
empirical or theoretical approach within the field of consumer culture, which does not recognise the moment of consumption as an active meaning-making process for the consumer, is unlikely to ‘tell us how that artefact is used in social relations and what significance it obtains as a consequences of this usage’ (Du Gay et al. 1997, p.84). Hence, the emphasis in the analysis of the symbolic sphere of consumption is placed on revealing relatively simplistic associations between the passive consumption of symbols - generated by the producers – by the consumers according to their positions in social structures such as social class, ethnicity and gender. Thus, as Lupton (1996) suggests in relation to the structural approaches applied to food practices, they tend to be somewhat essentialist, assigning a single meaning to symbolic texts without fully acknowledging the dynamic, highly contextual, and often contradictory meanings around social practices.

### 3.4.2 Consumers’ perspective

Here I elaborate a relatively different perspective, which concentrates its energies on how consumer products and symbolic attributes are used in everyday life; a direction which favours the consumers’ perspective. The emphasis is not on how far the consumers can actively consume, but on what impact consumption has on their everyday experiences. The presentation below is developed through the two key features of the consumers’ perspective approach, everyday life and the creative role of the consumer. The discussion of these two key features is significant for this study in terms of highlighting their absence from health-related research projects associated with the consumer status of smoking, eating, drinking alcohol and exercise (section 3.5.2, p.73-76).

Historically, the focus on the consumer’s perspectives started to be generated with the challenge of the structural analysis of consumer culture in the late 1970s by a very different body of work in which the moment of consumption was made legitimate and even celebrated as a meaning-oriented activity of consumers (Nava, 1992; Barker, 2000). This body of work goes beyond the view that lifestyles, self and consumption are entirely manipulated products of consumer society (see for example McRobbie 1989 and Nava 1992). All these texts focus on the active and creative relationship of the consumer with different forms of consumption (Nava, 1992; Barker, 2000). This
body of work is expressed through the notion of ‘culturalism’\textsuperscript{28}, which stresses the ‘ordinariness’ of culture as a description of everyday processes and the ‘active, creative capacity of people to construct shared meaningful practices’ (Barker, 2000, p.15).

In this light, individuals’ consumer activities, identities and lifestyles are approached as relatively autonomous practices as expressed through modes of consumption (see Miles, 2000). The focus is on how the symbolic sphere of consumption can act as an arena in which people experience forms of cultural lifestyles and identities. In parallel the notion of lifestyle or at least a particular aspect of it is seen as an autonomous playful space beyond determination (Featherstone, 1991). Featherstone (1991, p.83) characteristically states:

‘While the term – lifestyle has a more restricted sociological meaning in reference to the distinctive style of life of a specific status group (Weber, 1968...), within contemporary consumer culture it connotes individuality, self-expression and a stylistic self-consciousness. One’s body, clothes, speech, leisure pastimes, eating and drinking preferences, home, car, choice of holidays, etc. are to be regarded as indicators of the individuality of taste and sense of the owner/consumer’.

Lifestyle is more concerned with active ways of expressing a ‘way of life’, which at the same time connotes a sense of ‘the owner/consumer’. The core of a lifestyle is to be found in the construction of individuals’ identities. It is in the cultural matrix of consumption that the aspects of individuals’ lifestyles and identities are theorised as being inseparable (Featherstone, 1991; Bocock, 1993; McCracken, 1988). The significance of consumption as a cultural and not a material phenomenon is viewed by Giddens (1991, p.81) as an explanation of how issues of identity and lifestyle are interconnected. ‘A lifestyle can be defined as a more or less integrated set of practices which an individual embraces, not only because such practices fulfil utilitarian needs, but because they give material from to a particular form of self identity.’

The lived experience of individuals receives greater empirical interest when consumption is understood as an opportunity for consumers to create cultural

\textsuperscript{28} According to Barker (2000) the term culturalism owes its sense precisely to a contrast with structuralism.
meanings. The emphasis on the everyday consequences of the cultural manifestation of consumer products or activities, is more tied up with the culturalist tradition within the discipline of cultural studies, and concentrates on the active interpretation of cultural meanings as a way of understanding everyday life and thereby culture (Mackay, 1997; Du Gay et al., 1997; Barker, 2000). In opposition to the structural method, - which concentrates on revealing ‘objective structures’ defining the ‘real’ world – culturalist forms of analysis seek to show how people utilise the symbolic sphere of consumption to position themselves and to explain their actions (Barker, 2000; Krug and Hepworth, 1997). It is in this context that people’s accounts are epistemologically valued as a valid form of data in researching consumer symbols and how individuals are actively engaged with them in their daily lives.

As noted above ‘everyday life’ - a concept which ‘lies at the very heart of cultural studies’ (Mackay, 1997, p.7) - consists of a distinctive feature of the consumers’ perspective approach. The primary emphasis is located in relation to the consequences of the cultural forms of consumer practices in the everyday lives of young people. The way that ‘everyday life’ is used in the context of this approach reflects its primary emphasis on ‘the contexts of consumption, the situated character of everyday practices’ (Mackay, 1997, p.11). The emphasis is on the meanings produced by consumers through the use to which they put those objects in the practice of their everyday lives (De Certeau, 1984). Everyday practices as ‘ways of operating’ or ‘doing things’ (notions used by De Certeau, 1984) are primarily connected with the meaning-making process of the consumer. Along the same lines, Miles (1998, p.1) states regarding the interdependency of consumption and everyday life: ‘How we consume, why we consume and the parameters laid down for us within which we consume have become increasingly significant influences on how we construct our everyday lives.’

Empirical qualitative research on the everyday appropriation of cultural artefacts – how individuals make consumer products and activities meaningful (Du Gay et al., 1997) – is favoured within the consumers’ perspective approach. The emphasis in these studies is on how consumers translate consumer objects for their own ends and with what effects (Du Gay et al., 1997). Willis (1978) and Hebdige (1979) are considered among the first to attempt to articulate the lived experience of consumption
of a particular social group. They explore the ways in which rockers, teddy-boys and punks used commodities as signifiers in an active process of constructing 'oppositional' identities (Du Gay et al., 1997). Similarly, Miller (1997) uses several cases studies - council flat kitchen in London, soap opera and soft drinks in Trinidad and shopping in London – showing the creative role of consumption for the individual for constructing identities. Miles also (1998, p.146) explored qualitatively the ways in which young people interact with consumer lifestyles from day-to-day and concludes as follows, ‘consumer lifestyles provide young people with a means of coping with the ups and downs of social change as that change is expressed through their everyday lives’. What connects the above examples is their emphasis on the everyday consequences derived from the meanings that consumers put on those objects in the practice of their everyday lives. As Mackay (1997, p.6) remarks, ‘such consumption writing differs from both Bourdieu’s work and the “critique of mass culture” in its qualitative approach: through ethnographic research methods, “real” consumers in everyday settings were investigated’.

It is in the context of cultural studies, which is primarily concerned with the experience that consumers are not merely seen as cultural victims but also examines ‘what is rewarding, rational and indeed sometimes liberating about popular culture29; (Nava, 1992, p.193). Based on the consumer’s perspective approach, the symbolic element of consumer culture is seen more optimistically in people’s everyday lives, and not necessarily as a form of subordination. Nava (1992) for instance discusses a number of studies which stress the positive effects of consumer culture: as a sense of identity (Carter, 1984); as pleasure (Modleski, 1982; Radway, 1987; Radford, 1986); as a source for developing critical skills in interpreting advertisements (Nava and Nava 1992); as a source of power and resistance (Hebdige, 1979, 1988); and as political activity30 (Nava 1992). Valentine et al. (1998, p.24) argues that research projects, ‘which actually recognises the energy that young people put in creating their own cultures and does not represent them as passive consumers and victims of commercialism’ are still needed. Likewise, Miles notes (1997) that the actual everyday

29 The notion of popular culture here is used with respect to the meanings consumption produces (Nava, 1992, p.192).
30 Here Nava (1992) discussed consumer boycotts as one of the most effective weapons available to the black population in South Africa.
experience in which consumer meanings are actively constructed is relatively unexplored.

As with ‘consumer’s compliance’, the consumers’ perspective approach is not without its problems. As Du Gay et al. (1997) state, many studies conducted in this same way appear to end up disconnecting consumption entirely from the structural forces. ‘These accounts project a vision of consumption practices as inherently democratic and implicitly “subversive” ’ (Du Gay et al., 1997, p104). In a similar way, Bourdieu argues that ‘a research strategy which consists largely of eliciting from informants accounts of and for their behaviours will produce a misleading picture of social life’ (Jenkins, 1992, p.52). These critiques are concerned with the failure of taking into account the socially structured aspect of people’s lives.

3.5 Health promotion and health-related behaviours as consumer activities

In the preceding sections, I elaborated two different areas in which consumer theorists and researchers concentrate their energies on the analysis of the consumer practice. The first, consumers’ compliance, is primarily concerned with the underlying structural purposes upon the final choice, whereas the second, consumers’ perspective, on the consumers’ visions of the use of consumer activities within their everyday lives. Here, I discuss their applicability within the field of health promotion. The former has been theoretically and empirically (although limited) manifested within the field of health promotion, while the latter, remains unexplored and not adequately developed within the framework of health promotion. It is the latter analytical perspective that I choose to explore as an original orientation within the health promotion field.

3.5.1 Health Promotion and consumers’ compliance

In this section, I review a few studies in the field of health promotion, which roughly adopt the ‘consumer’s compliance’ approach. The main issue which is raised by these studies is that the consumption of health-related behaviours is constrained by the social and material contexts in which people live out their lives (Nettleton, 1995). The focus
on revealing structures as predictable regularities of consumer choices, as outlined in the consumers' compliance approach, provides health promoters with the tools to illustrate factors which reinforce or obstruct the healthy choice. In this light, the consumers' compliance approach is straightforwardly associated with the idea of *health logic* which favours the identification of positive or negative factors towards the healthy choice.

One of the most common cultural critiques associated with the compliance of consumers is the assumption that ‘advertisers produce particular meanings which exploit personal insecurities and convince consumers that their identities derive from what they buy’ (Nava, 1992 p.174). This position also appeared within the literature of health promotion. For instance, Lupton (1996, p.24) in a summary of theorising on food as a commodity, refers to the power of marketing upon food choices:

‘Products such as savoury snack foods and soft drinks are commonly marketed in such a way as to link these “meaningless” products with established values such as youth, vigour, sexual attractiveness and fun times, rather than the taste of the food or drink itself’.

In the context of health promotion, these types of food, which may lack nutritious benefits, are labelled as ‘meaningless’ despite the fact they are inscribed with other cultural meanings. The concern in the health promotion field is how consumer marketing influences positively or negatively the adoption of the ‘healthy’ choice, a position which is in accordance with the *health logic*. This is also apparent in the way that Amos et al. (1998, p.491), who investigate the relationship between fashion images from youth magazine and smoking, conclude that, ‘these magazine images of smoking may be acting to reinforce smoking among young people’.

The growing use by health promoters of increasingly sophisticated marketing techniques in order to promote a healthy lifestyle among individuals has also been subjected to a similar type of criticism known as ‘surveillance critiques’. The surveillance critiques are defined by Nettleton and Bunton (1995) as those approaches that have focused on the programmes and technologies of health promotion and how these serve, on the one hand, to monitor and regulate populations, and, on the other hand, to construct new identities (Armstrong, 1983; Nettleton, 1992). In this respect, such techniques are not restricted to contributing to the creation of healthy lifestyles and healthy bodies but also healthy minds and healthy subjectivities (Nettleton and
Bunton, 1995). In fact, these critiques regard the technologies of health promotion as capable of functioning as forms of social regulation. These arguments are connected with the consumers’ compliance approach.

The work of Bourdieu (1984), especially his suggestion that consumer products are significant markers of social difference and distinction, is characterised by Nettleton and Bunton (1995) as a key influence on studies which focus on the relationship between health, lifestyle and consumption. The key benefit from this body of work, for the purposes of health promotion, concerns the determination of people’s tastes and preferences with respect to health-related choices. Bunton and Burrows (1995), drawing on the work of Bourdieu, illustrate significant differences in ‘taste’ for different types of alcoholic drink in relation to gender and social class. They also illustrate certain consumption patterns relevant to health amongst the British middle class in the light of evidence given by Savage et al.’s (1992) study. In this study, the consumption of different health-related goods and services were found to be amongst the strongest markers of social difference (Nettleton, 1995). For instance, practices associated with health and body maintenance were strongly associated with high incomers (Savage et al., 1992). Lupton (1996) identifies relationships between the ‘habitus’ and food preferences and the gendering of food (see examples Lupton, 1996, p.94-130).

The final examples concern studies, which involve the examination of meanings and interpretations, which people apply to their health-related behaviours. Here people’s meanings are understood and explored as reproductions of the social context in which they live their daily lives. Nettleton (1995) reviews studies which provide evidence, via people’s accounts, on how smoking and consumption of food is not separated from socioeconomic circumstances (such as Charles and Kerr 1988; Graham, 1987). Here, the interpretations of people are theorised as a straightforward means of reproduction of the social circumstances of individuals. This function of people’s accounts is expressed vividly in Pavis et al.’s (1998, p.1417), arguments developed within their study. They demonstrate how the smoking and drinking habits of teenagers in Scotland are constrained to a significant degree by arguing that ‘structural and cultural factors both supply the individuals with meanings and choices and simultaneously constrained their perceptions and the options open to them’.
The orientation of empirical work generated from the consumers' compliance approach is particularly insightful in identifying the role of consumption as a source of structural constraints or opportunities associated with young people's lives and their health-related preferences. In this light, the consumers' compliance approach is straightforwardly associated with the notion of health logic which reflects the primary interest within the field of health promotion in explaining the determinants of the healthy choice in young people's lives. The consumers' compliance approach gives a valuable theoretical perspective for this aspiration, developed within the field of health promotion, by indicating how the consumer manifestation of health-related behaviours obstruct or support the healthy choice. Nevertheless, as was argued in chapter 2 the pervasion of the health logic unduly constrains the identification of young people's own concerns regarding their day-to-day experiences with health-related behaviours. Likewise, as was shown in this chapter, the main critique associated with the consumers' compliance is concerned with the absence of the consumers' perspective (see section 3.4.1, p.65-66).

### 3.5.2 Health Promotion and consumers' perspective

The consumers' perspective concerning the cultural manifestation of health-related behaviours has received relatively little attention within the field of health promotion. As noted above, this gap can be understood as an outcome of the pervasion of the health logic within the field of health promotion. This critique is expressed vividly by Rugkasa et al. (2001, p.131-132) who argue that an analysis, 'which focuses upon children's experience and which recognizes children's agency' is concealed when the attention is given primarily, 'to the structural aspects of childhood and adolescent smoking'\(^{31}\).

In the present section, I examine this gap within the field of health promotion. In particular, I discuss the significance of a research project within the field of health promotion which concentrates on the two key features of the consumers' perspective

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\(^{31}\) The consequences of the structural oriented analysis of consumer activities has been also discussed in section 3.4.1, p.65-66.
as outlined in section 3.4.2. These are concerned with the centring emphasis on the consumers’ perspectives and the lived experience. The value of studies which concentrate on young people’s ‘way of seeing’ health-related behaviours in the context of their day-to-day lives is elaborated via major principles of health promotion: empowerment, choice and lifestyle (see section 2.3.1). Throughout this presentation, I clarify the empty empirical space that the present study aims to fulfil and thus justify its relevance.

Respecting individuals’ perspectives regarding consumer manifestation of health-related behaviours is consistent with the idea of choice and empowerment as developed within the field of health promotion. Here, I refer to the health promotion aspirations to facilitate the healthy choice by providing people with empowering competences (Tones, 1997). As stated by Tones (1997, p.34), ‘the main modus operandi of health promotion is one of enabling not coercing; the focus should be on co-operation rather than on compliance’. Thus, giving voice to young people and paying closer attention to their viewpoints is more consistent with the health promotion aspirations to co-operate and empower rather than to ‘force’ towards a healthy choice. This suggests that health promotion initiatives might need to be based not only on the contextual and structural barriers to positive action for children and young people, but also on the self-perceptions and self-interpretations of individuals in their contexts.

As outlined above, health promotion premises on the potential capacity of individuals to be empowered towards a healthy choice, a position which acknowledges a degree of agency for the individuals. Therefore, the way that young people make sense of the consumer manifestation of health-related behaviours should be taken into consideration. This point is strongly made by Rugkasa et al. (2001) who explore some of the symbolism involved in smoking behaviour from the vantage point of children. ‘Recognition of agency is entirely consistent with the current general approach within health promotion’ (Rugkasa et al., 2001, p.140), which aims at empowering individuals to exert control over the determinants of health. Thus, the capacity to act intentionally and to choose certain forms of consumptions (within restrictions) must be recognised and explored by centring on young people’s experiences and views as a basis of their agency (Rugkasa et al., 2001). This position has strong links with the
consumers’ perspective as outlined above, which centres its energies on exploring the meaning-making process employed by consumers.

The second advantage of this approach, as expressed by Mackay (1997, p.6), concerns its value for ‘foregrounding’ everyday practices. This value is achieved in studies which focus on how consumers ‘appropriate, and make sense of, various cultural forms in their routines in everyday setting’ (Mackay, 1997, p.1). ‘Isolated interventions which have little perceived relevance to the lifestyles of those who they are aimed at’ is considered, by Stockdale (1998), as one of the essential weaknesses of health promotion interventions. The everyday consequences of the cultural forms of health-related behaviours therefore needs to be acknowledged as a vital part of young people’s lifestyles. Respectively, Brannen and Storey (1998) argue for starting

‘... with research on body-image, fashion, consumption patterns and the market in order to focus on the contexts and concepts in which health and wellbeing are central to the lives of children and young people, rather than starting with health issues as defined by health professionals’ (summarised by Moore and Kindness, 1998, p.7).

Lack of empirical studies focusing their energies on capturing young people’s self-interpretations of meanings, associated with smoking, eating, drinking alcohol and exercise, as they go about their day-to-day lives, is a vital deficiency in the area of health promotion. Hence, the adoption of the consumers’ perspective as an empirical approach could be a step towards a more ‘culturally appropriate health promotion stance’ (notion used by Davison et al., 1997) which emphasises the everyday meaning-making process of understanding these behaviours.

The consequences in everyday lives of health-related behaviours as consumer activities, from the point of view of the consumer, are rarely explored. As discussed in the preceding section, the inscribed consumer traits of health-related behaviours are primarily explored with respect to their effects upon the adoption of the healthy choice. In this light, Pavis et al. (1998) for instance, argue for recognising the inclusion of health-related behaviours among other leisure activities and consumption patterns in young people’s cultural repertoires through which they actively understand their personal lives.
In the present section, I discuss the empirical benefits for the field of health promotion to follow the consumers’ perspective path for exploring health-related behaviours as consumer activities. The emphasis of this approach, which concentrates on the meaning-making process of the consumer and their lived experience, enable a health promoter to come closer to young people’s perspectives and their everyday lives. Thus, the approach suggested in the present section can be seen as a valuable tool for ‘health-related’ researchers to ‘escape’, at least empirically, from the health logic and come closer to the everyday life of their participants. As Weare (1992, p.80) argues, ‘Recognising and respecting the cultural understandings, values, knowledge, and meanings of the learner is vitally important when devising health education and health promotion programmes’. I will take this issue further by arguing that the everyday consequences of the cultural forms of health-related behaviours needs to be acknowledged as a vital part of what is meant by the notion ‘cultural understanding’. Correspondingly, as discussed in section 1.1 (p.13), consideration of the young recipients’ understandings of health-related behaviours is a factor that contributes to the effectiveness of health promotion and education.

3.6 Consumer meanings in this study

In this section and in the light of my chosen empirical direction, consumers’ perspective, I will define ‘consumer meaning’: a key term of the study in accordance to the focal points of the research project. I also discuss my focus on the participants’ consumer meanings.

‘Consumer meanings’ as a central term within my research project expresses the way that my participants make sense of the symbolic sphere of health-related behaviours in their daily lives. Both concepts - ‘consumer’ and ‘meanings’ - and their relationship, reflect the two key ideas which define the way that the term ‘consumer meanings’ is used in the present study. The notion of consumer meanings as used in this research study, refers to cultural consumption as a specific moment in which these meanings are produced. Cultural consumption, as one of key moments of the biography of a cultural artefact, is concerned with the meanings that ‘are made in consumption,
through the use to which people put these products in their everyday lives’ (Du Gay et al., 1997, p.5). Correspondingly, my emphasis, when I label smoking, eating, drinking alcohol and exercise as consumer activities, concerns the capacity of these behaviours to be interpreted as cultural ‘things’ and what meanings they obtain as a consequence of their consumer ‘usage’. This position is in line with the consumers’ perspective approach which explores consumption as a meaning-making activity by the consumers.

The term ‘meanings’ within the context of ‘consumer culture’ is strongly associated with the participants within a culture giving ‘consumer activities’ meanings by how they use, or integrate them into their everyday lives. It also ties in with the notion of culture –as discussed in the section 3.2 - both as a frame of interpretation and communication which participants bring to them, and its use to mark out different ways of living. Neither of the two - meanings nor culture - can exist independently: cultures need interpretation because they are in themselves complex acts of interpretation; and interpretations a cultural pattern. In this sense, all meanings involve cultures and all cultures involve meanings. Bringing both terms within the context of my study, consumer meanings reflect the ways that my participants make sense of and articulate their ‘imagined’ cultural symbols of health-related behaviours which prevail within their socio-cultural context.

The second point is concerned with the centrality of the participants’ ways of seeing health-related behaviours as consumer activities, which is adopted in this present study. My primary focus on the participants’ accounts is not to suggest that I validate them as the only authors of the consumer meanings embedded in health-related behaviours. Consumers cannot endow meaning in consumer goods completely freely (Miles, 2000). People’s consumer meanings are ‘partly pre-given and constructed in a social world where advertising and marketing are such powerful institutional influences’ (Miles, 2000, p.49-50). Nevertheless, young consumers should not be perceived as uncritical and completely unaware. I choose – for the reasons given in the preceding section - to consider the participants’ interpretations of their experiences with consumer meanings of health-related behaviours, instead of attempting to elicit any hidden meanings in their experiences, which lay somehow behind or beneath their accounts.
This position is strongly expressed through Miles (1998, p.159) words, he asserts that ‘consumerism’ is a way of life in the sense that regardless of the power relationships it engenders, it also actively constitutes a subjective reality. As he frequently reiterates in his study, ‘lifestyles are not free standing; they present a mirror, or at least a reaction to and interaction with the sorts of structural influences that affect young people’ (Miles, 1998, p.146). Yet, his empirical focus as he explained, ‘is more concerned with the active ways in which young people conduct their lifestyles than the more rigid sub-cultural or structural analyses’ (Miles, 1998, p.127). Consumer lifestyles are understood and thereby explored in his study as a recourse according to which young people can ‘relate aspects of structure and agency’ (Miles, 1998, p.145). Correspondingly, my empirical focus on the participants’ interpretations of consumer meanings aim to come closer to what they perceive to be reality in terms of health-related behaviours. My study does not aim to mirror the social structures embedded on the consumer meanings of health-related behaviours via my participants’ account. Rather, I aim to illuminate how the participants perceived the structural forms of the consumer manifestation of health-related behaviours as aspects of their lived experiences. The clarifications made in this section with regards to my research project, are further developed in the next chapter which describes the methods used in order to accomplish its empirical focal points.

3.7 Conclusion

In chapter 2 I examined, through the notion of health logic, the absence of young people’s voices regarding their day-to-day experiences with smoking, eating, drinking alcohol and exercise. In the present chapter I expanded further the health logic argument and justified the increased popularity, in the field of health promotion, to explore health-related behaviours as consumer activities through the consumers’ compliance rather than through the ‘consumer’s perspective’ approach. Correspondingly, young people’s own concerns regarding the consumer manifestation

32 Consumerism is defined by Miles (1998, p.5) as ‘a psycho-social expression of the intersection between the structural and the individual within the realm of consumption’.
of health-related behaviours remains largely unexplored within the field of health promotion. This is because health promotion concentrates its energies on identifying structural limitations on young people’s choices and explain their compliance or not to a healthy choice. Without devaluing the use of the consumers’ compliance approach, this study follows the consumers’ perspective approach as a valuable but neglected empirical direction within the field of health promotion. It centres on young people’s ‘ways of seeing’ their experiences with health-related behaviours as consumer activities within the context of their everyday lives.
Chapter 4
Methodology

4.1 Introduction

In this chapter, I explain how and why the research was constructed in the way presented here. The methodological chapter consists of three main sections. The first main section gives a general description of the research project, and its significance in the health promotion field (section 4.2). The second section demonstrates how the research project started with a general area of interest - young people’s talk about smoking, eating, drinking and exercise - and how it progressively focused on the participants’ consumer meanings inscribed in these four behaviours (section, 4.3). It consists of two main sub-sections, the pilot (section 4.3.1) and the main study (4.3.2). In the former, I explain the way I initiated the study. In the latter I discuss how the design of the main study was redefined based on the results of the pilot study. I clarify the way I collected the data according to the emerging research design. Finally, the third section presents the process of analysing the interviewing data according to the main study’s research agenda (section 4.4).

4.2 General descriptions of the research project

4.2.1 Aim of the study

The overarching aim of the research is to explore how young people talk about the consumer meanings of smoking, eating, exercise and drinking alcohol in the context of their everyday lives. This empirical focus aims to fill a gap apparent in the area of health promotion. As demonstrated in chapter 2, the health dimension of smoking, eating, drinking alcohol and exercise acts, explicitly or implicitly, as an interpretative perspective within the field of health promotion. These four behaviours, the role of the surrounding socio-cultural context and the way that young people talk about them, are largely theorised as positive or negative contributory factors to a ‘healthy’ practice. In
effect, young people’s views of the role of these four behaviours in the context of their everyday life, independent of their health relevance, tended to be obscured.

The same tendency – labelled in this study as *health logic* – emerged in the review of health-related behaviours as consumer activities (chapter 3). The pitfall is that health research here plays down young people’s views of the consumer meanings within the context of their everyday lives by overemphasising the influences upon the final choice. In the light of this tendency, the current study approaches consumer meanings not as ‘measurable’ influential factors but rather as a set of processes and practices that are integrated into everyday life. The exploration of the consumer meanings is rooted in the process and practices of everyday life from the vantage of young people: an orientation, which is consistent with the principles of health promotion (see section 1.1, p.13 and section 3.5.2, p.73-76).

In short, what is distinctive about this study is its emphasis on consumer meanings ascribed to health-related behaviours by focusing on young people’s perspectives and the role of these consumer meanings in their everyday lives. In parallel, it is also my objective to contribute to the sociological critique of the limitations of health promotion’s perspective on health-related behaviours.

### 4.2.2 Qualitative choice: theory - practice - method

This is a substantial qualitative research project. The conception of the research project as qualitative is a broad one and means many things to many people (Silverman, 2000b). It is, however, precise in defining the features which describe the present research project as qualitative. I seek to distinguish three main features of my research project which are deployed as common elements of qualitative research. The first concerns the design and the implementation of the research project, which gives primacy to ‘a research process as a whole’ (Alasuutari, 1995, p.7). The second refers to the interpretation of young people’s meanings as a form of knowledge concerning health-related behaviours. The third relates to the use of qualitative interviews as the main method of collecting data. These three features are elaborated below.
I regard my research project to be qualitative since it involves a constant dynamic process which links together theories, methods and data (Bryman and Burgess, 2000; Flick, 1998; Janesick 1998; Creswell, 1998). Consequently, the research process is not seen as 'a clear cut sequence of procedures following a neat pattern, but a messy interaction between the conceptual and empirical world, deduction and induction occurring at the same time' (Bechhofer, 1974, p.73 cited by Bryman and Burgess 2000, p.2). Specifically, my research project shares a central feature of grounded theory, which suggests 'a back-and-forth interplay with data' (Strauss and Corbin, 1998, p.177). It follows a path of discovery, which entails 'messy', continuous, backward and forward movements between different aspects of the research project such as the research design, data collection, data analysis and theory. I began my data collection, analysis and review of the literature in the first six months of this research project. I was constantly in motion, provoking a creative interaction between the empirical and theoretical components of my study. I was interviewing, analysing and writing up more or less simultaneously leaving space for interaction between these activities. Ideas evolved both inductively and deductively throughout the research process and were constantly informing and transforming the data collection processes, analysis and writing up. Similarly, my role as a qualitative researcher was experienced through a constant interactive communication with the field and the research participants.

The second ‘qualitative’ feature of the present study concerns the attempt to make sense of and interpret health-related behaviours in terms of the participants’ meanings. Qualitative studies typically show a preference for meanings rather than behaviour (Silverman, 2000b), by providing thick accounts\(^{33}\) of the points of view of the people studied through small samples and intensive methods of data collection and analysis. The emphasis on the people’s own interpretations is more accurately connected with phenomenology since it focuses on, ‘how human beings construct and give meanings to their action in concrete social settings’ (Denzin and Lincoln, 1998, p.xvii). Accordingly, I seek to arrive at rich descriptions of how the participants talk about the consumer meaning ascribed to health-related behaviours in their everyday exchanges.

\(^{33}\) By the term ‘thick accounts’, I refer to qualitative data and analysis, which signifies ‘the multiple dimensions of a problem or issue and displays it in all of its complexity’ (Creswell, 1998, p.15).
This decision reflects the need, as outlined through the concept of *health logic* (chapters 2 and 3), to construct empirical studies within the area of health promotion, attempting to uncover the interpretative understanding that individuals bring to their life experiences and not merely to demonstrate causal factors associated with health-related behaviours.

Thirdly, this project incorporates qualitative interviews as a method which can ‘provide access to the meanings people attribute to their experiences and social world’ (Miller and Glassner, 1997, p.100). No matter how difficult it is to define the qualitative interview it has certain ‘tendencies’: to prefer ‘natural’ conversational settings; to prefer open-ended questioning (Gilbrert, 1993); and to allow the respondents ‘to choose the topics to be discussed and the way in which they are discussed’ (Madge, 1965, p.165 cited in Holstein and Gubrium, 1995). These tendencies characterize the qualitative nature of my interviewing process throughout the study. Qualitative interviews were fundamental, for this project, since they constantly informed the development of the research design. The process I followed is described in the next section where I demonstrate how the study started and how it has progressively developed.

### 4.3 Research development

The second section of this chapter describes the main procedures that I went through in order to construct this research study. Fundamentally, it describes the way in which the underlying reasons for my pertinent decisions were made whilst conducting the pilot and the main study. Both stages incorporate a set of qualitative interviews (5 interviews for the pilot and 25 for the main study).

### 4.3.1 First stage of the research project (pilot study)

My research aspiration, as it evolved at the very beginning of the research project (December, 1996), pertained to the fundamental design of a project which gives the opportunity to young people to talk about the way they experience health-related
behaviours. The main puzzle at this initial stage concerned the need, as manifested in the area of health promotion, to develop a research project which can give voice to young people rather than starting with the health issues as defined by health professionals (Brannen and Storey, 1998). Therefore, I decided to begin my research project by becoming familiar with young people’s accounts of health-related behaviours. The purpose was not to gather data but to search out areas and ideas for further investigation via a sample of young Cypriots. The method, sampling, data collection and analysis were developed in accordance with this purpose.

4.3.1.1 Sampling
The first stage of the research project involved five qualitative interviews, conducted open-ended and one to one. Three of the interviews were very close relatives: my brother and two of my cousins (aged 14-16). The remaining two were close family friends. I tried to take advantage of my familiarity with background information concerning their lives (family life, school life, hobbies) and the relationship of trust which already existed with these young people. I felt that I could more easily identify possible issues for investigation, which could not have been identified if I had not been familiar with both the immediate and the wider socio-cultural background of the respondents. The possible bias, which might have occurred during the interviews due to the close relationship with them, did not prevent me from implementing and using these conversations since the purpose at this stage was not to gather data, but to refine the research design.

4.3.1.2 Method
In the pilot study, qualitative interviewing is employed ‘as a search and discovery mission’ (Miller and Glasser, 1997, p.116) that can retrieve the participants’ points of view about a subject. It expressed my desire to employ the ‘inductive logic’ in the methodological design, which concentrated on the discovery of themes through my research participants. As Fielding (1993, p.137) suggests, one of the common usages

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34 Kvale (1996) compares the role of the interviewer in this type of interview as a miner who seeks to uncover a subject’s pure experiences uncontaminated by the research process.
35 This concept refers to a stage when the researcher constructs a research design through an interactive exchange with the participants, and not to extreme exaggerations that a research design can be constructed without the ‘interference’ of the researcher.
of the qualitative interview is to pilot a research field by utilizing a 'very broad topic guide with as few direct questions as possible'.

Accordingly, the design and implementation of the conversations are aimed at enhancing the possibility of capturing young people’s accounts of health-related behaviours. I chose one-to-one interviews as a more secure environment for the respondent to express their own opinion. At the beginning, I introduced myself as a student who needs their help in order to find out young people’s opinions on smoking, eating, drinking alcohol and exercise, and their relevance to health matters. I began the conversation by asking them ‘what comes to mind when you hear the words smoking, exercise, nutrition and alcohol consumption’. Then I attempted to continue the conversation by forming subsequent questions based on previous statements made by the respondents. This technique limited the possibility for myself to control the conversation in conformity with any of my preconceived ideas. I tried to continue the conversation based on the participants’ highlighted topics. Overall, I attempted to be very sensitive to respondents’ own views and I participated in the interviewing process in such a way that acknowledged young people as active thinking individuals, having their own valid perceptions, beliefs and understandings.

4.3.1.3 Analysis

My major concern at this initial stage was to list the key themes that my respondents chose to discuss throughout the interviewing process. It can be characterised as a bottom-up approach, which aimed to give a representational view of the content of the conversations. Some of the key themes which I identified included: the role of the family; the role of friends; the social context where health-related choices are practised; practical constraints in choosing health-related behaviours; and the way participants experience differences between boys’ and girls’ choices. Among these themes, I noticed that my participants frequently described young people’s health-

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36 Nevertheless, I believe that group interviews for this stage of research would have been more beneficial since my purpose was to orient the researcher to a field of inquiry (Gaskell, 2000). The advantages of one-to-one interviews instead of group interviews for this study are discussed in section 4.3.2.4.1 (p.102-103).

37 The role of this technique in enhancing respondents’ space to express their own ideas is discussed in section 4.3.2.4.2 (p.103-104) since it was also used for the main study. Nevertheless, the role of an interviewer has to be approached with caution since I actively participated as a person with my own preconceived ideas with respect to young people and health-related behaviours (see section 4.3.1.3, p.86).
related choices as matters of style or self-image. For instance, eating fast food was valued as a ‘cool’ choice rather than as a matter of taste preference. I became particularly interested in the symbolic investments that the participants ascribed to these behaviours such as ‘cool’, ‘in’, ‘trendy’ and so forth. The desire of the interviewees to discuss the tendency of young people to behave in accordance with these symbolic attributes was one of the main factors which influenced me to concentrate on the symbolic manifestation of these behaviours.

Nevertheless, my move towards the cultural symbols attached by my participants to health-related behaviours did not merely emerge from my participants. I recognised, particularly during the transcription process, that the touchstone of my personal interest in the symbolic dimension of these behaviours was also apparent in the way that I was probing during the interviewing process. It was an empirical direction inspired fundamentally during the pilot study which was then supported by the review of the literature within the area of health promotion and consumer culture. In addition, one of the primary benefits of the pilot study was my personal reflective encounter with the issue of health logic within the study. In particular, I realised that the apparent health background of the study directed the young participants to discuss the impact of young people’s lifestyles with respect to health. They tended to comment on health issues while referring to the four behaviours: how individuals and their daily behaviours could be seen as responsible for promoting their health. Their accounts were judgemental in terms of why young people do not follow a healthy lifestyle. That is not to say that health issues are not relevant with the choices of young people. Nevertheless, I experienced great difficulties in these pilot interviews in generating fruitful conversation about the interviewees’ own experiences regarding smoking, eating, drinking alcohol and exercise within the context of their everyday lives. In several moments throughout the interviewing process, I asked the respondents to concentrate on the role of smoking, eating, drinking alcohol and exercise within their

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38 The reasons which directed me to focus on the way that young people talked about the symbolic manifestation of health-related behaviours were also discussed in chapter 1.

39 For instance, at that stage my participants explained to me why young people prefer to eat fast food rather than healthy food. When I asked them if health had appeared as a conscious criterion in relation to their fast food choices, their answers were in most cases negative. The intervention of health logic within the pilot study is further discussed in section 4.3.2.4.3 (p.104-107).
everyday lives. The contrast between ‘everyday’ and ‘health-related’ behaviours within a health-related research project has been supported through the development of chapter 2 in which I argued that this contrast ought to receive more empirical attention within the area of health promotion (see section 2.3, p.32).

4.3.2 Second stage of the research project (Main Study)

4.3.2.1 Research design
The initial stage of my research was fundamental in clarifying the empirical direction of the main study. I decided to explore how the participants talked about the consumer meanings of health-related behaviours in the context of their everyday lives. This direction reflects my focus exclusively on the participants’ accounts regarding the symbolic attributes given to health-related behaviours. The aim of the study was then divided into three research questions. These questions were developed soon after the pilot study and gradually refined during the following data analysis stages (see section 4.4.1 116-117 and section 4.4.2 p.117-119).

RESEARCH QUESTIONS
1. What kinds of consumer meanings do Cypriot young people ascribe to health-related behaviours?
2. What are the roles of the consumer meanings in the everyday lives of these young people?
3. How do the participants understand their own position in relation to the consumer meanings and the roles of these meanings in their everyday lives?

The above questions are ‘what’ I wanted to extract from the interviews. Another dilemma was ‘how’ to extract this information without leading my interviewees towards the subject of health. As discussed above, through the pilot study I realised that the responses obtained had been influenced by the visible health background of the study, whereas my objective was for the participants to talk about smoking, eating,

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40 Consumer meanings is used as a key term in exploring the way that my participants understand, and talk about the symbolic investments of health-related behaviours in their daily lives. See section 3.6 (p.76-78).
drinking alcohol and exercise as everyday practices and not explicitly as health-related ones. This recognition guided me to certain data collection strategies applied in the conversations in order to remove health as a given background for my participants and replace it with everyday life (see section 4.3.2.4.3, p.104-108). In the subsequent sections, I discuss practical and methodological considerations regarding the use of qualitative interviewing with respect to the two constituent elements of the evolving research agenda: (i) focusing on consumer meanings and (ii) bypassing the health logic.

4.3.2.2 Sampling
In this section, I firstly discuss the selection of the respondents and then how I accessed the research participants.

4.3.2.2.1 Sample selection
The sample consists of 25 young people (12 men, 13 women) aged between 15 and 17 living in the urban area of Nicosia (Appendix 1). As is typical of qualitative research, purposive sample techniques were used to select interviewees with specific characteristics, which are relevant to the research agenda (Gaskell, 2000). Below, I provide the sampling frame for the evolving research agenda.

1. Cypriots
2. Living in the urban area of Nicosia
3. Age range between 15-17
4. Diverse socio-economic backgrounds
5. The favourite going out area in Nicosia

Cypriots
The choice of Cypriots rather than any other nationality was initially due to practical circumstances and personal aspirations. It was easier for me to access young Cypriots rather than English, or even English Cypriots, despite the fact that the research project was initiated in London.

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41 The particularities of the Cypriot context with respect to this study are elaborated in section 1.2 (p.16-20).
My familiarity with the language, cultural values, common cultural rituals, shared origins and a common past was also an advantage for exploring young people’s ‘way of seeing’ the consumer meanings of health-related behaviours. It allowed me a more accessible exploration of the cultural manifestation of health-related behaviours by asking questions relevant to my participants’ experiences, with which I was also familiar (Holstein and Gubrium, 1995). For instance, I constructively elaborated with them the prevailing dietary ‘disgust’ for pulses among young people in Cyprus in a collaborative atmosphere since I was familiar with this phenomenon within the Cypriot context.

Yet, familiarity with the cultural context is not without its cost. As Alasuutari (1995, p.135) argues, the researcher in such a case needs to create distance and ask about issues that ‘seem so clear and so self-evident’. As an adult, I could gain an outsider view of the perspectives of the youth culture of the 1990s in Cyprus. Moreover, my presence in London over the last seven years gave me a privileged position to detect the cultural specificities of Cyprus and to directly experience a consumer metropolis. As a final point, I would also argue that this study does not aim to illustrate the cultural differences between Cypriot culture and others, but rather it explores the way the participants view the significance and consequences of consumer meaning within their lived culture(s). Moreover, as Miles (1998. p.67) argues the globalisation in the area of consumption is skin deep in people’s understanding of consumer products and thereby ‘the impact of consumerism on place and space is far from clear cut’.

**Living in the urban area of Nicosia**

I chose to focus my research geographically on the urban area of Nicosia, where the developments of consumption sites has been fundamental. Therefore, communication with young people who live and interact in the centre rather than in the periphery was more desirable since these young people have more access to a consumer milieu. Two interviews with young people from villages, not included in the final sample, were conducted in order to refine my decision concerning the sample composition. These rural young people had not made strong inferences about any symbolic dimension of these behaviours. Since comparisons regarding the consumer

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42 See further descriptions in section 1.2 (p.16-20).
manifestation of health-related behaviours in different locations was outside the scope of my study I decided to use a homogenous group in relation to residence. My aim was to reveal the processes through which young people deal with the consumer manifestations of health-related behaviours, rather than to examine who are the ones who are more likely to use the symbolic sphere of health-related behaviours in their everyday lives.

15-17 years-olds
In the Introductory chapter, I justified my empirical orientation to explore the ways of seeing consumer meanings as part of the life experiences of young people in Cyprus (section 1.1). Here, I explain in further detail why I chose this specific age group.

I did not attempt to gather data from a younger age group since the age of 15 in Cyprus is when people can act relatively autonomously in terms of spending leisure time on their own or with their friends, and have more opportunity and independence to decide what to consume. Here I do not mean that the consumer choice of the young people becomes ‘uncontrolled’ but that it is not always ‘given’ by the family. It was therefore reasonable for me to use an age range of respondents who were experiencing a period of their lives when they start to construct their own distinct consumer identity. My decision not to gain data from an older age group was that young people in Cyprus graduate from school at the age of 18. I did not want to get involved in a period when young people had begun to experience pressures concerning their vocational or academic future.

Diverse socio-economic backgrounds
Another factor which I considered, regarding the sample selection, concerned the socio-economic backgrounds of the informants. Parents’ occupation as stated by the participants (see Appendix 1) was the main controlling tool to incorporate various socio-economic backgrounds. My intention here was merely to enhance the mixture of

43 This statement relies on my personal observations due to the lack of sociological studies regarding young people in Cyprus.
44 Here there is a range of possibilities. Some young people seem to be more eligible to choose what they want than others. The degree of independence from the family, as related to money and time, was found to be crucial.
the participants’ backgrounds rather than to make comparisons between the groups.\(^{45}\)
The mixture was significant in terms of the multiple ways that my participants understood and used the consumer manifestations of health-related behaviour. A young person whose father is a driver and mother a housewife perceives pizza restaurants as a luxurious place to visit and eat, whereas another of my participants, who comes from a more affluent environment (pharmacist and beautician), insisted that the 'pizza place' is for everyone; for him a 'steak place' is a luxury location. Nevertheless, comparisons between the different socio-economic groups were avoided due to the use of a small sample.

While I intended to gather data from diverse socio-economic backgrounds, I purposefully avoided individuals who I estimated had encountered great barriers to buying products or activities relevant to health-related behaviours. It is indeed worth pointing out that the lack of spending power does not necessarily mean that they do not construct their own consumer notions of the surrounding products (Hall, 1989; Miles, 2000). Nevertheless, I wanted to avoid causing emotional distress during the interviewing process resulting from the lack of power to buy these products like other young people.

**The favourite going out area in Nicosia**

So far, I have elaborated upon features of my selected respondents which have remained stable throughout the whole process. The final criterion - the favourite going out area in Nicosia - which formulated the sample selection, emerged as a significant one at a later stage of my interviewing process.

At the very early stage of the interviewing process, I could distinguish different ‘personal styles’ among the participants. However, separating several individuals’ styles was a complicated task since boundaries were blurred. In order to be able to trace these possible plural styles I decided to choose my sample on the basis of 'going out activities' as this was largely related to 'personal style'. What was of great significance were the favoured places of my participants in terms of identifying

\(^{45}\) I did not therefore classify the research participants into socio-economical backgrounds according to their parents’ occupations (see Appendix, 1).
multiple ways of understanding the surrounding symbols concerning areas associated with health-related behaviours\textsuperscript{46}. I tried to expand my sampling in relation to the choice of the going out places in order to gain a balance between the different styles of young people (see Appendix 1 and 2).

4.3.2.2.2 Access to the sample

I accessed this second sample principally through the snowballing technique. This approach involves ‘contacting a member of the population of interest and asking whether they know anyone else with the required characteristics’ (Arber, 1993, p.74). In the case of the present study, two key points should be made. Firstly, I did not recruit all my interviewees starting from one participant. Instead, I used seven starting poles through personal contacts in order to cover different areas of Nicosia. This could have been difficult to achieve if the sample was recruited from one interviewee. I also wanted to break the connected networks between the individuals since this entailed the danger of passing on information about the interviewing process and possibly the underlying health aspects that they may have been revealed after the completion of the interview.

Secondly, the required characteristics which I aimed to fulfil concerning the sampling were not stable throughout the research process. As shown above, at the later stages of the interviewing process I asked my participants to help me to make contacts with other young people, who may go out to certain places, according to the needs of my research. Therefore in some particular cases, when my participants referred to a distinct style that they assimilated and regarded as 'modern' or 'traditional', I asked them again to introduce me to other young people who may follow a different style based on their ‘going out’ activities.

4.3.2.3 Method

In this section, I present the main features, potentials and limitations of the qualitative interview with respect to the emerging focus of the study. After the implementation of

\textsuperscript{46} It is worth noting that a similar movement appeared in marketing research: ‘In the past decade or two, those involved in marketing began to categorize people by lifestyle rather than by class or income level (Mackey, 1997 p.5). A further discussion of this phenomenon is given in section 3.2, p.56.
the pilot study, I had to re-consider whether qualitative interviews were appropriate for exploring the participants’ accounts about the consumer meanings of health-related behaviours. In the first sub-section, I use the notion of active interviewing (Holstein and Gubrium, 1995), which depicts the way I approached qualitative interviews after the completion of the first stage of the study. Hereafter, I explore the possibilities and the limitations that this method offered me for the research agenda.

4.3.2.3.1 Re-definition of the qualitative interviewing process: active interview
My reconsideration of the interviewing process began when I started to collect data for the main study and had to make sense of the absence of health discourses from my participants’ accounts47. Nevertheless, I do not want to suggest that the later accounts are closer to my participants’ realities or that I found a more clever way to get ‘authentic’ data, after having removed the idea of health from the interviewing process. Rather, I perceived the difference between the two data sets as a matter of dissimilar interviewing contexts. The interviewing process also led me to question the relationship between my participants’ accounts, and elements of the interviewing setting, such as who I am, how I look to them, how I present myself, where and when the conversations are implemented and so forth. These considerations were fundamental in re-defining the interviewing process as my main method of collecting the accounts of young people. I had to refuse the status of an interviewee subject, who is the owner of meanings, and the role of the interviewer as a technician, who can retrieve those meanings; rather I found myself in a space between the interviewees and myself and the forces that were at play in the interviewing process. I was therefore directed to discover new ways of thinking about the interview as an interactive occasion; this is subsequently discussed on the basis of the notion of the ‘active interview’.

The notion of the ‘active interview’ does not represent a particular type of interview. It simply accepts the interactive situation of all interviews. Holstein and Gubrium (1995, p.4) who introduced the idea of the active interview, state: ‘we are not suggesting that the active interview is a distinctive research tool; instead, we use the term to

47 A comparative example of the two stages of the interviewing process is given in section 4.3.2.4.3 (p.105-106).
emphasize that all interviews are reality-constructing, meaning-making occasions, whether recognized or not. Similarly, Barker (1997, p.131) argues, that ‘the process of interviewing is better described not as data “collection”, but rather as data “making” or data “generation”. The idea of the active interview challenges traditional conceptions of an interview as a research tool, which ‘is generally likened to prospecting for the true facts and feelings, residing within the respondent’ (Holstein and Gubrium, 1997 p.116). Conversely, it is seen as ‘an occasion for constructing, not merely discovering or conveying information’ (Holstein and Gubrium, 1997, p.120).

The notion of the active interview redefines the role of the interviewee and the interviewer in relation to the traditional way of understanding the qualitative interview. From the perspective of the active interview, a ‘respondent’ is perceived as the active constructor of knowledge, in collaboration with the interviewer, rather than as ‘passive vessel of answers’ (Holstein and Gubrium, 1997). In the active interview approach, the image of the subject is epistemologically active in the sense that he/she engages in the production of knowledge. The respondent does not only hold and offer experiences and facts for response, but she/he ‘constructively adds to, takes away from and transforms the facts and details’ (Holstein and Gubrium, 1997, p.117). From this perspective, the subjects projected behind the respondents are neither empty of experiences nor do they emerge in their totality; they can convey their stock of meanings uncontaminated. Accordingly, the interviewer is the other member of the dynamic meaning-making activity whose ‘objective is to activate the cultural constructions, which are fruitful for his/her research agenda’ (Holstein and Gubrium, 1997, p.123).

The idea of the active interview stresses the need for detailed depictions of the procedures and the circumstances involved in the production of knowledge. Issues of validity and reliability are conceptualised differently when compared with traditional forms of interviewing. Reliability according to its traditional definition - the extent to which questioning yields the same answers despite the questioner - seems irrelevant when the interview is seen as a dynamic meaning-making occasion (Holstein and Gubrium, 1997). As Holstein and Gubrium (1997, p.117) argue, ‘one cannot simply expect answers on one occasion to replicate those on another because they emerge from different circumstances of production’. Similarly, validity, in its traditional form,
is challenged since the notion of the ‘correct’ answers is understood as the outcome of the ‘hows’ and the ‘whats’ of the interviewing interaction. An interview response is therefore ‘correct’ in terms of its validity only if it is contextualised within the interviewing process.

4.3.2.3.2 Potentials and limitations of qualitative interviews associated with this research project
While I accepted and experienced the interactive situation of the interviewing process, I found it difficult to link it with my research aims and aspirations. I found it difficult to escape from the ‘romanticism’ of the interviewing process as a medium of gathering my participants’ meanings of health-related behaviours. It was only at the later stages of my research experience that I not only accepted the interviewing process as an interactive activity, but also recognised that the mutual interaction is one of the best ways to gain insights into my participants’ experiences of the consumer meanings of health-related behaviours. The points below summarize the benefits for choosing a qualitative interview as the main method of the study:

- It is the only route for the researcher to explore the participants’ understandings of the consumer meanings of health-related behaviour.
- It allows an in-depth exploration of the consumer meanings.
- It is compatible with the way I approach consumer meanings and the young people as consumers.
- It enables me as a researcher to create space for my individuals to reflect on their consumer meanings of health-related behaviours.
- It emerges as a learning activity for the young participants.

The first reason for using a qualitative interview within the present study concerns its capacity to access the perspective of the person being interviewed (Patton, 1990). How the young participants make sense of the consumer meanings of health-related behaviours in their everyday settings is not an observable phenomenon. As Patton (1990) stressed, the use of the interview is of particular importance for the researcher when the phenomenon cannot be directly observed. Here, the empirical emphasis is not what the young people do - a case which benefits from the observational methods -
but what the participants think about the consumer meanings of health-related behaviours. Thus, asking young people to talk about their daily lives was seen as a medium to explore whether the participants ascribe consumer meanings to their behaviours; what kinds of meanings they attribute to their own or others’ behaviours and what is the significance of these meanings in their everyday lives. Since my empirical orientation is towards the participants’ perspectives of consumer meanings I found this method suitable; it can minimize the researcher’s own assumptions about what is in the head of the participants and maximize space for the participants to reveal their own notions.

It should be noted that asking young people to describe consumer meanings of health-related behaviours is not part of their everyday lives. On the contrary, it is an unusual phenomenon for them. Through the interviewing process it was clear that they do not discuss with friends the role of health-related behaviours as media for cultural communication. In this sense, the interviewing process can be seen as artificial. It is however, seen as the only route for the researcher to explore a topic which cannot be retrieved otherwise. As Arksey and Knight (1999, p.32) state: ‘Interviewing is a powerful way of helping people to make explicit things that have hitherto been implicit - to articulate their tacit perceptions, feelings and understandings’. Participants consented to take part in the interviewing event but sometimes with hesitation and skepticism. In agreeing to do so, they departed from their everyday ways of interacting, talking and possibly thinking. They entered into an interactive process in which they re-present and evaluate their daily experiences, already ordered to some degree, with all the opportunities and constraints the form of the interview entails.

The second point concerns the capacity of qualitative interviews to explore the consumer meanings of the participants in depth (Arksey and Knight, 1999). This feature of qualitative interview makes it particularly well situated for the research questions (see section 4.3.2.1, p.87). At several moments during interview, the interviewees were encouraged to give details of a situation, which was determined by the symbolic signification of health-related behaviours. The qualitative interview was found to be powerful in allowing the respondents to give details about the particularities of the consumer traits ‘stored’ in health-related behaviours (see research question 1, p.87). They also had the opportunity to describe the role of the consumer
meanings in a specific social setting, chosen by themselves (see research question 2, p.87). In addition, the use of qualitative interviews encouraged the interviewees to stand back and explain their own standpoint regarding the consumer manifestations of health-related behaviours (see research question 3, p.87).

Thirdly, the qualitative interview as a method which focuses on the way people interpret a situation corresponds to the ‘consumers’ perspective’ approach chosen in this study for exploring health-related behaviours as consumer activities (see section 3.4.2, p.66-70 and section 3.5.2, p.73-76). This approach corresponds to the way I define consumer meanings and approach young participants as consumers (see section 3.6, p.76-77). The definition of consumer meanings, as the participants’ ways of seeing the cultural form of health-related behaviours, reflects its primary concern with the significance of the reception\(^{48}\) of consumer meanings - the situated meanings generated by consumers themselves. The qualitative interview, as it is viewed through the idea of the active interview accepting the interviewee as epistemologically active\(^ {49}\) in the production of meanings, is in line with the position adopted in this study regarding the consumer role. The priority of the actors’ meanings - and in this case the young Cypriot consumers - reflects my empirical focus on their viewpoints of consumer experiences. Such a focus led me to use the qualitative interview, which shows an appreciation of human perspectives, and an acceptance, therefore, of the creative meaning-making activity of the consumers.

Fourthly, and as a corollary of the above, I employed the qualitative interview as reflective activity. I tapped into the participants’ pre-existing\(^ {50}\) capacity for standing outside the consumer manifestation of health-related behaviours and explaining their own position. Nevertheless, it should be stressed that not all of the participants elaborated the consumer meanings of health-related behaviours with the same strength and depth. Some of them needed more encouragement and required more effort, and

\(^{48}\) The notion of reception here refers to the cultural consumption as a crucial moment of the construction and the circulation of consumer meanings (Mackay, 1997). As discussed in chapter 3, the consumers’ perspective approach explores forms of consumption as an active meaning-making moment for the consumers. This position relies on the recognition that consumer meanings ‘are not just ‘sent’ by producers and ‘received’ passively, by consumers’ (Du Gay et al., 1997).

\(^{49}\) See relevant discussion section 4.3.2.3.1, p.94.

\(^{50}\) This position expresses an ontological assumption regarding the ability of the participants to reflect on the cultural manifestation of health-related behaviours. It could be argued that my epistemological stance presupposed an active agent who constructs his/her perspectives in the actual field.
others found their way faster. Reflecting on these ambiguities, I realize that there are no final endings regarding people’s capacities or limitations for self-reflection. What was striking was that young people were reflective and resourceful commentators on their own lifestyles, recognitions, which also manifested themselves in other health-related studies (e.g. Morrow, 2001b).

I used qualitative interviewing as a method which can create situations for participants to display and reflect on the consumer meanings of health-related behaviours. In this sense, the interview’s situational ability to draw out reflections mirrors my empirical desire and my health promotion aspiration to prioritise young people’s viewpoints, without neglecting the structural forms of their meanings. On the one hand, self-reflections as an integral part of the interview allowed me to access young people’s personal judgements of health-related behaviours as meaning-making forms of consumption. It is precisely this capacity of qualitative interviews to access the respondents’ self-reflections which gives primacy to agency. On the other hand, the active interview as an occasion for inter-reflective communication permitted me to access social structures. At several points during the interviewing process the participants not only present popular cultural meanings ‘stored’ in health-related behaviours, but also articulate their embeddeness within these ‘imagined’ cultural repertoires. They explained how they personally experience and understand the collective stories of health-related behaviours as forms of consumption.51.

Lastly, the interactive situation appears as a learning activity for the interviewees. In some cases they admitted they were encouraged to talk about issues that they were not often called to do, and others found themselves in a position to interact, share ideas, challenge their pre-existing ideas and explore unknown territory. The following example demonstrates this very vividly. One participant, through the process of the conversation, articulated that she preferred white wine rather than beer because she associated white wine with elegant people and high status. After making clear this point she added thoughtfully that she was excited to state this realisation because through her own words she became aware of something that she had not thought about.

51 How I structured the interview in order to encourage the participants to talk about these types of repertoires is described in section 4.3.2.4.4 (p.108-112).
To translate her words I would say that she felt thrilled to discover through interaction and intellectual stimulation something creative regarding her personal and particular way of thinking.

I will now elaborate on the open-ended and interactive character of the interviewing process by presenting some of the limitations that I encountered. The first point is concerned with the small sample size, which characterises most research studies obtaining data through qualitative interviews. This feature limited the possibility to make any cross case comparisons among the participants or to find out how widely other young Cypriot share similar experiences regarding the consumer manifestation of health-related behaviours. The method does not aim to propose any universal ‘way of seeing’ the consumer meanings of health-related behaviours; rather it explores in-depth the processes that the informants use in order to make sense of the nature and effects of these meanings.

‘Interviews are one method by which the human world may be explored, although it is the world of beliefs and meanings, not of actions, that is clarified by interview research.’ (Arksey and Knight, 1999, p.15). Although I directed the participants to talk about smoking, eating, drinking alcohol and exercise, I did not use their accounts as indications of their actions. The purpose of this study concerns the way that young people think or feel about the consumer meanings of health-related behaviours, rather than what they do or whether these meanings have a causal relationship with their actions. Nevertheless, it should be acknowledged that the interviewing process is not sufficient in itself to report on whether the consumer meanings have consequences for the participants’ behaviours. However, it gives in-depth insight into the meanings and motivations that the participants’ themselves recognized as being fundamental for young people’s actions.

Finally, I elaborate a significant puzzle which I came across regarding the use of qualitative interviewing, as outlined through the idea of the active interview. More precisely, it is concerned with the relationship between the accounts of my participants about the consumer meanings of health-related behaviours which were generated during the interviewing process, and their lived experiences. Do these accounts represent the participants’ ways of seeing consumer meanings of health-related
behaviours or are they simply products of the interviewing setting? This question raises the important methodological issue about whether, ‘interview responses are to be treated as giving direct access to “experience” or as actively constructed narratives involving activities which themselves demand analysis’ (Holstein and Gubrium, 1995 cited by Miller and Glassner, 1997, p.113).

An answer lies in the fact that the young people are not coming to the interview process empty of experiences or cultural knowledge. Radical social constructionists who suggest that interview data are exclusively the product of an interaction between interviewee and interviewer (Miller and Glassner, 1997) seem to miss out culturally specific elements in people’s accounts, which enable the production of the interview data. This approach, which implies that the respondents’ statements and actions are constructions of the research framework, undermines the importance of the cultural framework, where people have been living before and during the research. The identification of shared patterns across subjective accounts occurring in qualitative analysis, is, at the same time, a documentation of the use of common culturally available resources used by individuals in order to construct their stories. ‘Participation in a culture includes participation in the narratives of that culture, a general understanding of the stock of meanings and their relationships to each other’ (Richardson, 1990, p.24).

Therefore, it would be an exaggeration to suggest that all the ideas and meanings expressed within an interview are exclusively products of this interviewing setting. The participants’ consumer-related interpretations are generated within the interviewing setting, but at the same time, are generated from their own understandings of their personal lived experiences. The interview itself is understood as ‘a site for displaying the cultural knowledge of people’s everyday life; and not the thing – lived experience- itself’ (Densin, 1991, p.68). This position challenges the ‘romantic’ notion of the interviewing process identifying ‘an experience’ with ‘authenticity’ (Silverman, 1993, p.ix). Nevertheless, it also qualifies the interviewing process as coming closer to people’s lived experience through a mutual construction of plausible cultural versions. The interview may appear empirically as a restrictive way of capturing people’s realities; what, however, actually needs to be questioned is the
existence of a way other than the mutual interactive way of accessing the participants’ consumer interpretations.

‘Respondents’ talk is not viewed as a collection of reality reports delivered from a fixed repository. Instead, the talk is considered for the ways that it assembles aspects of reality in collaboration with the interviewer.’ (Holstein and Gubrium, 1995, p.79)

Therefore it should be recognised that the generated data is only a part of the participants’ consumer meanings of health-related behaviours; ‘a slice of cake’ which is in line with the research agenda.

Having elaborated the potentials and limitations of a qualitative interview, I came to conclude that it fits well into my research design. Nevertheless, reflecting on the judgements I made in respect of the use of qualitative interview for this study, I recognise the significance of the interviewing techniques as constructive elements of the environment within which my participants are called to reflect on issues concerning health-related behaviours. ‘The objective is not to dictate interpretation, but to provide an environment conducive to the production of the range and complexity of meanings that address relevant issues, and not be confined by predetermined agendas’ (Holstein and Gubrium, 1997, p.123). This argument concerns structuring situations and not an interviewing schedule.

This neat distinction, as outlined above, is clarified in the next section where I describe in detail how I encouraged my participants to talk in accordance with my research agenda (see section 4.3.2.1, p.87-88), without limiting their opportunity to participate in an open-ended interviewing situation. In particular, I discuss how I stimulate my respondents to develop topics regarding the consumer angle of health-related behaviours in the context of their everyday lives. Next, I move on to a more descriptive approach of the interviewing settings and demonstrate how my strategies are in harmony with ‘what’ and ‘how’ I want to explore the consumer meanings of the participants. The description of the interviewing framework in which consumer meanings are actively discussed is, at the same time, a depiction of how the selected techniques cohere with the research agenda.
4.3.2.4 The interviewing process in practice

The main features of the interviews were: one to one; unstructured; around young people’s everyday lives; and extensive probing concerning the symbolic dimension of health-related behaviours. The functions of these chosen features in relation to the research agenda of the study are described below.

4.3.2.4.1 One to one

Group and one to one interviews form ‘different types of interaction situation’ and ‘yield different types of research materials’ (Alasuutari, 1995 p.91). In the case of group interviews, meanings that emerge ‘are more influenced by the social nature of the group interaction’; whereas one to one interviews as a minimal interaction are ‘relying on the individual perspective’ (Gaskell, 2000, p.46). Both strategies can be useful in exploring consumer meanings. Group interviews can be valuably used to explore the way that consumer meanings are negotiated within a group of young people. Yet, my preference for dyadic interaction relies on my empirical orientation to tap into the interviewees’ personal perspectives on the consumer meanings and the role of these meanings within their everyday lives.

Eating, drinking alcohol, exercise and smoking are types of experiences that young people tend to frequently share with other young people. Nevertheless, in terms of this study, I felt that the discussion of the role of these behaviours as symbolic ones is a sensitive issue to be explored with other young people. This is because it was largely seen as a hidden agenda prevailing within their peer relationships. In my experience, for the young participants to express personal positions about their chosen consumer style meant to release private information about peer relationships and experiences. Indeed, in several cases the participants disclosed stories which were unlikely to have emerged if they would have had to take account of the views of others. Some of the participants acknowledged how their own behaviour was manifest in order to adjust to the consumer style of a particular group (see sections 6.4.2, p.181-183 and 6.4.3, p.183-190). Moreover, as some of my respondents told me in the context of their daily youth cultures, to accept that you choose something because of the ‘image’ which is portrayed can be negatively criticised by young people as a lack of ‘authenticity’ or personality of the consumer (see section 6.3.1, p.165-166 and section 7.3.1, p.207).
These kinds of realisations are less likely to occur within a group interview. For instance Miles (1997, p.164) who used group interviews regarding the relationship of young people with consumer products found: ‘Whilst young people choose consumer goods according to peer group meanings, they tend to see their own choices as individual’.

Since this research study aimed at exploring the way that participants view smoking, eating, drinking alcohol and exercise in their routine daily lives, I did not want to restrict the possibilities being explored by adding the pressure of the presentation of self to other young people. One to one interviews offered protection to the participants to explore these issues without facing any danger of being criticised about their consumer preferences. In addition, my presentation as a person who is absent from their social daily interactions, seemed to encourage them to expose more private feelings about consumer meanings.

4.3.2.4.2 Unstructured interviews

By classifying interviews as unstructured, I refer to a conversation which ‘is far more interviewee oriented’ (Arksey and Knight, 1999, p.96) and given by a researcher, my role, who ‘does not lead the inquiry with a set of predetermined questions’ (Gaskell, 2000 p.45). In particular, apart from the first question, I attempted to continue the conversation by forming subsequent questions based on previous statements made by the respondents (see Appendix 3). I tried to obtain clarification and amplification on points regarding consumer meanings of health-related behaviours with appropriate probing but focused concretely on the participants’ accounts53. Although this technique was not always possible, particularly in cases when the respondents tended to give limited answers, it invited my participants to talk at length in their own terms about issues that were meaningful to them.

52 The first question and its role is discussed in section 4.3.2.4.3, p.105.
53 This technique was also used in the pilot study, section 4.3.1.2, p.84-85
The unstructured interview allowed me to give more weight to the opinions of young people. This is a fundamental issue in this study. If the respondents had to follow a certain sequences of questions posed by the researcher, they might not have had the opportunity to express their own concerns in a manner and order which was meaningful to them. Moreover, this technique encouraged young people to talk about their everyday lives: a conversational setting appealing to my research questions (see section 4.3.2.1, p.87-88). Consequently, consumer meanings of health-related behaviours emerged as a topic suggested by the participants. This strategy enabled me as a researcher to tap into the consumer issues that interest and possibly concern the participants with respect to their daily lives. I largely avoided situations where the participants had to talk about the symbolic signification of products or activities, which they may not have considered beforehand. Likewise, the health dimension of these four behaviours emerged as one among the others, rather than dominating the interviewing process. It was an issue that some of the participants chose to mention while they were talking about choices in their everyday lives. I discovered my attitude to be crucial in order to enter into the world of the young person and lead interviewees’ accounts regarding their lives (Aggleton et al., 1996; Shucksmith and Hendry, 1998).

4.3.2.4.3 Regarding young people’s everyday lives

Introductions and the initial request for participation are crucial, in the sense that the researcher ‘provides initial contexts for how the respondent might possibly engage the interviewer’s inquiries’ (Holstein and Gubrium, 1995, p.76). My initial ‘failure’ (pilot study) to emancipate my research project from health discourses led me to two primary decisions concerning the interviewing process. These concerned the way I introduced myself and my opening question. These two modifications proved to be crucial for my objective to encourage talk about health-related behaviours situated in daily life.

Firstly, I decided to introduce myself as a student from the University of London who aimed to explore young people’s opinions regarding their everyday lives. I explained to them that my intention was to gain their personal views regarding daily life

See relevant discussion section 1.1, p.12-16.
experiences without being explicit about my interest on health issues. My decision was affected by the pilot study which demonstrated that an explicit and informative presentation regarding the health background of the study provoked judgemental concerns about young people’s lifestyles and health issues (see section 4.3.1.3, p.86-87). In addition, as exemplified in chapter 2, a similar strategy was reported by other health-related researchers in order to prioritise young people’s agendas regarding their health-related choices (see section 2.3.2.3.2, p.44-45). In this light, I felt that an explicit health background of the study would have affected the whole setting of a friendly and relaxed conversation around simple choices and experiences informed by the participants’ everyday context.

Secondly, I changed my initial question to a more general one concerning their interests at that particular stage of their life. I started the majority of these interviews with a broad, open-ended question about their current interests that allowed the interviewees to identify issues of concern to them (Appendix 3, examples 2,4,5).

Q ‘What are the main issues that matter to you during this period of your life?’

In many other cases, I engaged in conversations regarding issues that the participant had revealed at our initial interaction, such as their relationship with their parents, their future aspirations, holidays and friends (Appendix 3, examples 1,3). I then continued the conversation by encouraging them to talk about their everyday lives, formulating questions, which did not interrupt a logical and possible progression through the issues in focus (as explained in the preceding section 4.3.2.4.2).

These two modifications developed in the main study proved to be significant in encouraging my participants to talk about their everyday lives. The example below shows the difference between the data sets collected during the pilot and main study. It concerns the way that participants talked about ‘going out’ and ‘entertainment’. These two topic areas discussed in both sets of interviews were approached in relatively different ways. In the first case, entertainment was evaluated in relation to health matters, whereas in the second, as a ‘natural’ part of young people’s lifestyles. It is interesting how smoking and drinking alcohol are treated differently in these two sets of data, extracted from the first and second phase of the interviewing process. In the
first case the participant talked about smoking and drinking as unhealthy activities whereas, in the second, as indicators of an ‘older’ stage of life which is expressed through smoking and drinking in ‘going out’.

Data collected during the first stage of the interviewing process (pilot study)

Q ‘Does entertainment have any relation with health?’
A ‘Entertainment brings many bad things in many cases, getting drunk, smoking, both these two, too much alcohol may cause you too many effects. Besides the one who smokes, he will smoke only when he goes out.’ (Male, 15)

Data collected at the second stage of the interviewing process (main study)

Q ‘Elaborate on this. Have many changes taken place?’
A ‘My mum was thinking of me as a child (even though I would have done the same in her shoes). I wanted to go out and she would not let me. I used to end up crying. If we were allowed out, we tried to be easy-going and join in other people’s lives. We would hear that other girls were allowed to go out to places, buy certain clothes. If you went to a club, you would see everyone smoking, drinking. That is when I was making efforts to fit in with that group of people. I was thinking that if they did those things, why should I not do them.’ (Maria55, 17)

My questions, which in both cases were naturally generated from the preceding discussion, were critical with respect to the participants’ accounts. Indeed the absence of the health logic in the second stage of data collection related to the fact that I did not look for such explanations. The revealed difference between the two phases of my research project lies fundamentally in the dissimilar way that I introduced my study and started the conversation56. It can be argued, therefore, that by making the health-relevance of these behaviours central to the interviewing processes, the participants were led to judge everyday activities as positive or negative towards the ‘healthy’ choice: a case which is undesirable for my research agenda (see section 4.3.2.1, p.87-88).

55 Pseudonymous are used for the main study (see section, 4.3.2.7, p.115)
56 The difference between the two data sets led me to consider more critically the nature of the interviewing technique in collecting data (see section, 4.3.2.3.1, p.93-95).
Indeed, my participants chose to talk about their leisure activities, clubs, friends, clothing and so forth. They explained, for instance, why they preferred to go to a specific club and not to another one; what clothes they liked; how they spent their free time; what is considered ‘in’, ‘cool’ or ‘fashionable’ in Cyprus or among certain groups of young people; what kind of relationship they have with parents; and so forth. In this process, they mentioned food, drinks, smoking, different cigarette brands, basketball, gym and so forth. They located health-related behaviours at home, school, day or night time, in different clubs, cafes and generally through the process of action and interaction at the level of everyday exchanges. They described and explained their own lifestyles without necessarily being ‘obliged’ to justify their daily choices in terms of health. It is in this context in which ‘unhealthy’ behaviours tended to appear as rational (conscious or unconscious) lifestyle choices, reflecting the complexities of their own lives, rather than as irrational ones from the perspective of health concerns. It is also worth noting, that the issue of health did not appear in most of my conversations. In some cases, I intentionally explored the concept of health in relation to smoking, eating, drinking alcohol and exercise at the very end of conversations.

Despite the ‘success’ of these two modifications, - the initial introductory comments and the opening question - my decision to cover the ‘health background’ of the study as required for the pursuit of my research aims, presents me with an ethical dilemma: whether it is legitimate or acceptable not to have informed the participants of the health background of the study. My decision to keep my research topic semi-covert, or semi-overt, is justified as my intention has been to stress the ‘everyday’ rather than the ‘health’ dimension of smoking, eating, drinking alcohol and exercise. This decision is a complex one since it involves the relationship between ethics and social research within a specific research setting (May, 1997; Bell and Nutt, 2002). It, therefore, requires a degree of ‘reflexivity’ and ‘reflective practice’ by myself, as a researcher, in order to justify the practical decisions within the actual research situation (Bell and Nutt, 2002). These negotiations are outlined in the following four points.

Firstly, these decisions were obtained as a means to focus the participants’ agendas regarding their everyday lives. Secondly, the analysis of the participants’ accounts, as presented in this thesis, is in line with my introductions to the project; to give voice to
young people’s visions of their experiences. The point here is that I did not use the health background of the study in order to present the data. I did not, for example, classify my participants’ meanings as conducive or not to health matters, a procedure, which exploits their ‘unawareness’ about the health background of the study. Rather, I channelled all my efforts into privileging my participants’ voices of their everyday experiences. Thirdly, and as a corollary, the semi-overt presentation of the study expresses more closely the research project. This is because it explores and analyses smoking, eating, drinking alcohol and exercise, not explicitly as health-related behaviours, but rather as ‘everyday’ behaviours. The interview scheduled was sufficiently loose for the participants to raise other topics. They were neither encouraged nor prevented from talking about the health dimension of these behaviours. Lastly at the end of the conversation, when the participants inquired, I provided further information about the nature of the study and its relevance to health matters.

4.3.2.4.4 Extensive probing into the consumer meanings of health-related behaviours

The final feature of the interviews concerned my extensive probing into the consumer meanings of health-related behaviours. At the beginning of the interviewing process, I used such strategies in a rather spontaneous way. It was only during the writing up process that I acknowledged the occurrence and potency of these probing strategies. Below, I first describe the main features of these probing strategies and then I give examples of the ones that proved to be very useful.

There are two main features of the probing strategies that I would like to stress. The first concerns the everyday context in which I decided to stimulate the participants to talk about the consumer meanings of health-related behaviours. Secondly, the probing strategies were made in such ways that they would flow naturally in the interviewing process. As an interviewer, I chose the suitable moments during the interviewing process in order to encourage the participants to get into a dialogue

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57 In the preceding section, I discussed how I managed to ‘guide’ my participants to articulated health-related behaviours in their daily lives without feeling obligated to make inference to these choices with respect to health matters.

58 This issue is also concerned with the unstructured nature of the interview, (section 4.3.2.4.2, p.103-104).
concerning the consumer meanings of health-related behaviours. Next, I describe each of these probing strategies separately by giving examples taken from my interviews.

**Asking why?**

Asking why in relation to issues relevant to the participants’ descriptions of their everyday life was a very useful technique for leading the conversations towards the symbolic elements of health-related behaviours. In most cases the conversation started with descriptions of young people’s daily activities such as ‘going out’, ‘eating’, ‘spending time with friends’ and so on. At these points I asked them to give me reasons why they, or other groups of young people, make certain choices as shown below.

- ‘Why did you choose Frappe?’
- ‘Why do you think boys mostly have Hooch?’
- ‘Why do you have Turkish coffee at ‘Gala Kathoumena?’
- ‘Why did you prefer pizza instead of soup?’

The conversations flowed in such a way that my participants exposed explanations relevant to the ‘everyday life’ framework in which they were operating. For example, asking why they eat fast food or not, did not imply ‘why do you have fast food since it is unhealthy’.

**Stimulating re-assessing given reasons for a health-related choice**

Within this strategy, I challenged young people’s suggested reasons for a health-related behaviour choice. This technique was primarily used when the participants gave practical reasons for a health-related choice such as ‘my mother does not cook’, and ‘fast foods are close to clubs’. In these cases, I encouraged them to re-think the significance of their suggested practical factors for choosing a health-related choice by providing alternative situations as the following examples.

- ‘What if there were some vegetarian restaurants near the clubs?’
- ‘What if you had the money to go to a tavern?’
- ‘If there was a fast-food place, which offered traditional Cypriot foods but in the same way fast-foods offer their food, would it have the same success amongst youngsters?’
- ‘What if your mother offers to cook for your friends?’
Escaping from ‘practical reasons’ was a useful strategy in order to enable the interviewees to explore their consumer understandings of health-related behaviours. For example, when I challenged one young woman who insisted that she had ‘take-away’ with her friend at home since her mother could not cook, she ended up explaining to me the symbols attached to home-made food and take-away food.

**Expanding on the inscribed consumer traits**

The participants regularly referred in their descriptions to their own or other’s daily choices (such as coffee shops, clubs, clothes) as being ‘cool’, ‘in’, ‘because of the image’ and so on. These types of phrases or expressions emerged in all conversations since they are part of everyday ‘slang’ and therefore appropriate terms for describing young people’s lifestyles. In these cases, I was probing to obtain further clarifications. After we had discussed extensively the suggested phenomenon, I tended to expand the discussion in various ways. The main ones were:

- Asking them to talk about other activities that may project similar personal traits for the same or other group of young people: ‘How does a girl who wants to be perceived as ‘cool’ [or any other of the suggested trait] also act?’
- Transferring their comments to other health-related behaviours: ‘Does the same happen with drinking?’
- Challenging them to discuss whether the same type of consumer traits prevails within different contexts such as with friends, without friends, at home, at school and so forth.

**Stimulating comparisons**

Another helpful strategy was asking people to make comparisons. In most cases, these comparisons were about the different styles that might be projected through certain health-related behaviours. Here, I present a few examples of my comparative type of questioning.

- ‘Would a girl who smokes Marlboros have any differences from one who smokes a lighter brand?’
- ‘What is the difference between practising a sport and attending a gym regularly?’
- ‘Earlier you said that you are not a “gym-type”, but you are a “white wine” type of person. Can you compare these two judgements?’
Creating scenarios relevant to health-related choices

The construction of certain scenarios about health-related behaviours in the everyday lives of young people was one of the most fruitful strategies which encouraged participants to talk about the consumer meanings of health-related behaviours. These scenarios were not pre-decided or pre-planned before the interviewing process. Generally I ‘invented and imagined’ them throughout the data collection process. I introduced these scenarios to my participants along with the process of the interview, and not at points where they might be seen as ‘imposing’ or irrelevant to the ‘current’ conversation. On several occasions I was inspired by their scenarios and I asked them to talk about a slightly different one by changing the place, the people involved and their health-related choices. I demonstrate below a few examples of my questions.

- ‘What if one of you would have liked to have fresh juice instead of your usual alcoholic drink [Hooch]?’
- ‘If you now suddenly stopped smoking, how would you feel amongst your friends?’
- ‘If you were at home with your family, would you have shown such a disgust for green black-eyed beans?’
- ‘What will happen if a Chinese restaurant opens close to the Enallax club?’
- ‘What do you think would be your friends’ reaction if someone from the group orders boiled potatoes instead of fried ones with his/her hamburger for health reasons?’

In other cases, I introduced scenarios used in preceding interviews, which provoked rich discussions about the consumer meanings of health-related behaviours in young people’s everyday lives. Frequently, I created a situation where they or other young people had to reflect explicitly about their choices in a public space. In particular, I asked not only about their reactions, but also how they felt about them. Here, I exemplify this scenario and some questions that I frequently asked in order to expand the conversation.

- ‘What if someone was doing a poll amongst the pupils in your class, and you had to say out loud in the presence of everyone what you had for lunch yesterday? What would you have been more comfortable with saying?’
‘Why did you previously say that it would have been easier for you to say that you had delivery food?’

‘How would you feel if someone in your class, in the presence of everyone, says that he has had a pizza at Pizza Hut?’

‘What if everyone else said that they had home-made food? What would you have said then?’

**Talking about different groups of people**

The promotion of ‘multivocality’ appeared as a valuable strategy within this study. By multivocality, Holstein and Gubrium (1995) refer to a position in which the interviewer encourages the respondent to address a topic from various points of view; a process which activates the multiple ways that the interviewee attaches meaning to the phenomena under investigation. Likewise, at several times during the interviewing process I asked my participants to reflect on groups of young people that they had previously suggested such as younger ones, girls, the ones who go to the X club. I took advantage of the participants’ references to these groups of people and asked my participants to imagine these particular groups in situations other than those they described at a later stage of the interviewing process. I then encouraged them to identify any differences in the way that these groups understand the surrounding events. Some examples of my questions are given below.

- ‘Let us say that one day you go somewhere to eat with the group of friends you met at Versus Club. One of them says that he would rather have a salad than meat because it is healthier. What would their comments be?’
- ‘Were you open to your friends about going on a diet, when you were fifteen?’
- ‘You have earlier described the boy who is holding his drink and cigarette in a certain way. Does the same apply to the girls?’
- ‘So, do you think that this guy would definitely have chosen to have Hooch?’

**Reflecting on others’ opinions**

The last probing strategy is concerned with cases in which I asked my respondents to reflect on others’ opinions. I found this technique important in encouraging my participants to speak about issues that may sound embarrassing to them. For instance, I
asked my participants to reflect on one participant’s preference to buy a sandwich from the school canteen rather than to carry one from home, even if the latter one would taste better. These types of interventions enabled me to create a relaxed environment of rapport and trust so that my participants felt comfortable enough to disclose information.

4.3.2.5 Location

The interviews took place either in the participants’ homes or in a coffee shop which they were asked to select themselves. The participants’ houses were used in three cases as they wanted to save time due to their busy timetable. In these cases I paid attention to the need for peace and quiet so that the interviewing process would not be disturbed; in particular, I tried to choose times when family members were absent. This strategy provided the opportunity for participants to discuss ‘sensitive’ issues which they might want to keep from family members, such as smoking, boyfriends or girlfriends, alcohol consumption, places of going out and so forth.

Coffee shops - ‘kafeterias’- are a core institution in Greek life. Their ‘European’ atmosphere is generally popular with young people in Cyprus as they constitute public places for communicating, discussing and establishing old and new relationships (Loisos and Papataxiarchis, 1994). A coffee shop, as a setting for an interviewing interaction, provided the chance for a relevant discussion on issues around youth culture and consumer practices. It was an ideal and natural way to initiate conversations with prompts like the following: ‘So, do you enjoy this place? Do you come here often with friends? What makes it so special?’ Participants engaged easily in this kind of conversation. They explained their preferences and gave valuable information about their going-out habits and their lifestyles within small subcultures, for example, places that they consider ‘cool’, ‘arty’, or ‘laid back’. In this light, sometimes, ‘kafeterias’ as relaxed spaces can be contrasted with private households where young people might have several restrictions: for instance they do not smoke in front of their parents or they might not be able to drink alcohol. It is worthy of noting that some participants smoked during the interviewing process at the chosen coffee shop. Interviewing in a coffee shop gave me also the opportunity to continue the discussion, and hence the interviews while driving the participants back home. On some occasions, in these unexpected moments, participants made interesting
statements about their lifestyles and their own ways of thinking about them. They also gave me feedback with respect to the interviewing process.

4.3.2.6 Interviewer

'The decision of how to present oneself is very important... it leaves a profound impression of the respondents and has great influence on the success (or failure) of the study' (Fontana and Frey, 1998, p.58-59). Traditionally, the interviewer was viewed as a passive or neutral actor, who tried, in order to elicit truths to avoid the contamination of the interviewing process through neutral practices (Holstein and Gubrium 1997). Conversely, from the active interview perspective the research relationship is of great interest of producing a better quality of research material for the purpose of the study. Correspondingly, my empirical desire to encourage the participants to talk about their daily lives, as understood in their own terms, led me to position myself with regard to my personal appearance and attitude throughout the interviewing process.

At the beginning, my initial attempt was to establish rapport in a friendly way so that I could win and maintain trust and consent through the interviewing process (Deakon et al., 1999). Rapport, according to Fontana and Frey (2000), is about the ability of the researcher to take the role of the respondents and attempt to set the situation from their perspective, rather than superimpose his or her world of academia and preconceptions upon them. Since I was myself relatively young and needed to negotiate issues around youth culture, I positioned myself as a person who was related to youth culture. I avoided presenting myself as a distant adult figure with academic interests who was approaching young people in terms of completing a research project and then moving to my own professional and personal space. I also avoided presenting myself as a teacher, an authoritative figure linked with education and government policies, so that I could maximise the opportunities of equal communication.

Several practical decisions were made in order to position myself as a person who was friendly towards youth culture rather than as an adult figure or as a neutral observer. Looking 'relaxed' and 'informal' was particularly important and involved wearing 'simple' clothes and carrying a ruck-sack. Second, sitting on the floor in the participants' room or in other spaces of the house also created an informal interviewing situation. Thirdly, I purposefully became involved in a discussion
concerning the ‘going out’ places in a way that made it apparent that I was not only familiar with these places but that I also engage in a youthful ‘going out’ lifestyle. Lastly, I was careful about the type of language I employed. I tried, in many cases, to use terms that are popular within the youth culture in Cyprus.

4.3.2.7 Data management (recording, transcription and translation)

All the interviews were tape-recorded and transcribed as soon as they were completed. Participants were informed about this process and they consented to it under the agreement of using pseudonymous in my writing process. In order to clarify the gender of the participant, I use female names, which end with ‘a’ - such as Maria - and for male, which end with ‘os’ - like Theodoros. I also indicate the age of the participants in each bracket. For instance, (Markos, 15) means a man (os) who is fifteen years old.

I tried to complete the transcriptions as soon as possible after the completion of each interview. This strategy provided me time to think separately for each interview and record any additional information regarding our non-verbal interaction. I merely focused on the content of the original conversation, leaving out all the sounds and utterances that appeared. I paid attention only to words, pauses and laughs which could help me to focus on the ‘actual details’ that were important for the aims of my study (Silverman, 2000a, p.148).

The process of carrying out Greek-English translations was complicated not only because the act of translating spoken words into written text is problematic but also because certain spoken phrases were used in a specific context of youth culture. Those constraints were unavoidable and only partially overcome. Frequently, I found equivalent or satisfactory English phrases, in certain cases suggested by my British Cypriot students at the community school where I was teaching Modern Greek GCSE in London. Those students were familiar with both cultures since they travel frequently to Cyprus; they have friends and relatives there; and they themselves have to solve translation problems in order to communicate their experiences. Moreover, many of the participants were using common English expressions to denote an attitude or a behaviour. These phrases, such as ‘cool’, ‘to show off’, and ‘image’, are nowadays commonly used in Cyprus.
4.4 Making sense of the data

The last section of this chapter describes the process of analysis employed, in order to explore how my participants talk about the consumer meanings of smoking, eating, drinking alcohol and exercise. In the first section, I give an overall description of the data analysis procedures followed in this study. Then, I explain, how I developed the data analysis in three analytical categories - Symbolic, Role and Reflective categories – in accordance with the research questions (see section 4.3.2.1, p.87). Finally, I concentrate on the coding strategies employed in this study for the development of the three analytical categories.

4.4.1 Data analysis procedures: some general observations

The data analysis was not a separate phase in the research process: it informed, and was informed by, the data collection and the research design. The method of data analysis adopted in all these stages developed by using the strategies of a grounded theory approach (Strauss and Corbin, 1990), which includes simultaneous data collection and analysis throughout the research process and an integration of the theoretical framework. Grounded theory consists of procedures concerning the content analysis of the interview; this I used in a flexible rather than prescribed way. During all stages of the study I identified themes emerging from the data. I looked for patterns in the data and made comparisons across cases. Informed by theoretical concepts derived from the work of consumer culture, I developed coding categories that relate my data and to the aims of the study.

The second feature of the data analysis procedures concerns my role as an interpreter of the data. So far, I used the notion of the active interview in order to highlight my role as an interviewer in generating data according to my research agenda. In terms of the analysis, the notion of the active interview sheds light on my active role in interpreting the data in collaboration with my research agenda (see section 4.3.2.1).

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59 These stages can be separated to pilot study, analysis in the field and final presentation
60 The practical procedures of the content analysis of the participants' accounts are presented with respect to how I finally decide to code and analyze my data (see section 4.4.3.3, p.125-127).
Specifically, the presentation of findings is in accordance with the constructive notion of grounded theory, which recognises the active enterprise between the researcher and subjects in order to arrive at a certain ‘discovered’ reality which arises from what the researcher views, defines and analyses (Charmaz, 2000, p.524).

The way I decided to analyse my data was not a decision taken at the beginning of the thesis. After the completion of the pilot study, several attempts at analysis were made during the collection of data. The following stages of analysis were more dynamically developed with the other aspects of the research process, particularly with the literature review of issues regarding health promotion (chapter, 2) and consumer culture (chapter 3). These stages were significant for the present study for three primary reasons. Firstly, these attempts enabled me to refine my research questions (see section 4.3.2.1, p.87). Secondly, I developed further my understanding of consumer culture and its role within the whole research design. These diverse movements between theory and data enabled me to arrive at certain theoretical positions concerning the relationship between consumers and the symbolic sphere of consumption; ideas, which are elaborated in chapter 3. Thirdly, these stages of analysis were significant in terms of understanding my interactive role in the data collection and analysis processes.

While the data analysis accompanied the whole process of data collection, there was a period in which the analysis was refined and more explicit theoretical findings began to emerge. Amongst a range of possibilities for the presentation of the data, I chose those which seemed to fit better in respect to my research agenda. Next, I justify how I ‘reconstruct the original story told to me by the interviewee into a story I want to tell my audience’ (Kvale, 1996, p.185).

4.4.2 Categories of the final analysis

In section 4.3.2.1 (p.87-88) of this chapter, I have outlined the research design through, what I define, as its two constituent elements. The first element concerns my focus on young people’s consumer meanings of health-related behaviours, which subsequently was sub-divided into three research questions. The second element concerns a critical explanation of health logic and my motive to situate and understand smoking, eating,
drinking alcohol and exercise within the context of young people’s broader lives and cultures. So far, in the methodological chapter, I have described how I designed the interviews in order to meet these two elements. Next, I explain how these two key elements of the research design – focusing on consumer meanings and by-passing health logic - determine the analysis.

I purposefully sought to bypass from the health logic with respect to the consumer meanings when analysing the data. This mirrors my main concern to try to avoid making judgements associated primarily with health matters. Instead, I proceed to an analysis which focuses on young people’s perspectives regarding their day-to-day experiences. Correspondingly, the analysis was accompanied through a number of refusals. I did not use the participants’ accounts to elucidate factors which led young people to certain choices rather than others. I did not use my data to justify the non-rational (‘unhealthy’) choices; nor to give reasons for non-compliance to a healthy choice; nor to retrieve the cognitive capacity of young people to estimate the health hazards in comparison with the consumer dimension of these behaviours. What matters in the present analysis was not the assessment of health-related choices: if they are healthy or unhealthy or whether consumer meanings are conducive to ‘good’ health.

My main concern was to show how the participants view consumer meanings of smoking, eating, drinking alcohol and exercise as embedded in their everyday lives: why those choices are meaningful to them and the ways in which the consequences of making those choices are understood. The analysis followed in this study aims at supporting health promotion discourses by demonstrating how smoking, eating, drinking alcohol and exercise are discussed as consumer choices in the everyday life experiences of young people. To this end, I disclosed the way that young people make sense of, and articulate, their ‘imagined’ consumer meanings of health-related behaviours prevailing within their socio-cultural context. These categories focus firstly on embedded consumer traits (e.g. the quality of being ‘cool’), secondly, the role of these traits (e.g. use in projecting an image) and thirdly, reflections on the traits and

61 In the health-related research review, I discussed some of these ‘refusals’ as indications of the health logic within empirical studies associated with health-related behaviours (section 2.3.2).
their role in the context of their everyday lives. Each of these categories reflects respectively the research questions of the study (section 4.3.2.1, p.87). Below, I elaborate in more detail the three analytical categories.

**A: Symbolic categories**
The first category of analysis focuses on the kinds of consumer traits that the young people ascribe to health-related behaviours (e.g. the quality of being ‘independent’ and ‘high class’). I entitle the emerging *symbolic categories* since they are concerned with the symbolic association between health-related behaviours and personal traits. The emphasis here is placed on elucidating the manifold types of consumer traits ascribed to different forms of health-related behaviours.

**B: Role categories**
The *role categories* concentrate on the consequences of those traits in young people’s everyday lives. In particular, I sketch out the ways in which the participants talked about the *functionality* of health-related behaviours as consumer activities. I move to the ‘lived’ experience through my participants’ accounts, describing how health-related behaviours are important to them within a social setting.

**C: Reflective categories**
The third set of categories labelled as *reflective categories*, explore the way young people come to understand themselves as subjects who adopt a particular standpoint with respect to health-related behaviours as consumer activities. The intention here is to show how young people evaluate their own standpoint with respect to the consumer meanings of health-related behaviours and their role in the context of everyday life.

### 4.4.3 Process of data selection

This section sets out the boundaries within which I choose to manoeuvre with respect to the interview data. I indicate the way I selected and coded the data with respect to the purposes of the three categories of analysis. The first section includes some descriptions of the interviewing data in order to introduce the language of ‘consumer meanings’ as one among others ways of talking about health-related behaviours (section 4.4.3.1). After presenting the various ways of talking about health-related behaviours, the second section clarifies what kinds of accounts I chose to explore in
the data analysis as consumer meanings (section 4.4.3.2). Finally, in the third section I describe the coding system employed for the selected data regarding the three analytical categories (section 4.4.3.3).

### 4.4.3.1 Interview data: health-related behaviours as everyday life activities

Asking my participants to talk about their everyday lives as multi-vocal phenomenon incarnating several dimensions of health-related behaviours. Apart from their specific health status and their understanding within the health promotion framework - as health enhancing or health damaging - they are part of a wider, everyday context. In the following table, I exemplify some of those dimensions of health-related behaviours. My intention here is to introduce the consumer dimension of health-related behaviours – which I chose to focus on - as one among others.

#### Table 4.1: Health-related behaviours as everyday activities: examples from coded segments of data

<table>
<thead>
<tr>
<th>Health-related behaviours as everyday activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ‘It depends on how hungry each one of us is.’ (Fotos, 16)</td>
</tr>
<tr>
<td>2. ‘I cannot even taste beer. It is bitter.’ (Dimitra, 17)</td>
</tr>
<tr>
<td>3. ‘I am addicted now and I cannot quit smoking.’ (Alexandros, 17)</td>
</tr>
<tr>
<td>4. ‘Going to the gym just to keep fit.’ (Georgia, 16)</td>
</tr>
<tr>
<td>5. ‘There are times when we are hungry but we prefer to eat something fast (takeaway). We might even have it in the car so we are at our destination on time.’ (Katerina, 16)</td>
</tr>
<tr>
<td>6. ‘If you go to a pub, with your friends you would see everyone smoking and drinking. They are part of their going out habits.’ (Manos, 15)</td>
</tr>
<tr>
<td>7. ‘I play the piano, play volley-ball and I am learning Italian.’ (Dora, 16)</td>
</tr>
<tr>
<td>8. ‘Eating snacks whilst watching a film with your friends at the cinema.’ (Ifigenia, 16)</td>
</tr>
<tr>
<td>9. ‘Having fun with friends, giving each other hugs and singing together. Sitting somewhere nice, go clubbing to dance, eating.’ (Maria, 17)</td>
</tr>
<tr>
<td>10. ‘I used to go there [a pub] with my ex-boyfriend. I still go there and drink vodka lime as we did.’ (Katerina, 16)</td>
</tr>
<tr>
<td>11. ‘Exercise to get the bad substances out of your system.’ (Markos, 15)</td>
</tr>
<tr>
<td>12. ‘You feel your body like a machine which is re-energized.’ (Athos, 15)</td>
</tr>
<tr>
<td>13. ‘Pulses helps the organism by adding calcium in order to function well.’ (Athina, 17)</td>
</tr>
</tbody>
</table>

As illustrated in section 4.3.2.4.3 (p.104-108), one of the key features of the conversations was the encouragement offered to young people to talk about their everyday lives.

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62 As illustrated in section 4.3.2.4.3 (p.104-108), one of the key features of the conversations was the encouragement offered to young people to talk about their everyday lives.
The participants discussed them as routine behaviours involving bodily experiences that young people, as living beings, seek to have, such as satisfying hunger, taste preferences, addictions and fitness (1-4). In other cases they gave a number of practical reasons why they, or young people in general, may choose an activity in their everyday lives (5). They talked about them as being part of their entertainment, as extra leisure activities or simply as pleasurable activities in their own right (6-8). They were also seen as part of their social activities involving family members and friends (9). In a limited number of cases, they stressed their emotional aspect (10). Among these accounts, few elaborated the health consequences of smoking, eating, drinking alcohol and exercise. They weighed up costs and benefits by paying attention to the biomedical risks and benefits of health-related behaviours (11-13). These extracts were a minor part of the conversations regarding young people’s everyday experiences.

Along the same lines, the consumer meanings ascribed to health-related behaviours do not suggest the rejection of other ways of talking about them as everyday practices. They were generated as one aspect of the participants' accounts concerning health-related behaviours as everyday activities. At several points, the respondents referred to a symbolic dimension, which was reflected when someone engaged in a health-related behaviour: 'It shows something', 'they portray an image' and 'it gives an impression'. These behaviours were labelled as 'cool', 'high class', 'feminine', 'traditional' and so forth. It is this symbolic dimension, as articulated by the interviewees, which I have chosen to focus on. It is a dimension, which does not reject other dimensions of talking about health-related behaviours; it is simply another way of presenting them, as another way of understanding, using and conceiving them.

4.4.3.2: Interview data: health-related behaviours as consumer activities

In this section, I clarify what kind of data I selected which incorporates my participants’ consumer meanings of health-related behaviours. The two main features, which determined the idea of consumer meanings for the data selection process, are: firstly, the central role of the participants’ perspectives; and secondly the symbolic manifestation of health-related behaviours (see section 3.6, p.76-78).
In order to ‘guide’ my data selection process, I use a baseline to determine ideas regarding consumer culture. As outlined in chapter 3, the idea of consumer culture is advanced in order to challenge the instrumental and/or material value of consumer products or activities as the exclusive reason for people to consume them. Consumption is not analysed here as the simple satisfaction of a biologically rooted set of needs, but rather as consumption which actively involves signs, symbols, ideas and values, which have a cultural ‘touchtone’ (Bocock, 1993). Correspondingly, I selected data in which young people referred to the symbolic exchange of these behaviours. I use three examples where I clarify the symbolic and the instrumental and/or the material dimension of health-related behaviours: specifically when the material dimension was challenged, ignored or was seen as a parallel to the symbolic.

I begin with an example of cases where the participants referred to the symbolic dimension of young people’s choices by challenging the material value of health-related behaviours as the main criterion of their own or others’ choices. For instance, most of the participants suggested that young people did not smoke because they are addicted or because they like its effects on the body. An ex-smoker described the ‘disgusting’ material consequences of smoking as unconvincing compared to its symbolic capacity ‘to show an image’.

Q  ‘Smoking?’
A  ‘Yes of course, surely, surely, yes. I used to smoke when I was at secondary school and then when I got transferred from that class, I really changed a lot as a character and I realised things because there is no meaning [pause]. Since I used to smoke, I know that nobody likes smoking when he tries it for the first time. It is disgusting, you smell awful, cough, you feel dizzy, and you get a stomach pain. There is nothing to say about smoking that makes you feel nice. If you are not addicted you do not want to smoke so whoever smoked once and continues he surely does it not because he likes it but in order to project an image.’ (Nicos, 16)

The second example demonstrates cases when the consumption of health-related behaviours was treated as a matter of their symbolic manifestation without necessarily devaluing their physiological or material effects. Dimitra characteristically explained the way that the adoption of exercise involved both physical and symbolic reasons. As
she explained, one might go to a gym in order to achieve a nice body, but the selection of the gym might be significant in terms of its symbolic dimension.

‘There are some people who exercise because they are athletic types and some who do it because they want to keep in shape. There also those who have enrolled at a gym just because it is famous. For instance, they want to exercise just to keep fit but they will not enrol at a gym that is convenient to them, but they will go to one that is miles away from their area just because high class people go there. These people are only “fashion victims” in my view.’ (Dimitra, 17)

Finally, there were also cases within the interview process when the consumer manifestation of health-related behaviours was mentioned as an embedded feature of the physical dimension of health-related behaviours. For instance, the female participant of the extract given below considered that those who exercise can be seen as well adjusted and integrated personalities who can function in their environments and consequently with the wider culture. Therefore, it seems that she understood physical activity not only as a way of maintaining a fit body, but also as a way of achieving a more flexible and attractive personality within dominant consumer meanings. A fit body appeared to be culturally understood as more presentable and desirable.

Q  ‘What does sport mean to you?’

A  ‘It has to do with the body. For instance, I have always had a body full of muscles and I know that I do not have a body full of fat. I have acquired a good body since my legs are full of muscles and I do some sports, I do a bit of weights… you do not feel constrained it makes you feel a bit liberated. You do not have the complexes that a person who does not do sports has. In my classroom, there are three girls, who practice sports daily. If you compare them with the others [girls] you will find that they go out, they eat whatever they want, they do not worry like others who do not exercise. They usually say: “I will take something light or what should I wear, or it is obvious that I am fat” but they might be thin. The way the bodies of people who exercise are, betrays the fact that they have been exercising, they do not care [laugh], they know that physically they are very good for instance.’

(Katerina, 16)

In the preceding examples, I determined ‘consumer meanings’ as they are explored in this research study, reflecting the participants’ interpretations of the cultural
manifestations of health-related behaviours within their social context. The emphasis -as shown in the above data extracts - is on the meanings produced by the participants as consumers through which they put those behaviours into practice within their everyday lives.

In the light of the above considerations, my analysis takes into account the participants’ consumer meanings up to the point that they themselves wanted to emphasise. My decisions regarding the process of selecting data, reflect the orientation of the analysis which is primarily concerned with how my participants make sense of the symbolic exchange of health-related behaviours within the context of their everyday lives. Yet, the process obtained in this study excludes other ways of identifying consumer meanings that need to be acknowledged.

Firstly, the participants’ perspective is not the only route to determining consumer meanings. The biography of the cultural dimension of the consumer products or activities involves a number of separate processes between the production and consumption, which lead to variable and contingent outcomes (Nixon, 1997). Secondly, it must be appreciated, as Lupton (1996) argues in relation to food consumption, that phenomena which are often understood to be largely biological such as hunger, are also products of the socio-cultural environment in which we are born. Indeed, in many cases I felt that the young respondents referred to hunger or nicotine addiction as a cultural rather than a biological assertion. Nevertheless, I do not expand on such conclusions in this study since the emphasis is on how the participants themselves view the consumer meanings of health-related behaviours.

Thirdly, consumer meanings can also be identified through an objective view of the participants’ accounts: the emphasis in this case is on what their accounts may imply rather than what they say. For instance, in some cases young women used the phrase ‘being mellow after a few drinks’ whereas boys used the expression ‘drunk’ without acknowledging the gendered dimension of drinking. In this case, as an analyst, I could have suggested that the degree of alcohol consumption is attributed to ‘male’ or ‘female’ images. However, this type of analysis is neglected in the present study since my main concern is to present the way that the participants view the consumer usage of the health-related behaviours. In short, I do not analyse the data as coded language
i.e. gendered language (such as the majority of young men like whisky and young women wine).

4.4.3.3 Coding strategies according to the three analytical categories

Below, I explain how I gathered and analysed the selected sets of data for each of the three categories (Symbolic, Role and Reflective). The coding concepts of grounded theory (Strauss and Corbin, 1990) are shown below in italics. Specifically, I use the same set of data for all the subsequent coding descriptions regarding the three categories. I show how this specific set of data is coded differently for each one.

Initially, I separated sets of data when participants pointed to the consumer meanings of health-related behaviours, as discussed in the above section. For each set of data I noted two types of information across all categories. These were the type of behaviour (first type of coding information), and the public sphere where different kinds of signification regarding health-related behaviours are activated (second type of coding information). The appropriation of the term ‘public sphere’ refers to certain settings (e.g. the symbols ‘existing’ at the Zoo club) or groups of people (e.g. symbols ‘existing’ among males in Cyprus). It also describes broad settings or groups according to the participants’ views such as the symbolic manifestation of health-related behaviours which ‘exist’ in Cyprus or among Cypriots. A third type of information was added for each category of analysis (Symbolic, Role and Reflective Categories) according to its aim. An example of these three types of information is given below (see table 4.2).

Q ‘Tell me about drinking.’

A ‘They might not know what they are drinking but they sit there and they ask the barman to offer them a drink. To show that they are cool they will have shots. I think at the time when I went it was cool to have shots. You were considered to be easy-going and perfect, if you could drink more than three even if you became drunk and they had to carry you home. In discos you are not given shots. They serve you whatever they find and you sit there and you drink and they consider it entertainment [pause] It does not matter to me.’ (Athina, 17)
Table 4.2: Coding procedures: example

<table>
<thead>
<tr>
<th>Coding categories</th>
<th>Examples of data</th>
</tr>
</thead>
<tbody>
<tr>
<td>First type: The type of behaviour</td>
<td>Drinking alcohol at the bar</td>
</tr>
<tr>
<td>Second type: The context</td>
<td>They/other people who go to the bars</td>
</tr>
<tr>
<td>Third type: In accordance to each category</td>
<td>A: ‘Cool’, ‘easy going’, ‘perfect’</td>
</tr>
<tr>
<td></td>
<td>B: ‘To show’, ‘you consider to be’</td>
</tr>
<tr>
<td></td>
<td>C: ‘It does not matter to me’</td>
</tr>
</tbody>
</table>

Firstly, I generated specifications regarding the type of behaviour (e.g. drinking alcohol at the bar) and then the context where the symbolic connection is activated (e.g. among young people who go to bars). The third type of information differs for each category of analysis. For the symbolic categories, I specified the content of the symbolic trait (‘cool’, ‘perfect’, ‘easy going’). For the role categories, I indicated the participants’ views concerning the role of the symbolic traits in their everyday lives (‘to show’, ‘you were considered to be’). The emphasis of the second category is on the capacity of smoking ‘to show’ something about the consumers’ personality rather than to ‘what’ it shows. With regard to the reflective categories, I noted the participants’ personal reflections on the consumer traits and their role (‘it does not matter to me’). The three types information for each category of analysis, are exemplified in table 4.2.

After the completion of the coding stage, I classified the gathered codified extracts into concepts according to the content of the third type of information given for each category. For instance, for the symbolic categories (A) the above set of data was classified into three concepts, which were ‘cool’, ‘easy going’ and ‘perfect’. These concepts were then classified together under a higher order (category). Each of the symbolic categories was defined according to the area that the symbolic association created. In relation to the above example, ‘cool’, ‘easy going’ and ‘perfect’ are classified under the same category labelled ‘Personal attributes’. I followed a similar procedure for the Role and the Reflective categories (see section 6.2 and section 7.2).
4.5 Conclusion

The discussion in this chapter was based on the two constituent elements of the study: focusing on consumer meanings and bypassing the health logic. Firstly, I explained how the principal features of the interviews allowed me as a researcher to create the space for the participants to talk about the consumer meanings of health-related behaviours within the context of their everyday lives. These principal features were: open-ended; one to one; and to allow the respondents to talk about their everyday experiences which determine their behavioural choices. Then I described the processes through which I have organised and interpreted the data gathered in order to escape from the health logic and concentrate on the perspectives of the participants regarding the consumer meanings of health-related behaviours. Special attention was paid in both research stages – data collection and analysis – to situate smoking, eating, drinking alcohol and exercise within the context of young people’s broader lives and cultures.

The participants’ consumer meanings were deployed in three analytical categories. The first -symbolic category- focuses on revealing the kinds of the embedded consumer traits associated with health-related behaviours (e.g. the quality of being ‘modern’). The second – role category – identifies the roles of these consumer traits at the level of young people’s everyday lives (e.g. their use in evaluating a self-image). The third – reflective category – demonstrates the reflections of the participants on the consumer traits and their role. In the following chapters (chapter 5, 6 and 7) the main findings of each analytical category (symbolic, role and reflective categories) are presented. The next chapter concentrates on the symbolic traits ascribed to health-related behaviours.
Chapter 5
Symbolic Categories

5.1 Introduction

The main task of this chapter is to describe the content of the symbolic traits attributed to health-related behaviours. This constitutes my first category of analysis of health-related behaviours as consumer activities (see section 4.4.2, p.117-119). The main point generated from the first category is that the consumer traits, which are inscribed by my participants in health-related behaviours, signify self- and/or life- style images, a theme, which is theoretically developed with respect to consumer products and activities (Bocock, 1993). The findings of this category are significant for the development of my main argument that health-related behaviours can entail consumer meanings which may have little to do with health in its biomedical perspective. It also acts as a baseline for the subsequent categories of the analysis.

This chapter consists of three sections. In the first, I summarise the three main symbolic categories and discuss the similarities and the differences among the participants’ inscribed self- and/or life- style images (section 5.2). Hereafter, I give examples of the different categories of symbols that are inscribed by the participants in health-related behaviours (sections 5.2.1, 5.2.2, 5.2.3). Then I comment on the role of context concerning the way that health-related behaviours could be interpreted as self- and/or life- style images (section 5.3). Finally, I concentrate on the participants’ accounts regarding fast food and healthy food as a small case study in order to enrich the analysis of the symbolic categories (section 5.4).

5.2 Symbolic Categories

The first category of analysis aims to show the meanings of the different types of consumer traits, which are inscribed in health-related behaviours by the participants. I
identified three *symbolic categories* through the coding system (see section 4.4.3.3, p.125-126), which focused on the type of symbolic trait that the participants ascribed to health-related behaviours. These categories and their main subcategories (shown in brackets) were defined according to the area that the consumer trait associated. I give extensive examples of each category in the following three sub-sections (5.2.1, 5.2.2, 5.2.3).

a. Personal attributes ('cool', 'easy-going', 'independent', 'daring' etc)
b. Socio-demographic characteristics (social class, gender, age etc)
c. Contemporariness: modern versus traditional ('old fashioned', 'traditional', 'progressive', 'to be in')

What connects these categories is that the consumer traits which are projected through health-related behaviours, signify multiple types of people and ways of living. Each category consists of a web of meanings, which can be described as consumer traits associated with health-related behaviours regarding different groups of people such as the 'young', 'male', 'traditional' and so forth. The idea of health-related behaviours as a means of projecting consumer traits with regard to people's lifestyles and identities are strongly associated with the idea of consumer culture (Bocock, 1993; Falk, 1994; Sarup, 1996a; Kellner, 1992). Correspondingly, the symbolic categories include the inscribed self- and/or life-style images in health-related behaviours suggested by my participants.

The participants talked about health-related behaviours as consumer activities, which have the capacity to be linked with a specific style of self and ways of living. It has been impossible to distinguish two clear-cut and separate categories regarding self and lifestyle. For instance, the term 'mature' implies both lifestyle (discussing your life, not expressing your feeling by drinking) and self-related traits (a serious and conservative personality) in the following set of data.

> 'Girls are more conservative, more serious and therefore more mature than boys. They do not have the need to express their feelings by

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63 My choice of the phrase self- and/or life-style images instead of identities and lifestyles is clarified in section 3.2, p.57-58.
drinking like boys do. They are mature enough as to go to a nice restaurant for a dinner and have a serious chat about their lives.’
(Georgia, 16)

The difficulty in separating lifestyles and self-styles emerged in the data analysis reinforcing theoretical ideas which stress the role of lifestyle practices on issues of identity within the context of consumption (Miles 2000; Featherstone, 1991; Sarup, 1996a; Chaney, 1996). ‘The highly flexible nature of consumption and the diversity of ways in which meanings can be endowed in consumer goods make it an ideal arena for the construction of identities through lifestyles’ (Miles, 2000, p.127). This is because I use the phrase self- and/or life- style images. Further discussion is provided in section 3.4.2, p. 67.

Interviewees referred to the consumer traits associated with health-related behaviours: not as independent or sole activities and irrelevant to other everyday practices. These consumer traits were rather seen as associated elements of a broader network of significations consisting of other activities such as dressing up, the choice of a club and an eating out place. In a way smoking, eating, drinking alcohol and exercise function as elements of a network of several chains of significations. For example, Dora associated clothing within drinking preferences and different types of people.

- ‘I can imagine a fat bloke with a beard, holding a glass of whisky and a tall, thin man in a suit, holding a glass of wine.’
- ‘A well dressed lady, in high heels, could be holding a glass of wine. An older woman in a suit holding a glass of whisky.’

(Dora, 16)

Another interviewee, Alexandros (17) combined clothes, eating habits and smoking habits as cultural indicators of the individuality and lifestyle of a specific group of people defined by himself as ‘boys in Nicosia who dress like gays’. Specifically, ‘non-smoking’ or ‘smoking only special brands such as Camel’, ‘cutting their food into little pieces and eating it slowly’ and ‘having the most gay looking attire’ were all discussed as more or less equal and supportive to each other as symbolic indicators for this specific group.
This stage of analysis is characterised by extensive similarities\textsuperscript{64} regarding the participants’ inscribed self- and/or life-style images\textsuperscript{65}. For instance, independently of their own personal reflections, none of them rejected the association between fast food and youth, pulses and ‘older generations’, or Marlboro with a laddish, masculine style and machismo within their socio-cultural context.

The participants’ common cultural experiences of living in Cyprus, sharing roughly similar cultural meanings, might have a relation to the prevailing level of homogeneity that appeared in the participants’ accounts regarding health related behaviours. These images are employed as cultural facts ‘out there’ rather than as being merely their personal ideas. The way that Hall (1997, p.2) uses the idea of culture sheds light on why the participants interpreted in a roughly similar way the consumer meanings of health-related behaviours in their social settings. ‘To say that two people belong to the same culture is to say that they interpret the world, in ways which will be understood by each other’. Thus, the participants who had a specific culture as a point of reference interpreted the consumer traits which relate to health-related behaviours in broadly similar ways. This common understanding acts as a cultural base for the participants to communicate via the generated meanings associated with health-related behaviours. The capacity of someone to convey cultural meanings to other people relies on the fact that they can be de-coded and read in similar ways. This notion of culture is vividly expressed in Elena’s words.

\textit{‘The difference, though between smoking Marlboro or Silk Cut exists, just because the rest of the people believe there is a difference. The Marlboros are boyish cigarettes and Silk Cuts are girlish... It is the notion of that girls cannot handle strong or heavy things, so automatically, those things are associated with boys.’} (Elena, 15)

Nevertheless, within the ‘boundaries’ of a broadly common understanding, there is also diversity in the participants’ interpretations. Next, I highlight some cases in which

\textsuperscript{64} It is of note however that the qualitative nature of the interviews does not allow me to make detailed comparisons in regard to the content of the consumer accounts of the participants since a number of themes did not appear in all the conversations. Nevertheless, I can make some observations based on ones which were discussed amongst all or at least at the majority of the interviewees such as smoking and youth (see also section 8.3, p.231).

\textsuperscript{65} Here, I do not refer to any differences or similarities, which are detected in their personal reflections in regard to the consumer meanings of health-related behaviours: a case, which is analysed in chapter 7. I refer to the participants’ estimations of the consumer traits associated with health-related behaviours.
the participants seemed to disagree about the ‘prevailing’ consumer traits with respect to certain health-related behaviours. The list below shows the participants’ self and/or life-style images ascribed to a young smoker.

- ‘macho’
- ‘weak’
- ‘popular’
- ‘relaxed’
- ‘smooth’
- ‘cool’
- ‘good looking’
- ‘real lads’
- ‘risky’
- ‘independent’
- ‘trendy’
- ‘mature’
- ‘elegant’
- ‘chic’
- ‘stupid’
- ‘brave’

My participants used the above self-images both positively and negatively. Similar contradictions were found in my participants’ consumer meanings regarding exercise. For instance, aerobics was characterised either as

- ‘great’
- ‘fashionable’
- ‘liberating’
- ‘stylish’
- ‘showing independence’
- ‘dynamic’

or as a type of exercise for

‘...stupid girls who have money to spend and they believe that with aerobics they will loose 10 kilos in one week.’ (Manos, 15)

‘...weak people who do not have strong will in order to be athletes.’ (Dimos, 16)

The above examples show the dynamic and often contradictory consumer traits that the participants ascribed to these behaviours resulting from subjective interpretations. The plurality of the participants’ interpretations highlight their active role not only in terms of their personal reflections but also as translators, constructors and mediators of the cultural manifestation of health-related behaviours.
Next, I elaborate each symbolic category: Personal attributes, Socio-demographic characteristics and Contemporariness. The presentation of each category seeks to give a sample of the various types of consumer traits associated with health-related behaviours as employed by the participants. My intention here is not to arrive at rigidly fixed conclusions concerning the content of the symbolic categories (e.g. smoking equals with 'independence') but rather to give a qualitative shifting picture of each category. As shown above, this stage of analysis is characterised both by similarities and differences in the way that the participants 'translate' the prevailing consumer traits regarding health-related behaviours. Moreover, it should be noted these three symbolic categories are not clear-cut but tend to overlap. For instance, what it means to be 'cool' is determined via the other categories such as, something which is 'youthful', 'fashionable', 'modern' and 'high class'. However, the separate presentation aims to give a flavour of the different sorts of self- and/or life-style associations suggested by the participants regarding health-related behaviours as consumer activities.

5.2.1 Personal Attributes

The first category, personal attributes, is concerned with the capacity of certain health-related behaviours to convey self- and/or life-style images associated with personal 'character'. I labelled this category 'personal attributes' since it consists of certain characteristics of the individual's personality (such as 'easy-going') rather than of other socio-demographic standard characteristics (such as 'high' or 'low class' etc). Through the interviewing process, the participants named personal attributes invested in health-related behaviours as they experienced them when they go clubbing, when they see friends in a coffee shop and when they eat something in a fast food place. They linked personal traits such as 'cool', 'risky', 'independent' and 'tough' with the choice or the rejection of certain health-related behaviour. The following table (5.1) illustrates some of the participants' accounts concerning the prevalence of self- and/or life-style images with regard to health-related behaviours. The bold data extracts, indicate the types of personal attributes that participants inscribed in certain health-related behaviours.
Table 5.1: Personal Attributes: examples from coded segments of data

<table>
<thead>
<tr>
<th>Smoking</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>‘When you play backgammon with your friends and you hold a cigarette in the other hand you show that you are <strong>different, relaxed</strong>.’ (Manos, 15)</td>
<td></td>
</tr>
<tr>
<td>‘They [smokers] are real <strong>lads</strong>.’ (Ifigenia, 16)</td>
<td></td>
</tr>
<tr>
<td>‘They [smokers] do not have <strong>strong will</strong>.’ (Georgia, 16)</td>
<td></td>
</tr>
<tr>
<td>‘They [smokers] are not like the others who always do what they are told, who study very hard [pause] <strong>nerds. They are crazy</strong>.’ (Theodoros, 15).</td>
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</tr>
<tr>
<td>‘They are the <strong>organisers</strong> of the group of friends [pause] the ones who say “come on, let’s go there, let’s do this”’. (Markos, 15)</td>
<td></td>
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<tr>
<td>‘You are almost like a <strong>tramp</strong>.’ (Adamos, 15)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Eating</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>‘If someone goes to Kentucky on Tuesdays he feels <strong>free and independent</strong>.’ (Theodoros, 15)</td>
<td></td>
</tr>
<tr>
<td>‘They only say that they have special preferences just to be <strong>different</strong>.’ (Alexandros, 17)</td>
<td></td>
</tr>
<tr>
<td>‘The one who prefers the home-made food can not be <strong>advanced or cool</strong>.’ (Natalia, 15)</td>
<td></td>
</tr>
<tr>
<td>‘The one who eats healthy food will be more of a <strong>dumb</strong> person.’ (Dimitra, 17)</td>
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</table>

<table>
<thead>
<tr>
<th>Drinking alcohol</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>‘They are, especially, after the image of looking <strong>cool, tough</strong> whilst holding a glass of alcohol.’ (Yiannos, 16)</td>
<td></td>
</tr>
<tr>
<td>‘That you are macho, <strong>cool, easygoing</strong>.’ (Ifigenia, 16)</td>
<td></td>
</tr>
<tr>
<td>‘I notice that some young people of my age hold their drink for a long time [pause] some of them ask for colourful or strange drinks, they may show that they know, they are in, <strong>cool, independent</strong>... they are strong enough, they are drinkers [pause] you know.’ (Panagiwta, 16)</td>
<td></td>
</tr>
<tr>
<td>‘You show off that you got drunk and acted <strong>crazy</strong>.’ (Liza, 15)</td>
<td></td>
</tr>
<tr>
<td>‘They will be very descriptive about the amount and kind of alcohol that they had. They will then say how they vomited and did all sorts of crazy things. They want to give the impression that they are <strong>crazy</strong> party animals.’ (Dora., 16)</td>
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<table>
<thead>
<tr>
<th>Exercise</th>
<th></th>
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<tbody>
<tr>
<td>‘It makes me feel <strong>special</strong> [handball].’ (Dimos, 16)</td>
<td></td>
</tr>
<tr>
<td>‘I do not go to the gym. If I say that I do, I will show that I am <strong>cool, independent</strong>.’ (Natalia, 15)</td>
<td></td>
</tr>
<tr>
<td>‘Going to the gym is back in fashion. The person who says he goes to the gym looks <strong>cool</strong> and <strong>dynamic</strong>.’ (Fotos, 16)</td>
<td></td>
</tr>
<tr>
<td>‘Being an athlete, means that you are a <strong>calm and kind</strong> person, you have all the good qualities of an athlete. You have more <strong>discipline in your life</strong>.’ (Georgia, 16)</td>
<td></td>
</tr>
<tr>
<td>‘I have a friend who is very good in high-jump and also came first among the Greek nation. He is <strong>popular</strong>. I can see how satisfied he is. Even though, he is not good at all in other subjects, he is pleased with himself because he has put his talent to good use and reached high achievements. He has <strong>strong will</strong>.’ (Elena, 15)</td>
<td></td>
</tr>
<tr>
<td>‘I can picture a <strong>dynamic, independent</strong> girl who enjoys exercising and goes to aerobic sessions.’ (Maria, 17)</td>
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</table>

The game of imagination, represented here, is remarkable since it demonstrates the possibility to be considered ‘**crazy**’, to be imagined as ‘**cool**’, to be viewed as ‘**mature**’
and ‘independent’ through certain health-related behaviours. To be ‘cool’, ‘independent’, ‘easygoing’, ‘dumb’, and ‘nerd’ were the most common personal attributes, which were referred by the participants. The popularity of these personal attributes relies on their connection to what they estimated as youthful or not: an issue, which was extensively discussed in the conversations. With respect to health-related behaviours, going to the gym, eating home-made food, eating fast food, drinking alcohol or smoking at a bar in the presence of other young people were also the most common activities that they associated them with personal attributes.

Next, I elaborate ‘coolness’ - a dominant description appearing in all the interviews – in order to give a more extensive illustration of how the participants made links between health-related behaviours and personal attributes. Certain foods, alcoholic drinks and brands of cigarettes are scaled and marked as ‘cool’ and not ‘cool’. ‘Cool’ products or activities are those which are frequently consumed and advertised amongst youth culture. Below, I list health-related consumer products or activities which were labelled by my participants as ‘cool’ (table, 5.2).

**Table 5.2: Cool products and activities: examples from coded segments of data**

<table>
<thead>
<tr>
<th>Smoking</th>
<th>Eating</th>
<th>Drinking alcohol</th>
<th>Exercise</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Marlboro’</td>
<td>‘hamburgers’</td>
<td>‘Vodka’</td>
<td>‘skating’</td>
</tr>
<tr>
<td>‘Silk Cut’</td>
<td>‘pizzas’</td>
<td>‘shots’</td>
<td>‘riding a bike on one wheel outside a crowed disco’</td>
</tr>
<tr>
<td>‘smoking in front of girls’</td>
<td>‘Macdonald’s’</td>
<td>‘holding a glass of alcohol’</td>
<td>‘lifting weights’</td>
</tr>
<tr>
<td>‘asking for a lighter’</td>
<td>‘Kentucky Fried Chicken’</td>
<td>‘getting drunk’</td>
<td>‘dancing on your own’</td>
</tr>
<tr>
<td>‘blowing smoke rings’</td>
<td>‘having a croissant at a coffee shop’</td>
<td>‘drinking alcohol from the same jar’</td>
<td>‘announcing to girls that you go to aerobic classes’</td>
</tr>
</tbody>
</table>

Smoking, eating fast food, drinking alcohol in public spaces among other young people and exercise at a gym were the most frequently mentioned practices which have the capacity to give the impression of a ‘laid-back’ image, a ‘cool’ image. These three activities as cool ones were a prominent theme emerging through almost all conversations. Despina (15) promoted the idea, through young people’s experiences, that cool images made these activities very similar to each other. However, as she
argued, these three activities are very different if someone considers their health-related qualities, an aspect which is irrelevant to the day-to-day experiences of young people.

A ‘They would do something according to whether it is cool or not. If there was an option of something being healthy but not cool they would not have chosen to do it. The only healthy thing they do is go to the gym and they only do it because it is cool and not because it is healthy.’

Q ‘Could you elaborate on this?’

A ‘Young people do not choose their options because of health reasons, because it is good for them but because it is cool. They do things to make an impression on others. This is why they smoke, drink alcohol or go to the gym, which is the only positive of the three.’

Q ‘Does doing something unhealthy encourage people to do it?’

A ‘I do not think that they might do something just because it is unhealthy. For instance they like to smoke and go to the gym. They do things because they are cool. Nowadays, whatever is considered cool, is good for young people.’

The participants defined the idea of being ‘cool’ through other personal and lifestyle traits such as ‘fashionable’, ‘in’, ‘attractive’, ‘independent’, ‘modern’ and ‘casual’; personal attributes are explicitly or implicitly connected with what is typically connected with youth culture. Similarly, Miller (1997) states that the image of being ‘cool’ seems to be associated with modern values like independence and autonomy, which are highly valued amongst young people. The following examples show how the ‘cool’ image is interconnected with other personal attributes, which are shown in bold.

- ‘When you have delivery food you show a different character, more outgoing and attractive than having home-made food prepared by your mum or grandmother. You give evidence of a person has a degree of independence and does not depend that much on his family; you look cooler.’ (Despina, 15)

- ‘When the first one started smoking the others thought of him as being cool, crazy and we followed in his steps. I now think that not smoking is fashionable.’ (Alexandros, 17)

- ‘Saying that I had a type of food that is in would make me feel that I belong in that cool group of people.’ (Liza, 15)
‘Cool’ products or activities are consequently considered as acceptable and edible in the youth culture, as indications of a ‘cool’ style. The following examples show the normative character of these personal attributes connected with the indication of a ‘cool’ style. Deliberately, I choose specific data segments where the young interviewees refer to certain health-related behaviours as indications of a ‘cool’ style for a young person in Cyprus independently of their own private estimations. Dimitra agrees with the association between fast food and a ‘cool’ image as understood by ‘the majority of the young people’. While Yiannos accepts the prevailing association between smoking and alcohol drinking with a ‘cool’ image, he is totally opposed to the idea; a position, which was primarily expressed through his facial expression.

- ‘A person who prefers home-made food cannot be superior or cool. The majority of young people will think of the person who likes the ready-made food as cool and more modern.’ (Dimitra, 17)
- ‘They sit at the bar, drinking slowly-slowly their drink, holding the glass with the edge of their fingers, checking their mobiles; and they consider it fun simply because the others watch them and they think that they are so cool behaving like that.’ (Yiannos, 16)

### 5.2.2 Socio-demographic characteristics

The next category - socio-demographic characteristics - emerges from the participants’ consumer associations between health-related behaviours and people’s socio-demographic status as a cultural phenomenon. It deals with the participants’ perceptions of the ways that socio-demographic characteristics are culturally represented via the consumption of certain health-related behaviours. According to them, a health-related behaviour can project images which convey socio-demographic features. A ‘high-class’ person rather than a ‘working class’ person or a ‘woman’ rather than a ‘man’ is associated with different types of health-related behaviours. These types of associations concern the participants’ cultural imagined features of how the socio-demographic characteristics of people are manifested through their health-related choices.
Social class, gender and the stage of life were the most frequent socio-demographic subcategories expressed by the participants. Others, such as place of living, political orientation and ethnicity, received less attention within the conversations. I can only argue with caution that class, gender and stage of living are issues which seem to preoccupy most of the participants when they talked about their everyday experiences.

In the following table (5.3), I exemplify a sample of consumer traits associated by the participants for the most frequent sub-categories (see above). Primarily, emphasis is given to the type of consumer traits which emerged more frequently in the data. What needs to be reiterated is that the three sub-categories were constructed based on the participants’ cultural understandings regarding these groups of people (such as ‘young’ and ‘high class’) rather than on any ‘objective’ social categorisation (such as defining high class with respect to social and economic status).

Table 5.3: Socio-demographic characteristics: examples from coded segments of data

<table>
<thead>
<tr>
<th>Stage of life</th>
<th></th>
<th></th>
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</tr>
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<tbody>
<tr>
<td>1.1 ‘Smoking makes you feel that you are grown-up.’ (Fotos, 16)</td>
<td>1.2 ‘I know people who might feel embarrassed to have a milk-shake, because it contains milk. They associate it with being a baby.’ (Maria, 17)</td>
<td>1.3 ‘If your mum is cooking for you, it makes you feel of a younger age.’ (Adamos, 15)</td>
<td>1.4 ‘Now at the age of seventeen we might order a bigger portion because it is more suited to our age. We still eat casual food like pizza, but we have a better time going out to a restaurant for some chicken or a steak [pause] It is now obvious that we have grown older and our taste is different. We do more substantial things than for instance just have a pizza for dinner [pause] It shows maturity, being older.’ (Nausika, 17)</td>
</tr>
<tr>
<td>2.1 ‘Those who go to the gym show that they have more money than others.’ (Natalia, 15)</td>
<td>2.2 ‘They might smoke Winston or Camel. Expensive brands. They want others to think that they belong to a higher class.’ (Yiannos, 16)</td>
<td>2.3 ‘At the gym, because they all know that they pay to be there, makes them big-headed.’ (Panagiwta, 16)</td>
<td>2.4 ‘Take-away food might show that someone is well off. It shows that they can have ready-made food from the canteen every day, without having to save money by bringing food from home. The others might then think, that someone is poor or that his parents do not give him enough pocket money to eat out.’ (Elena, 15)</td>
</tr>
<tr>
<td>3.1 ‘Wine makes a lady look chic.’ (Maria, 17)</td>
<td>3.2 ‘It is more a boy’s thing to have whisky.’ (Georgia, 16)</td>
<td>3.3 ‘The Marlboros are boyish cigarettes and Silk Cuts are girlish.’ (Fotos, 16)</td>
<td>3.4 ‘Boys eat a lot, girls eat very little or nothing.’ (Ifigenia, 16)</td>
</tr>
</tbody>
</table>
The participants discussed health-related behaviours as cultural indicators in association with different life phases, social class scales and gender identities. The first sub-category ‘stages of life’ stemmed from the respondents’ associations between life-course stages and certain kinds of health-related behaviour. In the above examples, the participants viewed smoking as a ‘grown up’ activity (1.1) and drinking milk or eating mum’s food as a ‘childish’ one (1.2, 1.3). Participants also made even more subtle distinctions in order to mark shifts from different age-grade boundaries. As shown in the last example the respondent demarcated ‘younger’ groups based on her eating out choices (1.4).

Regarding the second sub-category ‘social class’, ‘high-class people’ were the most frequently mentioned by the participants. As shown above, high-class people were culturally associated with activities such as smoking expensive cigarettes brands (2.2), eating take-away (2.4) and joining a gym (2.1, 2.3). These activities were treated as a sign of a ‘high-class’ status. The third subgroup concerns consumer traits associated with gender identities. Being ‘male’ or ‘female’ means following certain choices, which coincide with general cultural norms of what is socially understood to be a ‘man’ or a ‘woman’, a ‘boy’ or a ‘girl’. Certain types of behaviour are considered masculine (Marlboros, Whiskey and large quantities of food) and most of the time their ‘opposites’ as feminine (wine, Silk Cut and small dishes).

5.2.3 Contemporariness

The last category – contemporariness - refers to the way young people make sense of ‘time’ as it is distinguished in conventional categories of the modern versus tradition and the signification that each epoch represents. Certain health-related behaviours were labelled ‘fashionable’, ‘modern’ and ‘in’, whereas others were viewed as ‘traditional’, ‘old-fashioned’ or simply ‘out of fashion’. The former group was associated with ‘our times’, ‘technology’, ‘foreign cultures’, ‘the new generation’, ‘progress’ ‘today’s belief’, whereas the latter were associated with ‘the old generation’, ‘village life’, ‘a conservative attitude’, and ‘grandparents’. All participants’ accounts of certain health-related behaviours were informed by such types of binary oppositions: fast food versus home-made food; Macdonald’s versus
pulses; Coke versus 7Up; Marlboro Light versus Rothmans; and going to the gym versus not caring about your body. In table 5.4, I classify a sample of accounts given by the participants into two categories: ‘modern-fashionable’ and ‘traditional-old-fashioned’

<table>
<thead>
<tr>
<th>‘Modern – fashionable’</th>
<th>‘Traditional – old-fashioned’</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘YES, YES the Mac style is more modern. It is more in, modern for young people. Basically they copy a different culture, which basically the Americans brought.’ (Athina, 17)</td>
<td>‘[eating lentils] you imitate the old generation and not finding out how many cool things have emerged nowadays. So they say: “Are you going to eat lentils?”.’ (Despina, 15)</td>
</tr>
<tr>
<td>‘They think that just because they are smokers they are automatically fashionable as well.’ (Natalia, 15)</td>
<td>‘Tradition basically. Whenever I go to a tavern I have to order humous. It is impossible not to have humous on my table and village salad.’ (Athina, 17)</td>
</tr>
<tr>
<td>‘Coke is more established among the youngsters. Again, is a matter of fashion.’ (Fotos, 16)</td>
<td>‘It is not suitable to ask a girl out to go and eat boiled potatoes, for instance. If you do that you will seem to be old-fashioned.’ (Manos, 15)</td>
</tr>
<tr>
<td>‘Going to the gym is back in fashion. People, nowadays, have realised that it is important to maintain a good body. It is also insulting for someone to go to the beach, nowadays without having a good body. It is good to have a fairly firm body.’ (Athos, 15)</td>
<td>‘If you see someone smoking Rothmans you will think of it as odd. It is out of fashion.’ (Liza, 15)</td>
</tr>
<tr>
<td>‘In order to be modern, you have to be a smoker, go out every single Friday and Saturday, be a drinker, go clubbing, and go home at five in the morning.’ (Theodoros, 15)</td>
<td>‘My grand mother drinks 7Up.’ (Adamos, 15)</td>
</tr>
<tr>
<td>‘Having ouzo at a bar. No this does not belong in our times. This belongs to tavern and older people.’ (Andreas, 16)</td>
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</table>

The choice of fast food, instead of home-made food, and particularly pulses, was one of the most frequent distinctions generated in nearly all the conversations. The exchange presented below is used here as an example of the way that health-related behaviours, and in this case eating habits, were elaborated by Despina, as representations of ‘time’ and why she considered it more positive to announce to her classmates that she had fast food instead of home-made food for dinner.

Q ‘Explain the “positive way”.’
A  ‘I simply go with the flow of my era and I do not confine myself to eating beans for instance. That is a “no-no” for our times. I am a follower of today’s belief. Young people today believe in eating in Pizza Hut, hamburgers, etc [pause] this shows that I am “in” and not cut off from the rest.’

Q  ‘How do you explain “the flow of the era”?’

A  ‘One should not bother too much about one’s family. He/she should spend time with his friends, cafes, music, computers. You should never have beans, but you should go clubbing. No one would ever mention that he, for instance, went on a picnic with his mum or mention anything else considering his family.’ (Despina, 15)

This exchange eloquently demonstrates how the participant distinguished ‘time’ as a dynamic and modern present or as an old fashioned past, and how eating habits are symbolically involved in these time concepts. In this polarisation, Despina stood on the side of the present; she found herself compatible with it and seemed to enjoy new technologies and its products through ‘modern’ food like pizza and hamburgers. Pulses, on the contrary, were labelled as ‘old-fashioned’ types of food and therefore incompatible with modern times. She chose the former since she considered herself a ‘follower of today’s belief’ and she refused to choose the latter since it might be not related to ‘our times’.

Pulses and fast food are not the single elements of the case, they are rather a link in the chain. They are part of a web of everyday practices associated with meanings, which pertain to certain generations. According to Despina, ‘fast food’ was connected within the lives of young people such as going out, having fun, clubbing or being with a friend. The list of the new generation’s activities could be extended through other participants’ accounts of how young people follow the trends of their time, the ‘must’ of their era. These are, for example, ‘staying awake until late’, ‘being up-dated about music trends’, ‘using new technologies’, ‘communicating through text messages’, ‘using email’, ‘chatting on the internet’ and so on. As Despina implies, families and older generations and correspondingly ‘pulses’ are alienating from these practices and they, as young people, are privileged to engage in these actions. Therefore, if they want to follow the trends of their times, they should avoid doing ‘traditional’ things with the family and relatives like ‘going on an excursion to the country side’ or ‘eating beans and lentils’. 
5.3 The role of context in the symbolic categories

In the preceding sections, I identified three types of symbolic categories associated with smoking, eating, drinking alcohol and exercise from the vantage of the participants’ concerns. In the present section, I discuss the way that the young people understand the impact of the surrounding circumstances on the inscribed self- and/or life-style images. For this purpose, I use Strauss and Corbin’s (1990) concept of ‘context’, defined as the underlying presuppositions that pertain to a phenomenon. The emphasis here is on the young people’s suggestions of the role of the context regarding the consumer attributes ascribed to smoking, eating, drinking alcohol and exercise. Through their ideas I stress the complexity of consumer meanings, by highlighting how these behaviours might be connected with different self- and/or life-style images under different sets of conditions.

The analysis in this section is based on the second type of information of the code note taken for each set of data, which was selected for all categories of analysis. As shown in section (4.4.3.3, p.125-127), the second type of information of a code note refers to the surrounding context where different kinds of consumer meanings regarding health-related behaviours are activated. Two main tendencies appeared with respect to the second code note of the analysis: the participants either made some broad generalisations or referred in detail to the contextual presuppositions regarding the consumer traits inscribed in health-related behaviours.

In the first case, they tend to make stereotypical judgements by associating certain health-related products or activities with fixed self- and/or life-style images. Hall (1997) identifies stereotyping as a process whereby people are reduced to a few, simple, essential characteristics which are represented as fixed by nature. The participants made these sorts of association without any detailed comments on the context in which their suggested consumer traits could be activated. ‘It is considered’, ‘all young people’, ‘most young people’ or ‘they’ - referring to young people - were typical statements in their accounts. The interviewees perceived stereotyping as part of the symbolic process that enables consumer traits to be attributed to unknown groups of people. Stereotyping, through the symbolic manifestation of health-related products,
appeared here as a constitutive element of youth culture as a ‘shared stock of meanings’ which reinforces communication among its members (see also section 5.2, p.131 and section 3.2, p.54-55). The examples below demonstrate how some of these stereotypical connections emerged in the participants accounts.

- ‘That person, is then considered to be mummy’s boy because a teenager is not expected to drink juice in a bar or a club.’ (Adamos, 15)
- ‘That is how young people see it. A pizza is more in. Young people include food in fashion. They consider a pizza as being cool, in. It is the same with hamburgers.’ (Natalia, 15)
- ‘Most of them, the ones who do not consider cigarette as cool are the minority, because most of them believe that if you smoke you stop being dependent on your parents.’ (Dimitra, 17)
- ‘If you smoke, you are not considered a mammy’s boy, you are constantly down town.’ (Markos, 15)
- ‘Young people consider them [non-drinkers] as inferior.’ (Fotos, 16)
- ‘Many, consider vodka as fashionable.’ (Ifigenia, 16)
- ‘Aerobics are considered to be more of a woman’s thing, because you do not build up muscles with it. You loose fat. But men, in order to look macho, do weight lifting. It is considered a woman’s thing.’ (Dora, 16)

Unlike the above data segments, at other points of the interviewing process nearly all of the participants emphasized the multidimensional character of a consumer trait that is open to change according to the particularity and the specificity of a situation. They gave detailed contextual descriptions regarding when consumer traits of health-related behaviours were activated and how they were de-coded. Two main contextual factors were primarily identified. The first concerns the space and the second the type of people who are present, features which are interconnected, since the people who regularly use a certain space constitute its main features such as home and family members.

Nearly all the participants highlighted the importance of the space by comparing how differently consumer traits attributed to health-related behaviours can be interpreted. One of the respondents explains:
‘Pizza, hamburgers like at the ‘Big Boy’ [fast-food chain], to do something that is “in”, both boys and girls are going to eat fast food, or food from abroad, like Kenny Roger. When a young person says, I went to Kentucky Fried, it indicates a style. Simply because you went somewhere pleasant and you ate something pleasing. It has to do with the location.’ (Theodoros 15)

The following example concerned the different consumer traits imputed to eating outside in a going out activity compared with someone’s home.

‘Young people like whatever has been advertised or been dished out to them. They never wonder whether something is healthy or not. When they are at home and their parents prepare their food, they will eat it. They will not think that they should not consume the food because it is not cool. They will eat it at home but when they are with their friends they become entirely different people. It is as if they put on a mask and they behave entirely differently.’ (Athina, 17)

In the above extract, it becomes clear that young people’s consumer interpretations may shift positions according to the place where the eating practice is activated. Athina suggested that the consumer trait attributed to certain foods is insignificant in the family space: such as food as ‘cool’ or not. As she commented, young people considered eating at home as a practical activity where there was not much choice or where food was mainly seen as a way of satisfying someone’s hunger. On the contrary, in a ‘going out’ space accompanied usually by friends, food was ascribed by consumer attributes projected in the eyes of their friends. Therefore, the participant chose the word ‘mask’ to show how young people’s performances might vary according to where they are. What, however, remained unexplored is whether eating at home with family, favours other consumer traits over ‘cool’ or whether the image of being ‘cool’ is simply irrelevant. The ritualistic element of eating at home with parents at specific times might hold its cultural significance; however, the above respondent did not appear to comment at all on this dimension.

The presence or absence of significant others, whether these are just close friends or boyfriends or girlfriends, or simply friends, may by itself constitute the nature of the ascribed consumer traits associated with a certain health-related behaviour. The
presence of people seems to operate as a significant cultural frame, which activates certain consumer traits as opposed to others. For instance, some of the participants stated that the gaze of the opposite sex influences the personality trait connected to their actions. As the following quotations demonstrate, the consumer traits ascribed to girls’ food options change completely in the presence of boys:

- ‘When there are only girls [pause] they choose the lightest choice. Whereas when boys are there, there is no way of commenting on diet issues, they will choose even a fatty pizza, saying to a male: “I am with you”.’ (Dimitra, 17)

- ‘If boys were with us, they would have considered it weird if we had home-made food.’ (Ifigenia, 16)

Both exchanges were taken from a conversation with two women who suggested that different consumer traits connected to food choices are dominate among a group which consists only of women compared to the one which includes men. As described in the first example, young women would choose the lightest choice when they are with female friends since a masculine presence is absent to interfere in their choices. In the presence of boys they choose something that is acceptable in a masculine culture where disregard for the pursuit of low fat products may be perceived as a positive value. At the same time their preference for a light meal while being with female friends was associated with ‘girly’ consumer traits such as ‘caring about your body’, ‘eating light’ and ‘being slim’. Ifigenia made it clear how home-made food received different consumer meanings according to gender.

The next example concerns the role of the style of a group of friends regarding the consumer traits attributed to certain dishes as opposed to others. This point was explicitly made by Nicos regarding the choice of boiled potatoes instead of fried for health reasons. For a certain style of the group, if you choose to go for the healthy option you might be subjected to laughter and criticism, while going for the unhealthy one, you are considered ‘young’, a follower of ‘modern’ times and proving to ignore the ‘boring’ and ‘paternalistic’ advice of healthy eating.

‘Perhaps, due to the fact that to order boiled potatoes which is something healthy rather than something which is not healthy [pause] you give an impression that you care, for instance, and you are afraid
that something will happen to you, so they might make fun of you that you are afraid and you worry about your health. They might say that: “We are young and we do not care about all these things”.’ (Nicos, 16)

On the contrary, there are groups of people who might prefer the healthier choice since it enacts a sophisticated and cultured way of living.

‘There might be some groups of friends, who are more “cultured” or “sophisticated”, all of them eat healthy food, and for them it would be strange to eat. The odd meal within this group will be fried potatoes or something harmful. It depends on the group of friends that you are with.’ (Nicos, 16)

The last example, with respect to the impact of the context, concerns the different consumer interpretations of the smoking behaviour within two different clubs in Nicosia. It shows how the space ‘defines’ the personality traits of the people who participate in smoking activity. At the same time, space is defined by the kind of people who happen to hang around a particular place. The complex interaction between a space and the type of people seems to create a cultural framework where smoking is symbolically understood.

A ‘It is the same for both places. None of the two places is non-smoking.’

Q ‘Do you find that smoking is done in a different style at the two places?’

A ‘Yes. Most people at Factory do it to show off, because they combine drinking with smoking and dancing. The same happens at Enallax. They combine the style of the songs with smoking. There are many people from my group, who many times, when we go to Enallax will definitely smoke. Even though, they might not smoke if we go to a café.’

Q ‘Does, then, smoking a cigarette acquire a different meaning?’

A ‘If you notice people in clubs, the way they hold a cigarette in their hands, the way they show off and share the cigarette is different. In Enallax you smoke as normal. I see a difference between the two.’

Q ‘What does the way people smoke, in Factory, show?’

A ‘It shows that you are cool and mostly boys, who are seen with their girlfriends in their arms, show that they are grown ups, mature men. In Enallax, things are calmer. You do not have to show that you
are cool. Being cool has a different meaning. We do not use the word cool that much.’

Q ‘What else?’

A ‘Having your arms around your girlfriend is not suited to the place. Holding a girl and dancing, in order to show off is not suited to the place. It is a more serious place.’ (Katerina, 16)

Katerina made a clear distinction between the two clubs. At ‘Factory’ young people pay more attention to stereotypical images of being ‘macho’ and ‘mature’ with a ‘laddish’ style, while at Enallax people are ‘calmer’ and more ‘sophisticated’. The first sounds more mainstream and the latter more alternative. Besides, the name of the second club means a different place, an alternative place. At both clubs, as she suggested, smoking maintained its symbolic value. However, smoking can be subjected to different consumer investments in each place. The first club, is associated with a more ‘masculine’ and mainstream (heterosexual) behaviour where smoking and ‘having your arms around your girlfriend’ appear as positive images; an admirable situation where a male clubber shows energy and an ‘active’ and ‘dynamic’ lifestyle. By contrast, in the second club, even though young people still smoke they do not need to exhibit the above practices since, as she noted, the atmosphere of that place is completely different. Smoking at Enallax was considered a more ‘natural’ activity rather than as an occasion to show off.

5.4 Case study of consumer meanings regarding ‘healthy food’ and ‘fast food’

In this section, I concentrate on the participants’ accounts regarding fast food and healthy food, which I purposefully use as a small-scale case study in order to enrich the analysis of symbolic categories (Stake, 1998). So far, I have explored the relationship between a health-related behaviour and a symbolic trait. In this section, I associate this sort of relationship with the participants’ ways of seeing youth operating within their socio-cultural context. Moreover, I exemplify using eating choices how health, as something (a value or a warning) added to these behaviours, may change the participants’ inscribed consumer traits associated with health-related behaviours. Lastly, I make comparisons with other studies concerning young people’s accounts
about eating choices, developed on the grounds of health promotion, in order to show how the health logic intervenes in their findings.

In the present study, broad agreement is identified in considering fast food very much as part of young people’s lives. Both those who employ ‘youthful’ habits as well as those who do not follow such habits, agree that fast food is popular among young people. Comments such as ‘youth of my age only take, take-away things to eat’ (Panagiwta, 16) and ‘these kinds of food have now been established as the food most young people eat’ (Ifigenia, 16) are typical. As opposed to fast food, healthy eating is negatively connected with young people. When I asked how a young person is viewed if he/she chooses something healthy the participants’ responses were as follow: ‘At this age, you do not care much about the ingredients in the food you eat’ (Theodoros, 15); and ‘people of my age do not care about what they eat’ (Dimos, 16). The vast majority of the participants described others’ reactions towards a young person who adopts a healthy choice, in a very similar way as in the next answer: ‘Oh [pause] that person will be laughed at. They will start saying: come on, why do you pay attention to health and why do you even care. This is the style most of them have’ (Stelios, 16).

The question as to why fast food (as opposed to healthy) is connected with youthful style, preoccupied many of my respondents during the interviews. Only a small minority failed to give reasons why fast food and not healthy food are popular among young people. Firstly, cost, availability and time were suggested as possible reasons for their popularity.

- ‘They are made fast [pause] and whenever you look there is a shop.’ (Stelios, 16)
- ‘...very good delivery services’ (Dimitra, 17)
- ‘Pizza is cheap. You pay significantly less especially if you divide the bill with friends it is about £1.50.’ (Markos, 15)
- ‘We did not have enough time to go out to eat and then go to a club to party.’ (Maria, 17)

66 The label ‘fast food’ is used here to describe an essentially core selection of foods originating from western culture which consists of Macdonald’s, KFC, Pizza Hut and Big Boy.
Accordingly, Turner (1994) suggests that fast food operates with a limited menu, precise measurements of food and standardized systems of delivery in order to achieve efficiency and reliability.

Nearly all the participants refer to cost, availability and time as significant factors in relation to young people’s leisure activities such as: going out; shopping with friends at the weekend; and eating together after watching a film. The majority see eating fast food as a pleasurable activity, which is experienced at home or out among other young people, rather than as a practical issue. It seems to be perceived rather like other youthful activities such as going to a club or to a coffee shop. In many cases, fast food places are used as meeting places among young people.

‘Whenever there was an event downtown, we used to go to Pizza Inn. There were no particular reasons for us to go there. It is just a place where people of our age used to hang about. There were places that I personally did not like going to, but I went because my friends liked to. I do not think that I was the only one who felt that way.’ (Fotos 16)

What is interesting here is that even though fast food is seen as the opposite of a family ritual meal, in the case of the participants, fast food is still somehow seen as a ritual communal habit among friends before or after going to a club. As Panagiwta (16) said: ‘When we started clubbing, we used to have a small party with fast food and then go to a club’. The absence of adults in fast food places was also included as an indication of the association between fast food and youth: ‘It is very rare to see adults in fast food places’ (Georgia, 16) and ‘I never went to a fast food place with my family’ (Theodoros, 15).

The fact that fast foods are overwhelmingly seen to be associated with enjoyable activities involving other young people is reported in other studies such as Watt and Sheiham (1997) and Story and Resnick (1986). Cost, availability and fast serving are labelled as ‘factors’ concerning the popularity of fast food among young people (Watt and Sheiham, 1997) or as ‘barriers to improving the diet’ (Story and Resnick, 1986). In both cases, young people’s accounts are employed by researchers in order to show how the social context can be both reinforcing or obstructing towards fast foods. As a consequence these researchers did not concentrate their energies on demonstrating the
way that fast foods operate in young people’s day to day lives, but rather on the health-related effects of eating choices. That is not to suggest that this direction of analysis is worthless, but as discussed in chapter 2, it conceals other roles of fast foods in young people’s lives.

The role of the consumer traits related to fast foods which are found in young people’s explanations of their day-to-day experiences should be also taken in consideration. For example, fast serving is not to be understood only as a practical and convenient strategy, promoting or not a healthy choice, but as a signifier of youth culture. In the light of the above argument, I discuss how the image of youth acts as a complex set of normative values of what the participants regard as a suitable self- and/or life-style images for a young person. The distinction of fast foods from healthy foods seems to be fundamental in the way that the participants culturally experience food in terms of what is accepted as a youthful way of living. Eating fast foods is seen as a medium for experiencing a youthful self- and/or life-style images, whereas exercising healthy choices is viewed as disturbing normative youthful images. The symbolic attributes regarding fast foods and healthy foods in respect of youth are explored below.

The participants regularly expressed the idea that eating fast food fitfully enacts a youthful lifestyle. As the next extract shows, eating fast food represents a youthful stage of life, which is recognisable through the style of eating for a young person rather than through other practical reasons as suggested earlier in the present section. In particular, Nausika distinguishes a home-made party style and the style of a take-away party. When I ask her about the difference between the two styles, she responds as follows:

‘If you have a party with home-made food, it appears to be more serious, more dinner-like and quiet. The type of party where you can have a quiet conversation. It is not suited to that age. People at that age are not so mature as to have a candle-lit dinner.’ (Nausika, 17)

Moreover, fast foods are seen as a sign of youth image. My participants connect fast food with a number of personal values, which are strongly associated with what they consider youth culture. Their comments imply a triangular association between fast food, youth culture and certain symbolic attributes such as ‘cool’, ‘in’, ‘attractive’,
'independent behaviour', 'modern' and 'casual'. What is of particular interest, is the fact that my interviewees seem to agree to a remarkable extent on which consumer traits are connected with youth in their cultural context. As Athos (15) states firmly: 'fast food are considered 'in' by all young people'. Nevertheless these attributes as forms of self-expression or symbols of their own 'style' or youth sub-culture seem to be viewed ambivalently by young people, thereby, expressing positive as well as negative connotations, a fact which was reflected in the tone of their comments.

As opposed to fast foods, the participants' comments on the reluctance of young people to adopt a healthy lifestyle originate from the negative normative youthful images, projected through healthy action. To be more precise, when health is presented as the main stimulus in young people's choices this reflects contradictory messages in terms of the normative youthful self- and/or life-style images. A similar issue is reported by Backett and Davison's (1995) study in which their respondents feel that it is 'boring', 'non-youthful' or 'middle-aged' to worry about healthy lifestyles. The 'non-youthful' images, which enact a conscious and purposeful health action seem to constrain them from exposing a personal interest in health matters. 'Healthy eating patterns' appears in this present study as the category which is most frequently heavily affected by cultural considerations of the young.

I begin by showing how 'not to care' about the physiological effects of food projecting youthful images, as reported by my respondents. In terms of a youthful lifestyle, young people are expected to experience various types of food than to restrict themselves to certain choices. A youthful stage of life is perceived as a time when people should seek out particular experiences. Moreover, it is perceived as more appropriate for young people to 'let themselves go' by eating a large amount of fattening food since they will not be able to do it in future.

A: ‘At this age, people in a group like to try lot of different things; for this reason I think that people who are very choosy and careful about what they try miss out on good times and experiences. For instance, someone might say that I never eat pizzas because they are too oily. He, then, may miss eating popcorn whilst watching a film or enjoy eating a rich cake. At this age, one should not be so careful - especially if there is nothing wrong with your health - you appear to be a boring person and people would get tired of the situation. For
instance, we might all order crepes and that particular person will start peeking at the others’ crepes, having ordered just a simple frappe with water and no sugar.’

Q ‘What is the meaning behind devouring a rich chocolate cake by yourself or scoffing lot of popcorn?’

A ‘It is a characteristic of our age; it is not as if we are often having eating contests but it is nice to do it sometimes. I do not believe that we will ever do something like that when we reach thirty. There is no room for such behaviour at a later age. You become serious and start being careful about what you eat.’ (Nausika, 17)

The idea of liberating and realising yourself in order to enjoy bodily pleasure by consuming to excess is suggested by Featherstone (1991) as one of the precarious states of consumer society. According to Featherstone’s (1991) notions, capitalism produces images and sites of consumption which endorse the pleasures of excess. Those images and sites are seen as the persistence and the transformation of elements of the pre-industrial carnivalesque tradition in which ‘excitement, uncontrolled emotions and the direct vulgar grotesque bodily pleasure of fattening food, intoxicating drink and sexual promiscuity’ are favoured (Bakhtin 1968 in Featherstone, 1991 p.22). In the past, societies offered opportunities to experience excess only in certain moments (during fairs and festivals) but today these opportunities are offered daily through the consumer culture industries. As Featherstone (1991, p.24) stresses, this does not represent an ‘eclipse of controls’. ‘The grotesque body and the carnival’ represent otherness, and since they are ‘excluded from the process of formation of middle-class identity and culture’, become an object of desire (Featherstone, 1991, p.79).

The preceding accounts exemplify a desire to ‘let go’ and to enjoy life through the ‘wrong’ type of choice in diet discourses. It also implies that such behaviour is experienced as a privilege of a youthful phase of life in which the need for greater control over the emotions and bodily functions are still in process. The experience of letting yourself go is experienced as an essential passage towards more controlled future adult behaviours. In the light of the above exchange, it can be argued that by engaging in an ‘unhealthy’ activity young people invite the possibility of being seen as incapable of the self-discipline required for good health. Yet, this eating performance seems to be used as reassurance about their own self-images as young people.
Denscombe (2001b) endorsed a similar idea with regards to smoking, that its pleasure may be derived for some young people precisely because they step aside from their health duties. Likewise, Nettleton and Bunton (1995, p. 56) suggest that within certain cultural settings many commodities are attractive precisely because they are associated with high levels of risk, contrary to the fact that ‘health promotion encourages a culture of risk minimisation’.

‘To care about your food choices’ is also associated negatively with aspects of youthful identities. Below, I show how certain personal characteristics of youth identities are negatively associated with being someone who cares about his/her eating pattern. Accounts which combine youthful identities with a choice of healthy food occur particularly when the conversations deal with young people’s reaction to a consciously healthy food choice. For instance, in many cases I was motivated by the conversation flow to ask about the reaction of a young person who chose boiled potatoes instead of fries, or salad instead of hamburger for health reasons. A person who cares about his/her food choices is characterised as ‘less cool’, ‘weird’, ‘not risky’ and ‘too mature’. These personal attributes, which are seen to be projected through healthy choices, are viewed in opposition to youth identities in public spheres. Young people are expected to be alert to the plurality of food choices, not afraid about their health status and not mature or serious in relation to their eating habits.

The non-youthful images projected via healthy food are also discovered in the Watt and Sheiham (1997) study. In this study ‘healthy foods’ are seen to be linked with the adult and not the adolescent world. Nevertheless, the weight of explanation given by their respondents for this linkage differs from my interviewees. The ‘ability’ of youthful body to suppress harmful effects caused by unhealthy food is presented by Watt and Sheiham (1997) as the common explanation for the link between healthy food and the adult world. By contrast, in my study this type of explanation is a secondary rather than a primary one. Healthy foods appear to be largely unappealing to my participants mainly due to non-youthful images which are attached to a preference for healthy food.

67 See section 4.3.2.4.4 (p.108-112), probing strategy: creating scenarios relevant to health-related choices.
The difference between both research studies can be understood on the provided background framework for interviewees’ responses. The capacity of a youthful body emerged as a logical response by Wall and Sheiham’s respondents when they were asked to explain why ‘healthy foods’ are linked to the adult and not the adolescent world. By contrast, in my study, the explanation for this link was raised spontaneously in conversations concerning everyday life. This stresses the importance of letting young people describe their own choices rather than the search for explanations located in health logic. I believe that the physical dimension of young age cannot sufficiently explain the reluctance of young people to make a healthy choice. Nevertheless, it can be suggested that the difference in the physical capacity of young and adult people, may contribute to the construction of adult-dominated cultural meanings attached to healthy choices.

The eating case study revealed various ways that all of my participants associated food choices with youthful style of living. The choice of fast food was purposeful in the sense that it presents one of the most common stereotypical connections regarding youthful lifestyle. Nevertheless, through the interviewing process the young people made similar remarks, but to a lesser degree of agreement among them, regarding the expression of youth cultures through activities associated with health-related behaviours. These primarily concerned, ‘practicing a risky sport’, ‘going to the gym’, ‘smoking Marlboros’ and ‘drinking vodka’.

5.5 Conclusion

In the first category of analysis, I concentrated on the content of the symbolic traits which are ascribed to health-related behaviours by the participants in a conversation regarding everyday life. These consumer traits were classified and discussed in three categories: ‘personal attributes’, ‘socio-demographic characteristics’ and ‘contemporariness’. These three categories demonstrated the value of health-related behaviours for what they say about the ‘person you are’. The main conclusion here is that young people talked about health-related behaviours not as health-related but
rather as consumer activities in the sense that they can project different self- and/or life- style images. Consumer culture, as an underlying field, was significant since it draws attention to the cultural attributes endowed on the consumer products and activities.

Two main interrelated themes were outlined throughout the first category of analysis. Firstly, the consumer traits found in products and activities associated with health-related behaviours appeared as resourceful communicative channels for young people. The participants could identify personality traits associated with different ‘known’ or ‘unknown’ groups of people and styles of living. The first theme is concerned with the cultural manifestation of health-related behaviours as a shared stock of meanings through which members of each culture can communicate. Secondly, the consumer traits cannot be strictly associated with certain health-related activities or products. The young participants did not always arrive at similar interpretations. Moreover, they acknowledged the changeable character of consumer traits by placing the performance of health-related behaviours in different spaces such as home, club and bar or in a broader network of signification where other consumer activities such as dressing and clubbing take place.

The contention here, directly related to health promotion discourses, is that through what young people say about their everyday lives, an invaluable framework is provided for conceptualising the young people’s ‘way of seeing’ the symbolic manifestation of those practices. Health-related behaviours are not simply mirroring consumer habits or health directed activities but provide a language of codes of images which represent different types of people and ways of living. The young people in this research study appear to know this sign language well and correspondingly find themselves in a position to speak of it fluently and use it to classify others according to their lifestyles in general, and their health-related behaviours in particular. They also know that what health-related behaviours portray for someone’s self- and/or life- style images is a contested area. Health-related behaviours as consumer activities challenge the idea that health-related behaviours entail a unique or simple set of meanings. Rather this conception argues for recognising the location of health-related behaviours in the arena of cultural consumption, which gives voice to the multiple meanings produced by young people as consumers.
The first category of analysis provided evidence that health-related behaviours, like consumer products, are infused with consumer meanings. It acts as a baseline framework for the following category, which aims to reveal the interviewees’ ‘ways of seeing’ the role of these symbols within the context of everyday life. The following stage of the analysis constitutes a unique feature of the present study as a health promotion one by concentrating on the roles of the symbolic categories within the socio-cultural context of the participants. This is because, as has been reiterated in this present thesis, the consumer meanings of health-related behaviours tended to be treated as reinforcing or constructing factors towards the healthy choice, a direction which underplays spoken voices and lived experiences.
Chapter 6
Role Categories

6.1. Introduction

This chapter aims to enrich the argument concerning the significance of health-related behaviours as consumer activities in young people’s everyday lives. So far, I have elicited the symbolic categories\(^{68}\) of health-related behaviours (chapter 5). Yet, just because the participants ascribe self- and/or life- style images to health-related behaviours, this does not show how these traits are embedded in their everyday practices. What is required is an illustration of the process how the participants inscribed self- and/or life- style images; a description of everyday practices in which their consumer attributions have consequences. The consequences of the consumer manifestation of health-related behaviours are identified in the participants’ accounts about the behaviours of others and their own actions as generated in the interview discussions. As discussed in chapter 3, it is the consequences of the symbolic significance of health-related behaviours, at the level of the everyday experience of young people, which are discerned.

The analysis undertaken here incorporates my second category\(^ {69}\) in the exploration of the participants’ ways of seeing health-related behaviours as consumer activities. While the first domain of analysis concentrates on the symbolic traits (discussed in chapter, 5), the second focuses on the consequences of those traits in young people’s everyday lives (chapter, 6). This chapter adds to the preceding one by indicating the way that the embedded symbolic traits (e.g. ‘cool’, ‘macho’, ‘fashionable’) are employed by the participants in order to explain how these traits function in people’s everyday lives. Talking about the role of the symbolic categories was a route, in the

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\(^{68}\)In chapter 5, the participants’ consumer meanings linked to health-related behaviours were classified in three ‘symbolic categories’. These are ‘personal’, ‘socio-demographic’ and ‘contemporariness’.

\(^{69}\)See the categories of analysis, section 4.4.2 (p.117-119).
interview process, for discussing the everyday consequences; how these symbolic traits act as a vital presupposition for these roles. This chapter discusses sets of data where the interviewees ‘select’ consumer traits in order to talk about a health-related behavioural choice.

This chapter consists of four main sections. In the first one (section 6.2), I elaborate the analytical concepts and strategies used for the second category. In the following two sections, I demonstrate, through empirical examples, the two main role categories and their sub-categories that emerged within the second category of analysis. These are first, the ‘elemental’ (section 6.3) and secondly, the ‘relational’ (section 6.4) roles of the consumer traits associated with health-related behaviours. Lastly, I discuss the significance of the context in relation to the role categories (section 6.5)

6.2 The analytical concepts and procedures of the role categories

The data focusing on the participants’ accounts regarding the role of the consumer traits (associated with health-related behaviours within the context of their everyday lives) as related to the second category was re-coded, as explained in section 4.4.3.3 (p.125-127). After having coded the roles for each interview, I made a summary of them. Every time I completed the coding for each interview, I made comparisons with the preceding summary and thereafter I constructed a new summary. This process enabled me to uncover the main roles of health-related behaviours as consumer activities in young people’s everyday lives. I then classified them in two role-categories: the ‘elemental’ and the ‘relational’. Projecting, experiencing or evaluating a self- and/or life- style image through health-related behaviours constituted the ‘elemental’ role category; making or rejecting friends, attracting or removing attention from themselves, being different from or similar to others, the ‘relational’ role category. The former refers to the fundamental roles of health-related behaviours as means for cultural communication. I labelled them as ‘elemental role category’ in the sense that each ‘raw’ role has only one constituent part which functions, in combination with other elementary roles, as the basis for the ‘relational’ ones. The relational roles can be identified as consequences of the elemental roles in a particular
locality or setting in young people’s everyday lives. Table 6.1 given below demonstrates the elemental and relational role categories, which are elaborated in the same order in this chapter.

Table 6.1: The elemental and relational role categories

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<tr>
<th>6.3 Elemental Role Categories</th>
<th>6.4 Relational Role Categories</th>
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<tbody>
<tr>
<td>6.3.1: projecting</td>
<td>6.4.1 attracting attention</td>
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<tr>
<td>6.3.2: experiencing</td>
<td>6.4.2 being similar to or different from a group of people</td>
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<tr>
<td>6.3.3: evaluating</td>
<td>6.4.3 joining a group of friends</td>
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Next, I complete the ‘picture’ by stressing the significance of context in adopting and rejecting a health-related behaviour as consumer activities (section 6.5). The previous chapter illustrates how context is valued as being important and relational according to the inscribed self- and/or life-style images in health-related behaviours (section 5.3, p.142-147). What was of great interest was the shifting positions and the contested images which could change from one situation to the other (such as smoking which signified a ‘loser’ in front of adults but a ‘cool’ person at the Factory night club). In this chapter, I illustrate the role of context in directing young people to choose a health-related behaviour. The emphasis is on the role of context in the elemental and relational roles of the consumer meanings of health-related behaviours. The interconnection of the two sections concerning the role of context (section 6.5 and section 5.3) is significant. However, I choose to separate them in order to be clearer regarding the various roles of context in relation to the consumer meanings of health-related behaviours.
6.3 Elemental Role Categories

The elemental roles of health-related behaviours as consumer activities include:

- Projecting a self- and/or life-style image
- Experiencing a self- and/or life-style image
- Evaluating a self- and/or life-style image

When the respondents describe the role of the symbolic manifestation of health-related behaviours in young people’s lives, it is hard to distinguish the three elemental role categories. Projecting, experiencing and evaluating a self-image become all embedded in their descriptions of a situation. To project an image signifies an experience and an evaluation of an image. To project a ‘cool’ self is at the same time an experience of a ‘cool’ way of living and being, but also presupposes a cultural context in which a ‘cool’ person is perceived (co-exists and interacts) within more or less the same activities. These three roles are interrelated in people’s everyday lives. However, for analytical reasons, I distinguish these three roles as representations of different moments in the participants’ experience of the consumer meanings of health-related behaviours.

These three categories, ‘projecting’, ‘experiencing’ and ‘evaluating’, correspond to a specific view of the self. ‘Projecting’ treats a self as an object, which can be ‘coloured’ by any kind of self- and/or life-style images. It is a process, which implies ‘an objectified sense of the self’, ‘the self as a stylised way of living’, ‘an accessorised experience’ or ‘a decorative body’. Accordingly, ‘projecting’ refers to a subject who chooses how and what to buy, what to do and what traits these actions entail. ‘Experiencing’ refers to a self as a subject who is a knower of its material and embodied content. The subject in this case (‘to experience’) understands the individual as a unique self and therefore can choose the suitable self- and/or life-style images: ‘I am a man and therefore I choose Marlboro’ (Fotos, 16). Lastly, ‘evaluating’ is embedded in the above two practices; a process, which involves judgements of self as object (the projected image) and subject (the embodied image).
The analysis is aided by the fact that the participants used different verbs to describe each role. To project a self-style is accompanied with ‘I want to show an image’, ‘to say something’, ‘to express something’, ‘just to show something’, ‘to show off’ or ‘to show to others’, ‘it makes you look’, ‘it seems’ and ‘to portray a picture’. This category is more concerned with the way you ‘look’, the appearance, not the physical one but the projected image which you depict in relation to the image which is portrayed. To experience a self-image is expressed through phrases such as ‘I feel’ and ‘it suits me or to the others’. To evaluate or to be evaluated through health-related behaviours is linked with terms like: ‘I regard’ or ‘to be regarded’, ‘I consider them’ or ‘to be considered’, ‘I like them’ or ‘I laugh at them’.

Next, through interview exchanges I elaborate each category. The sequence of the role categories, chosen for the presentation, reflects the participants’ opinions. ‘Projecting a self- and/or life-style image’ was largely regarded as an experimental period in young people’s lives, which proceeded ‘experiencing a self- and/or life-style image’. The latter requires an awareness of someone’s self, which is likely to be developed through a stage of experimentation with self- and/or life-style images. Lastly, evaluating a self- and/or life-style image, is presented as it is premised in both of the above role categories.

6.3.1 Projecting a self- and/or life-style image

‘To portray an image’ was one of the most common explanations used by nearly all the participants, either simply to describe, but mainly to explain, someone’s or his/her own health-related behavioural choices. This role occurred when the respondents made comments about how young people ‘look’ when they adopt or reject a certain health-related. This idea concerns the relationship between how young people would like to be (ideal image) and health-related behaviours as a symbolic attribute. The bold accounts indicate the role (e.g. makes you look) of the consumer trait (e.g. dumb) of health-related behaviours (e.g. drinking alcohol).

- ‘For instance, the fact that you are not drinking alcohol, makes you look a bit dumb. If I am drinking that makes me more advanced, more cool.’ (Manos, 15)
• ‘You look more cool when you smoke. You seem to be more risky, something like that.’ (Liza, 15)

These sorts of connections were supported mainly in two ways. Firstly, some of the interviewees stressed the significance of the consumer traits by challenging the existence of any other reason for people’s choices. They tended to compare the potency of health-related behaviours to project an image with other effects of the same behaviours. They highlighted the importance of cultural needs by distinguishing it from material or other kinds of needs. For instance, Yiannos (16) stated regarding coffee:

‘I notice them [pause] it is not because they only want to drink coffee, but it is the whole situation, the atmosphere. To take coffee from the machine and to drink it in a certain way showing that you are mature [pause] adult [pause] discussing your problem, I cannot explain it but I am sure that the desire which has emerged does not absolutely derive from the coffee.’

Alexandros (16) suggested that there are young people, ‘who do not even drink and they hold a glass of alcohol in their hand all night to show off to the girls that they are drinkers’. Likewise, Liza (15) asserted that, ‘There are people who do not really want to drink but they do in order to show that they are cool’. Moreover, as Dora (16) commented on smoking, ‘It shows an anarchic person who is getting upset and smokes until his throat is hurting but still smokes even more. They want to show off’. The idea which seems to be supported by the participants is that there is a cultural need concerning health-related behaviours which can even overshadow other reasons for consuming.

Another way of proposing the significance of the capacity of health-related behaviours ‘to portray an image’ was by making comparisons between a ‘real’ and ‘ideal’ self-image. The participants’ argument in this case was that health-related behaviours give the capacity to the consumers to project a self- and/or life- style image to others, which is not necessarily ‘real’ or ‘authentic’ for himself or herself. To project an image via health-related behaviours was treated in the participants’ accounts as a catalyst, which

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70 This distinction was also elaborated in chapter 4 in order to clarify the chosen selected accounts as the participants’ consumer meanings (section 4.4.3.2, p.121-124).
lessened the distance between a desirable self-image and a real self. For instance, these sorts of responses came out when I asked participants to explain the reason for the different eating preferences between girls and boys\textsuperscript{71}.

One young woman who informed me that boys usually have alcohol whereas girls have coffee when they go out, stated:

\begin{quote}
\textit{I believe that the reason is not because they prefer it more. They might like Nescafe, as well, but they feel that, because they are the males in the group, they should have something alcoholic. Show that they are men and they can have something alcoholic. At this age, boys want to show that they are becoming men, mature.} (Elena, 15)
\end{quote}

On the other hand, as she mentioned later, \textit{`when girls are having Hooch, they do not do it on purpose, in order to show that they can handle alcohol'}. Her latter comment seems to suggest that when girls choose to drink Hooch they do so not to enhance their self-image; rather, it was seen as enjoyment. Conversely, boys who are still too young to be perceived as men, drink alcohol in order to cover up their boyish image and gain a more appealing manly image.

Likewise, Athos (15) suggests that girls are more reluctant to smoke for symbolic reasons than boys since, \textit{`Parents are more strict with girls. A girl has to show a different image to the others. Boys of my age are more independent than girls, so we do not need to smoke'}. Here, the interviewee perceived girls, rather than boys, to be the ones who need smoking as an aid to portray an independent personality. According to him, boys do not smoke in order to achieve an independent self-image since they have more independent personalities compared with girls and thus they do not need to project such an image.

The young people made similar comparisons regarding the announcement of food choice in front of their school-mates\textsuperscript{72}. In many cases the participants’ views reflect young people’s aspirations to achieve an image which incorporates desirable self-traits. Alexandros (17) referred to his co-pupils’ answers in relation to their desire to

\textsuperscript{71} See section 4.3.2.4.4 (p.110), stimulating comparisons.
\textsuperscript{72} See section 4.3.2.4.4 (p.110-111) creating scenarios relevant to health-related choices
project a certain kind of self. In particular, he suggested that boys' and girls' answers are likely to differ since each group (boys and girls) aspires to different 'ideal images'.

'Most of them [girls] would say that they have salads and so on just to show that they are careful with their weight.' Whereas some of the boys preferred fast foods in order to project a well-off image.

'The image of having the means to eat out in comparison to those of us who eat at home, food that our mother prepares for us. He is showing off that he has the money to do it.'

The importance of announcing verbally the salad or the fast food preferences is relatively independent of actual practice. Salads and fast foods are announced as self- and/or lifestyle images. They were chosen because they can symbolise a person who cares about his/her body (salad) or has money (fast food). Both salad as a low fat meal and fast food as a meal which costs money (compared with home-made foods) would not have been selected if either of the two groups (boys or girls) had not aspired to the projected images. As Alexandros (17) hypothesised, both boys and girls may lie but they still choose to announce salad and fast food as a medium to assert a self-image for themselves.

The significance of the relationship between a consumer behaviour and ideal self-images is supported by Amos et al.'s study (1997), which explored how young people see themselves (self-image), how they would like to be (ideal image), and whether these differ according to smoking status. According to their findings, 'smokers in general and males in particular, embrace certain dimensions of self- an aspirational image of which druggy/ takes drugs, tough and tarty are signifiers' (Amos et al., 1997, p.857). They showed that smokers were more drawn to 'negative' traits (druggy, wild, tarty) than non-smokers (healthy). The findings of the present study fit in with Amos et al.'s study (1997), in the sense that, my participants experience smoking as a strategy for young people to achieve an 'ideal' self-image. Nevertheless, the idea of health-related behaviours as a medium for gaining ideal self-images is generated in this research study as the opinions of the young people rather than as an empirical outcome through statistical comparisons (smoking status and ideal self-image). Specifically, this study demonstrates how the participants themselves document the capacity of health-related behaviours for young people to achieve aspirational images.
The participants put forward the idea that a health-related behaviour can lessen the distance between an ‘ideal’ and ‘real’ self-image when they also wanted to justify their rejection of a health-related behaviour. The suggestion here is that young people, on certain occasions, may refuse a health-related behaviour not because of different preferences, but because of the absence of a cultural need regarding a desirable self- and/or life-style image. For instance, Athina linked her limited attraction to fashion with her non-interest in eating at Macdonald’s:

Q  ‘Do you think that there is fashionable food at your age?’
A  ‘Some people might be interested in this. Personally, I do not care. I do not even follow fashion that much. There are some people who might be interested. For instance, when Macdonald’s was opened, all of them went there. I do not care. Some of them are interested. I am not. I eat what I want. Whatever I have an appetite for.’ (Athina, 17)

Some others referred to a health-related behavioural change, because they either managed to reach their ideal self or their desired self-image changed. Characteristically, Maria (17) admitted that when she started to go out, she, ‘was not comfortable with having a milk-shake’ in front of her friends since she did not want to be perceived as a ‘child’. Yet, as she explained afterwards, ‘those times are long gone’ and now she is, ‘not interested in showing an image’. When I asked her to elaborate further, she associated this change with the fact that she was not allowed to go out compared with others. Therefore, as she explained, ‘I wanted to give the image that I was easy-going, cool.’ What seems to be implied by her comments is that a drinking choice used to be a means of covering a non-desirable self- and/or life-style image: someone who is not allowed to go out as often as he/she wants.

Another interesting point here is that the role category ‘to project an image’ is at the same time a certain self-image for the participants. In other words, a person who chooses a health-related behaviour in order to portray an image, projects at the same time a certain self-image. For instance, Alexandros (17) suggested that a non-smoker is liked by girls, ‘because they think of him as someone serious, mature, who does not need to smoke to show off’. Here the rejection of smoking adopts a double interconnected consumer meaning. It signifies a mature boy and the absence of a cultural need to show off. Smoking as a necessary activity for someone who aims to
fill the gap between the ideal and real self, acts at the same time as a signifier for the smoker. As Alexandros suggested, the ones who smoke for reasons of showing off are viewed in general, and by girls in particular, as less serious and mature. The young people not only identify the symbolic role, ‘to project an image’ of health-related behaviours, but they also use it in order to judge their corresponding consumers.

The idea of projecting a self-image is linked with the notion of desire as developed in the area of consumption. Consumer theorists who use the concept of desire to explain the cultural mechanism of consumption have emphasized the significance of individuals’ choices with regard to the construction of identity (Baudrillard, 1981; Sarup, 1996a; Featherstone, 1991). Health-related behaviours, as understood by the participants, entail images of self- and/or life-style, which are perceived as being desirable in the eyes of the consumers. According to the participants’ ideas concerning the capacity of health-related behaviours to project images, the notion of desire is linked with aspirational self-images rather than with the ‘real’ self. This idea, ‘to project an image’, which may not correspond with the ‘real’ self is supported by Baudrillard (1981) who suggests that desires and dreams are found to have stronger linkage with images rather than with the reality of the consumers’ needs. Sulkunene (1998) challenges the distinction between reality and image in relation to alcohol consumption by stating that a social reality of alcohol drinking can also be its projected images. Sulkunene’s (1998) position is reinforced by the above findings, which show the way in which the participants actively recognized the role of health-related behaviours as a conscious mechanism for projecting desirable self-images. As Bocock (1993, p.95) stated:

‘This process of identity construction and maintenance requires to be conceptualized in a way which addresses the role of desires, for an identity is not a static state, but an active set of performances which show to others, and to the person himself, the kind of person he desires to be taken to be’.

His argument is supported in this section, taking into account that the analysis here reflects the participants’ own interpretation of the processes in which they engaged, as they appropriate consumer products for their own needs and desires.

73 Evaluating as a role category is discussed in section 6.3.3 (p.170-173).
6.3.2 Experiencing a self- and/or lifestyle image

Experiencing a self-image is a slightly different activity, which occurred more frequently when the participants referred to their own choices. In comparison with the above sub-category, it can be suggested that there is a slight shift from exposing, showing and projecting to experiencing of self-images. Here I refer to the verbs 'feel' or 'suit' instead of 'show' or 'project', which also appeared frequently in the participants' accounts. Therefore, I chose to use the verb experiencing rather than projecting in order to highlight the fact that health-related behaviours, in the present sub-category, are treated in the interviewing conversations as means for experiencing themselves in certain ways, rather than merely exposing something which may also be irrelevant to themselves. The self here is not treated as an 'empty' object which can be filled with self-images but rather as a subject with a pre-existing embodied content. Based on the verbs 'feel' and 'suit' I identify two main ways of expressing the capacity of health-related behaviours as consumer activities to permit interviewees to experience aspects of their own or others' personalities.

The first, 'to feel', concerns the fact that a health-related behaviour gives people the opportunity to 'feel' their personalities in certain ways, at certain points of their lives. Below, I exemplify some of the participants' suggestions regarding how a health-related behaviour made them or others feel in certain ways.

- 'Smoking made me feel more cool.' (Panagiwta, 16)
- 'I feel, that it is stylish to go and eat at a good restaurant.' (Stelios, 16)
- '...it [mother’s cooking] makes you feel younger, whereas ordering food to be delivered makes you feel that you have the power to do such a thing.' (Katerina, 16)
- ‘...you feel free [sports].’ (Dimitra, 17)

In relation to the above example, what needs to be stressed is that the symbolic manifestation of health-related behaviours seems to be responsible for making the participant feel 'free', 'powerful' 'stylish', 'younger' or 'cool'. The nature of the revealed experience derives, to a large extent, from its perceived symbolic attribute. As Dora (16) suggested, she goes to Macdonald's, ‘...on a Friday, when I am tired and feel casual’. In other cases, Dora, ‘...wanted to go to a good restaurant where I could
dress up smartly'. In this case, Dora’s cultural interpretation of the two different spaces (Macdonald as a ‘casual’ place and a good restaurant as a ‘smart’ one) determines the experience of different lifestyles according to her temporary desire to spend time in a particular way. To sum up, the nature of the ‘lifestyle’ or ‘self’ experience, which is provided to the participants via certain health-related choices, are subjected to their cultural interpretations.

The following exchange similarly shows how the consumer investment in smoking influences the way that the participant experiences herself in relation to the smokers. According to Natalia’s (15) comments, she feels ‘inferior’ as she is the only one who does not smoke. What is significant, however, in this case is that the experience of an inferior personality derives from a projected self-image. It is a behaviour which signifies someone as being more ‘risky’ and ‘daring’ since she/he is not afraid of being ‘caught’ by her/his parents. Moreover, smoking is a modern activity. Her consumer meanings in smoking seem to have a great influence on the way that she feels as a non-smoker.

Q ‘How do you feel as a non-smoker?’
A ‘I feel as if I am missing something. The fact that they smoke and I do not, makes me feel inferior. I do not want to do it though.’
Q ‘In what way do you feel inferior?’
A ‘There might be five of us, four smoking, but not me. They then keep on trying to convince me to smoke as well. This makes me feel inferior to them.’
Q ‘Why?’
A ‘Why are they able to smoke, without any fear of being seen by parents or relatives? Even if I wanted to smoke, I am scared.’
Q ‘So you feel that you are not daring?’
A ‘Yes I am anxious that my mum will find out.’
Q ‘What else will make you feel inferiority at that particular moment?’
A ‘Smokers are more modern. I feel that smoking makes them more modern than me.’ (Natalia, 15)

The other verb which was frequently used by most of the participants in order to show the relationship between the symbolic attributes of health-related behaviours and their
choices is 'suit'. In these cases they wanted to show a straightforward association between their personality and health-related choices as carriers of self-traits. It is not something asserted by their personality; it is not something added; it is not a desirable experience. Conversely, it is a self-attribute which according to the participants' estimations already characterises their personalities and lifestyles. I take as an example the way that Nausika (17) justifies her choices. In a discussion about whether the places people go to, reflect the way that they dress, she explained:

'Your personality is being perfected whilst you are growing-up. I believe that I have acquired the personality of a person who does not like the style of hanging outside clubs in jeans or mini-skirts and transparent tights. My style is more elegant. For instance, I like wearing knee-length skirts. Where you end up going out to have fun, depends on the personality you acquire, because of the people you hang out with and the sort of family you were born into. The places you go to, at the age of seventeen-eighteen are the ones that express your personality and your style. At younger ages you try various places to discover which one suits you best, and your personality is being processed in that way.' (Nausika, 17)

Up to this point Nausika had elucidated on how the places to go out and clothes express a personality, which is more accomplished at the age of seventeen than at a younger age. Health-related behaviours were treated in more or less the same way. As she mentioned afterwards,

- '... when I have white wine I feel that it is in my personality to do so.'
- 'If I ever smoked I would prefer the slim-line cigarettes which are elegant and most suited to girls' personality.'

In addition, she informed me that she could not be an athlete since, 'Even if I tried it and managed to become an athlete, that would not express who I am. Why should I do something like that?' As a seventeen year-old woman, she has found herself capable of choosing what is appropriate for her elegant style. She approached herself not as an object but as an embodied self whose content was known. Among other everyday choices such as clothes and going out places, health-related choices appeared as an added component of presenting her 'developed' subject by choosing what is suitable for her own style.
Interestingly, she referred to ‘projecting a self- and/or life- style image’ role category (see section 6.3.1), as a fundamental aspect of her life a year ago, before developing a defined idea about her own style. In the interviewing process, she referred to this period of time as treating herself as an object, which was gradually discovered with the aid of different styles, through experimentation with different self and style of living images. The cultural manifestations of health-related behaviours are handled in this case as a resource for young people in order to find what matches to their personality. As Nausika explained:

‘At this age our tastes still develop and are liable to change. If I discover a new drink and I feel that it suits me more, I will keep having the new one and stop having wine’.

The interesting point here is that the discovery of a new drink is not suggested in relation to an aesthetic taste. It is seen rather as a cultural taste and possibly an added distinction that such a discovery might have on the personality in relation to the presentation of the self to others; an extra personal touch which is inscribed with cultural significance. She would change her drinking habits only if she found another drink which would better express her personality. When I challenged her about the choice of wine as a preferred drink for social occasions she responded as follows: ‘You have a certain drink, not because you like the taste of it or to join your friends, but because it suits your personality’.

To sum up, the second elemental category concerns the ideas expressed throughout the interviewing process concerning the fact that young people can experience self-images, which are in accord with their personalities. Next, I elaborate the final elemental role category which concerns the capacity of health-related behaviours as consumer activities, to evaluate and also to be evaluated by others.

6.3.3 Evaluating a self- and/or life- style image

The present section elaborates the third ‘elemental role category’ (see p.159, table 6.1) regarding the symbolic attributes of health-related behaviours. The idea discussed, concerns the fact that young people employed the symbolic traits of health-related
behaviours as a frame of reference to attribute personality features to ‘known’ or ‘unknown’ people. These sorts of ideas constituted the main set of data for the identification of the main symbolic categories (chapter 5). The difference here is that I concentrate on the process of evaluation as an elemental role category within the context of young people’s everyday lives rather than on the content of the inscribed personality traits to health-related behaviours. The young people’s self-attributions were transformed into evaluative comments only when the young people rated them positively or negatively; as expressed either in the tone of their voices, or made explicit through words used.

Initially, I introduced this role category with an interview exchange, which is very comprehensive in terms of demonstrating how young people described past evaluative comments and creatively elaborated them further. It also introduces the main issues concerning the evaluative role of health-related behaviours as consumer activities, which are elaborated further in the following sub-sections.

Q  ‘The time that you had two to three each [cigarettes], what was the reason for it?’
A  ‘One of the girls, there, said that she had tried it once when she was home alone and asked if we wanted to smoke as well. So we got one each and liked it. We then thought of having more. There were many of us there, and some were more innocent but they smoked too. We said to some of them, that we could not think of them ever starting smoking and to some others that they looked as if they were smokers.’

Q  ‘Which girls seemed to be the ones who were less likely to be smokers?’
A  ‘The more innocent looking ones, the ones who were more introvert and did not socialise that much. The others were dressed and talked differently, they were more easy-going. They looked as if they were smokers, for sure.’

Q  ‘What other characteristics would these two groups have?’
A  ‘Their relationships with boys.’

Q  ‘Which are you referring to?’
A  ‘Some were more easy-going about hanging out with boys and some were introverted.’

Q  ‘Which would you consider as more modern, then?’
A  ‘The ones which I liked from the way they dressed and talked, the more easy-going ones.’
Q  ‘So did you think of them as being the smokers?’
A  ‘Also they were the ones who were more enthusiastic about the idea of us smoking, that night. The rest were just following the crowd.’
(Dora, 16)

This exchange highlights the strength of the symbolic attributions of smoking as an evaluative source for young people. Here, Dora (16) described a certain situation, which happened in the past, when a sub-group of her friends tried smoking for the first time. In the light of this event, she divided her friends in two groups based on the smoking behaviour not as an actual practice (since nobody was a smoker at that time) but as an imaginary one. Some of the girls looked as smokers and some of them were seen as non-smokers. The criterion was not the actual smoking practice but whether smoking as a symbolic activity appeared to be appealing to their personality. The non-smokers were judged as ‘the more innocent looking ones, the ones who were more introverted and did not socialise that much’. Whereas, as she explained, the others who dressed, talked differently, and were more easy-going about hanging out with boys, ‘they looked as if they were smokers’. Dora correlated the smoking behaviour based on her inscribed self- and/or life- style traits associated with smoking behaviour. This is because she had great difficulty in classifying those who smoke as smokers if their self- and/or life- styles did not correspond to her consumer traits of smoking.

In the light of this exchange, it is clear how the interviewing situation gave the opportunity to the participant to elaborate verbally her consumer meanings in relation to smoking. At the time when the incident happened, she and her friends did not talk about the self- and/or life- style images connected to smoking in the same depth. She only remembered a comment that some girls made to the ones who were considered as introverted. ‘We said to some of them that we could not think of them even starting smoking and to some others that they looked as if they were smokers.’ Although the conversation started with a comment made at the time when she tried smoking, Dora, in collaboration with the interviewer, creatively elaborated further her evaluative judgements. She then very easily referred to other descriptions of the personality of a smoker compared with that of a non-smoker, remarks that she did not consider at the time of the incident. Therefore, it can be argued that the interviewing process appeared to have a double role in respect of the ‘evaluating a self- and/or life- style image’
elemental role category. First, the participants had the opportunity to report incidents, which are likely to happen or which happened in the past when they or other young people made their own self- and/or life- style evaluations. Secondly, the interviewing process as an interactive setting was an occasion for the respondents to construct further their ‘current’ self- and/or life- style evaluations based on health-related behaviours.

The process of evaluation self- and/or life- style images connected with health-related behaviour, was found to be an activity which was not openly discussed by the participants in their everyday lives. It was a personal consideration in young people’s minds rather than an openly exposed issue for discussion among friends. Yet, the inscribed self- and/or life- style images in health-related behaviours as an evaluative framework were found to have vital consequences in young people’s everyday lives. In the following two sub-sections I elaborate the participants as ‘evaluative subjects’, who evaluated others (section 6.3.3.1) and then as ‘objects of evaluation’ made assumptions about how others might have evaluated themselves based on health-related choices (section 6.3.3.2). I demonstrate how the participants not only understand health-related behaviours as ways ‘to evaluate’, but also ‘to be evaluated’ in relation to the projected self- and/or life- style consumer attributes of each behaviour. These were found to be the two main sub-categories of the ‘evaluating a self- and/or life- style image’ category. In both sub-categories I give examples of how consumer traits inscribed in health-related behaviours acted as an evaluative frame of reference for the participants.

6.3.3.1 To evaluate a self- and/or life- style image

The young people used the consumer traits inscribed in health-related behaviours as a personal source of reference for making their own self- and/or life- style judgments. These consumer traits of health-related behaviours contribute, among other criteria (such as clothes, music), to the construction of their personal opinions regarding other people. The following examples, demonstrate how the participants’ personal

74 As discussed in section 4.3.2.3.2, interview is seen as interactive occasion during which the participants do not only report events but also as a dynamic process, which activates the reflective capacity of the respondent (p.92-93).
preferences of certain personality attributes are formed partly by the aid of their inscribed consumer traits in health-related behaviours.

Both Alexandros (17) and Athos (15) labelled smoking as a 'non-serious' activity for girls. Yet, their personal preferences differ. Alexandros who prefers non-smoking girls stated, ‘...nowadays we got used to the idea, but I like a girl better if she is not a smoker. In my eyes, she looks more serious and mature’. He additionally commented that he would be ‘particularly cautious’ with a girl who smokes heavy brands such as Marlboros, ‘...because only a few girls smoke Marlboros. Most of them smoke light cigarettes’. On the other hand, Athos expressed a more positive evaluation of girls who smoke:

‘If you hang around with a girl like them, you never get bored. You do not get tired of talking with them. If a girl [a non-smoker] starts talking about lessons, it is only natural that you get bored’.

Yet, as he explained later, ‘if one is talking about fashion, or other subjects not associated with school, you do not get bored of talking to her’. Athos as a non-smoker, was puzzled by the idea that, ‘the non-smokers believe that smoking is not good. They do not hang out with male-smokers. The ones who smoke hang out with boys who smoke’. While both of these boys seemed to regard girls who smoke as less serious, they appeared to disagree about whether being serious is a positive or negative attribute for a girl. Alexandros viewed a serious non-smoking girl positively whereas Athos negatively.

The example above brings us to a point made by Amos et al. (1998) concerning the personal way that smoking images are evaluated. As Amos et al. (1998, p.499) argue, ‘negativity is a subjective concept’. ‘One needs to have a better understanding of what the traits which at face value appear to be negative, such as druggy, wild and tarty, mean to smokers and to non-smokers (Amos et al.,1998, p.499). By this, they challenge the objective negativity of the revealed cultural traits of smoking. In particular, they found that smokers rate themselves less negatively in terms of these cultural attributions than non-smokers. Researchers who study smoking images should therefore be cautious before drawing conclusions about the influence of the cultural traits of smoking behaviour (Amos, et al., 1998). The preceding example in this
research study supports Amos et al.‘s (1998) argument. One participant rated the consumption of a cigarette positively among girls, as a ‘non-normal’ girlish activity, while the other rated it negatively. The issue at stake here concerns the significance of the personal preferences regarding the symbolic trait of a particular kind of health-related behaviour. The employment of health-related behavioural practices as an evaluative source is subjected not only to personal interpretations of consumer traits (such as smoking projects a ‘cool’ image), but also to personal preferences (whether or not smoking as a projected image is evaluated positively or negatively).

The next example concerns the selection of sports as a criterion for the chosen relationship with someone. Dora (16) stated, that it is more likely that she can have a better relationship with a volleyball player than an athlete since, ‘If someone is a volley-player I find common ground between the two of us. If someone is a stadium athlete, they are more of an athlete’. The suggested distinction is based on the symbolic attributes that she ascribed to an athlete, ‘An athlete might be not an easy going person and might have too many rules in his life’. Dora arrived at her own personal preferences by comparing projected self- and/or life- style images of a volleyball player and an athlete. She then concluded that due to her personality, which is less disciplined, she could have a better relationship with the former than the latter. In this case, the participant did not attract positive or negative attributes to the two kinds of sports. Yet the personality traits attributed to each ‘unknown’ individual assisted the formation of her opinion.

The final examples concern the choice of foods as a resource for evaluating personality traits. To choose certain dishes means to choose between different personality traits. Nearly all participants proposed this idea. Nausika (17), captured their position with the following words.

Q ‘Does choosing food have anything to do with style?’

A ‘When I see someone eating a pizza, for instance, with a lot of toppings, I always realise what he is. I believe that you are what you eat. This, though, does not apply to all situations. I sometimes eat a lot of food and if someone sees me, he might get the wrong impression of me. Most of the times, though, the rule applies. Someone who is eating a pizza like in the case I have mentioned previously shows that he has got a different style than someone who, when having a meal of chicken,
separates the fat, or has greens and potatoes with his meat.’
(Nausika, 17)

Although she accepted that food choice cannot always be an effective criterion for the type of person projected, she insisted that, ‘the rule applies in most cases’. Based on the written text, given above, her favourite choice is not obvious, nevertheless, her tone of voice as well as her preceding comments, were indicative that she preferred the latter meal. Her favourite style was explicitly expressed in the following exchange.

Q ‘What are the two different styles?’
A ‘I sometimes think that when people say “I will go to Zoo and have this or that food”, that they do it to show off. I do not think that it is showing off if you go to Zoo every Saturday to have dinner. If you have the money to do that, I do not think that is showing off. I would like it better if a couple went to Zoo for a nice meal rather than if they went for a pizza. It shows that they are more mature and know what they want in life. I would not mind a couple going for a pizza but in the evening it is much nicer to go to a nice restaurant.’

The people or the couple who go to Zoo (which is a high-class restaurant-club) for a meal, not because they want to show off, but because they have money and can ‘naturally’ eat there, was rated as her first choice. She liked those people since, ‘they are more mature and know what they want in life’.

6.3.3.2 To be evaluated
In this section, I examine the cases where the young people commented on the role of the symbolic attributes connected with health-related behaviours not as an evaluative tool for them but as an evaluative mechanism to which they are subjected. In particular, I refer to situations where the participants acknowledged the fact that they become objects of evaluation with regard to their health-related behaviours. The respondents’ consumer meanings in a health-related behaviour by surrounding people is understood as the main presupposition for their placement as evaluative objects.

The reactions of others towards a health-related choice was one of the most common cases where participants raised the evaluative character of health-related behaviours, targeting themselves or other young people. In particular, the participants referred to
situations where young people exposed their critical reactions to adopting or rejecting of a health-related behaviour. I begin with Elena (15), who suggested that young people eat at the school canteen and do not bring food from home. When I asked her to give reasons for this phenomenon the conversation flowed as below:

Q ‘What do you eat at school?’
A ‘We eat at the canteen. Most people do not bring food from home.’
Q ‘Why?’
A ‘I do not know. I believe that they might think that people will assume that their mums are preparing sandwiches for them. People feel more comfortable buying food from the canteen like everyone else, rather than having home-made food, even if it is healthier. If someone is eating a home-made sandwich he might think that the others are going to make fun of him.’
Q ‘So having home-made food shows something different from having take-away food. Can you analyse the comparison?’
A ‘People make fun of the ones who have home-made food. On the other hand, take-away food might show that someone is well off. It shows that they can have ready-made food from the canteen every day, without having to save money by bringing food from home. The others might then think, that someone is poor or that his parents do not give him enough pocket money to eat out.’ (Elena, 15)

Elena commented on the peculiarity of the situations, since home-made food is healthier than canteen food. She explained that this peculiarity was due to the fact that young people associate home-made food with ‘undesirable’ self- and/or life- style images. The actual practices (bringing food from home and buying from the canteen) were not seen as responsible for the construction of the evaluative situation, rather it was attributed to the consumer traits suggested by the participants. Ready-made food from the canteen projected desirable self-images for young people such as ‘being well-off’. As she explained afterwards, despite the fact that she believed that this situation ‘shows immaturity’, and that she even preferred home-made food, she does not bring food from home. By buying food at school she could protect herself from being an easy target for teasing; an uncomfortable situation for her and also for most of young people.
Natalia (15) created a whole scenario in order to explain the possible reaction towards someone who refuses to smoke:

‘Let’s say we went out to a café with my friends. If two of the girls are smokers, they will make the rest take at least a drag of their cigarettes. If you refuse, they will mock you by saying that you are scared of your mum. Someone actually said that to me once’.

Again, here it is clear that it is not the smoking behaviour in its own right that causes a negative reaction towards a person who refuses to smoke, but the cultural attributes associated with the smoking behaviour. It is because refusing to smoke is interpreted as ‘mummy’s child’, ‘not brave’. Characteristically, when I asked her ‘How do they [the smokers] describe the people who do not follow in their footsteps’, she responded, ‘Out of fashion, less advanced. They think that just because they are smokers they are automatically fashionable as well. The ones who do not smoke are not in fashion and are un-cool’.

6.4 Relational Role Categories

In the present section, I shall discuss how the participants talked about the ‘relational role categories’. As noted above, relational role categories refer to situations in which the three elemental role categories are manifested as resources for other purposes in young people’s everyday lives. In particular, I indicated how ‘projecting’, ‘experiencing’ and ‘evaluating’ a self- and/or life-style image are embedded in the most frequently relational role categories which are: ‘attracting attention’; ‘being similar to or different from a group of people’; and ‘joining a group of friends’. My ultimate goal here is to reinforce further the role of the symbolic categories of health-related behaviours in young people’s everyday lives.

6.4.1 Attracting attention

The capacity of health-related behaviours to project a self- and/or life-style image, which can be decoded by people, was discussed by the participants as a resource to gain attention from ‘interested’ others. In the following table (6.2), I select some of the
participants’ comments about smoking and eating habits in order to exemplify how these behaviours were discussed as symbolic resources for young people in order to gain attention. Similar cases were mentioned in relation to the going to the gym or selecting of a specific drink.

Table 6.2: Attracting attention: examples from coded segments of data

<table>
<thead>
<tr>
<th>Smoking</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ‘There are many who might pay attention to the one who smokes even if next to her, there is someone who does not smoke and who may be even more beautiful [pause] and the one who smokes might say to the other “Look at them, they pay attention to me”’. (Panagiwta, 16)</td>
</tr>
<tr>
<td>2. ‘I was attracted to a girl and I knew that, by seeing me smoke, she would like me even more. So, that is how I thought then. Fortunately, my friend turned me away from it.’ (Fotos, 16)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Announcing an eating pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. ‘It [Dieting] is to get satisfaction from the others saying to you that you are thin and not fat. It is just to hear that you are thin. They do it to attract attention to themselves.’ (Dora, 16)</td>
</tr>
<tr>
<td>4. ‘Vegetarianism is very much in fashion, they may feel sorry for eating the poor animals. They also draw attention to themselves.’ (Dimitra, 17)</td>
</tr>
<tr>
<td>5. ‘If you, say though, that you eat a lot but never gain weight, the others will comment on the fact that you are thin.’ (Ifigenia, 16)</td>
</tr>
</tbody>
</table>

These examples demonstrate how young people might use smoking and announcing certain eating patterns as a way of soliciting attention. ‘To project’ and ‘to evaluate or to be evaluated’ (elemental role categories) appeared as essential presuppositions for attracting attention. Both roles and their interdependence were stressed by these participants when it came to explaining how these behaviours can help young people gain attention from the others. Each of these participants linked each practice with certain ‘projected’ self-images. Panagiwta insisted that a girl who smokes receives more attention because of being someone ‘special’, ‘and more relaxed with yourself and your behaviour’. Fotos suggested that ‘if you smoke, you are not considered a mummy’s boy’ but rather ‘a tougher’ man. In the same lines, revealing the fact that you are dieting (Dora), do not care about your food choices (Ifigenia) or are vegetarian
(Dimitra), were seen not merely as eating practices but as a cultural performance of an attractive body figure or an interesting personality.

Moreover, ‘evaluating a self- and/or life- style image’ appeared as an essential component of the capacity of these behaviours to attract attention. The consumer traits of these behaviours need to be de-coded in a similar way. Fotos expected to be seen as ‘tough’ and not a ‘mummy’s boy’ by the girl. According to his assumption, smoking enabled him to gain attention only because the girl ascribed similar self-images to this activity. If smoking had not been commonly interpreted, it might not have been used as a tool for him to be noticed. Therefore, he could not have been sure of avoiding the undesirable evaluations of himself as being a ‘mummy’s boy’. The symbolic attribution to smoking appeared to him as an overarching framework, which is much more powerful compared with his personal opinion. As he noted, despite the fact that he disagreed with the ascribed images of smoking as a ‘macho’ activity, he still used smoking in order to portray a non-‘mummy’s boy’ self-image and therefore a ‘masculine’ one. It is also worth noting that he acknowledged the type of people who interpret smoking as an activity representing independence from family. He judged the girl that he liked as one of those who viewed smoking positively in relation to a man’s self- and/or life- style image. Possibly, he would not have been tempted to smoke if the girl he was interested in thought differently.

As with smoking, the announcement of certain eating habits can attract the attention of others, but only when those present attach similar consumer traits to food. According to the above examples, the participants understood the announcement of an eating pattern as a means to gain compliments about one’s body. This happened within a cultural environment in which the cultural performance of eating can provoke such types of evaluations. Featherstone (1991) considers the ‘emphasis upon appearance’ (p.187) and ‘the careful bodily presentation’ (p.191) as important tendencies within the context of consumer culture. The preceding examples (3 and 5 in table 6.2) demonstrate one of the verbal that young people seem to adopt in order to perform a successful body image. It is not only through bodily performance but it is also through verbal comments about eating habits.
6.4.2 Being similar to or different from a group of people

In this section, I examine the role of health-related behaviours as consumer practices in regulating the extent to which young people may be classified or not as members of a group of people. By the term group of people, I refer to the ones that the participants specified in a broad way such as young people, athletes, others who go to a certain club. The participants went into detailed descriptions in order to explain how the act of health-related behaviours may satisfy their felt need to ‘fit in’ or ‘stick out’ from a group in terms of individuality and self-expression. By the terms ‘cultural inclusion or exclusion’ used in this section, I refer to the situation in which any young person is perceived part of, or excluded from, a group according to his/her projected self- and/or life-style images.

To be culturally perceived as a young person was one of the most rich and consistent social categories that the participants associated with certain health-related behaviours. The examples below aim to stress the role of these youth-related symbols for the participants, in order to include or exclude themselves from what they ‘imagined’ as youth culture. The choice of fast food instead of pulses, for instance, was seen as a passport to cultural inclusion within the youth category. The respondents exhibited an understanding that the ‘normal law’, within their socio-cultural context, would be to select youthful choices such as fast food in order to fit in a ‘youth culture’. Athos (15) preferred to announce that he had fast food rather than pulses in order to feel part of the youth category, even if he had to tell lies: ‘I think it is embarrassing to announce that you like eating pulses. I do not think it is “in”. No-one else does, so if I eat pulses it keeps me “out” ’. As Dora (16) explained, young people do not explicitly eat pulses because, ‘It is grown-ups who practice healthy nutrition. Younger people are into junk-food. That is why they do not eat pulses’. These sorts of ideas were frequently expressed. Accordingly, Athina (17) who showed a negative attitude towards fast food, regarded herself as an ‘exception’.

75 The analysis here does not concern the peer relationships, or groups that they have direct personal relationship: an issue, which is explored in the next section.

76 In the symbolic categories, I elaborated on the example of fast food as associated with youth culture, by concentrating on the symbolic traits (section 5.4, p.147-154).
Q  ‘If you go out to eat with your friends, are there any comments relating to food?’

A  ‘What kind of comments. Comments [pause] most of them love pizza. When I say that I like shrimp, “Yuk, How can you eat fish!”’. I then say to them, “Yes, I like fish very much”. ‘We might have eaten it once and that was at the tavern and we never tasted it again’. So again, I am the exception. I like that. That it is what I like. Most of them, “What type of food do you like most?”, “Pizza”.’ (Athina, 17)

Similar experiences are reported in Chapman and Maclean’s (1993) research project, where a young woman claims that her friends think of her as a ‘really weird teenager’ because she likes spinach and healthy food. The ‘weird’ preferences in this study are regarded as the healthy choices, whereas in my study unacceptable preferences were also the home-made ones. Personal views about fast food could not ‘distort’ the social symbolisation of youth style and fast food. As such, if a young person desired to be perceived as a member of a youth category he/she needed to follow the overarching prescribed cultural codes. He/she has to fit in them and to discipline him/herself in such a way that his/her choices would not challenge the legitimacy and naturalness of these cultural codes.

In other cases, the participants explicated how health-related behaviours can be used as a means for cultural inclusion in sub-groups. The following excerpt concerns a female participant, Maria (17), who managed, with the aid of smoking, to feel as a member of the people who go to the Zoo club. She stated several times with a sense of superiority that she is a frequent visitor to the Zoo club, despite the fact that only older people than herself can enter. She then explained how smoking enabled her to feel part of the clubbing people. As she stated, ‘The age of these people was older. They were around twenty-nine to thirty years old. I felt that I did not belong’. When I challenged her to make clear how smoking aided her to feel more comfortable and possibly part of the group, she responded as following, ‘If I did not smoke I felt that I was not involved in what was going on there. It was important for me then’. The age difference between herself and the other people attending the Zoo club was culturally reduced by the aid of the act of smoking as a carrier of self- and/or life-style images.

Practising a sport was one of the most common activities which was positively associated with the idea of being special and different from the ‘crowd’. All the
participants who practised a sport on a regular basis appraised their sporting lifestyle as a unique opportunity to feel a distinctive personality. Few examples are given below.

- ‘Not everyone can join. You get chosen from school, and only athletes are allowed to join.’ (Dora, 16)
- ‘I am practising a sport, which is something interesting and not many people can do.’ (Stelios, 16)
- ‘Practicing a sport is not like going to the gym that all can do.’ (Demos, 16)

The distinction between an athlete and the rest of young people has been viewed in relation to their lifestyle. ‘It is nice to know that you are someone who does not laze about, sitting around doing nothing’ (Dimos, 16). Likewise, ‘you are not like others who sit around all day, doing nothing. You have something to do, in which you are good at, and that makes you special’ (Stelios, 16). The active lifestyle that these athletes appeared to have, asserts something special in their personality, making them different from the rest. It is highly appreciated since no one can easily join. As one of them highlighted, involvement in a sport gives you a greater opportunity to distinguish yourself compared with smoking, which it is something that everyone can do.

6.4.3 Joining a group of friends

In the preceding section, I discussed how health-related behaviours could also act as a medium of separating or including oneself from a group of people not necessarily consisting of ‘known’ individuals. In this section, I explore the relationship between peers and the onset of certain health-related behaviours as consumer activities. I concentrate on cases where the young participants treated the adoption or rejection of a specific health-related behaviour as a vehicle for enhancing or weakening the strength of the ‘cultural inclusion’ of someone in a peer group.

I begin first with the case of smoking as the most frequently mentioned factor regulating the extent to which a person may be included or excluded from a group of friends. In particular, I chose to elaborate on regarding the role of smoking in peer relationships with Liza, a fifteen year-old girl. Initially she stated that she had her first
cigarette during the last grade of primary school (aged 12) in order to be different from the rest, ‘Because no one of my age smoked’. Apart from enabling her to distinguish herself from the others, a capacity which has gradually diminished - ‘Now, most of them do [smoke]’ - she then explained how smoking behaviour facilitates her to be accepted by a group of friends. Her comments prompted me, as interviewer, to probe further her notions concerning the relationship between smoking and peer groups.

At the beginning, she noted, that she viewed smoking as an obligation since she ‘was among older people from secondary school and they were offering cigarettes’. Her preference to socialise with older young people - ‘I do not like the people of my age. They are a bit immature. They do stupid things.’ - led her to smoke when she was with them. Later, she regarded smoking as a vehicle that allowed her ‘to keep on being with them’. If she stopped smoking, her friends ‘would not treat me the way they do now’ and therefore, ‘we would not be as close as we are now’. Smoking as a facilitating factor in her cultural inclusion within her group of friends was raised in several ways. She ‘admits’ that her smoking-related habits are strongly associated with the presence of her friends. ‘I used to smoke only in front of my friends for two years.’ She also prefers Marlboro light or Marlboro, despite the fact that she does ‘not notice any difference with other brands’, ‘they are supposed to be better’ and a ‘normal’ brand among her friends. ‘They are strong and only crazy people like me and my friends smoke them.’ In the case of smoking other brands, and especially Rothmans, her friends would have estimated it as an ‘oddity’. Correspondingly, the absence of a smoking behaviour was seen as an obstacle for her peer relationships. Apart from the fact that she felt the need to smoke by seeing the others smoking, she hypothesised that she could not be as close friends with the rest of the group, ‘They would not have been so friendly with me’. Another young woman, Panagiwta (16), reported similar reactions concerning how she felt during school break-times when she stopped smoking.

‘When I stopped smoking, during that period, I stayed in the classroom during break time, I did not go out, and then [pause] when my friends [female] told me to go for a walk when there was sunshine I refused, I did not go. I did not go out of the classroom.’

Here smoking was seen as a ‘self-confidence’ resource for the participant: an essential source in order to have friendlier relationships with a group of friends. As she then
added, she refused to go out because she feared how her friends would react to her as a non-smoker.

Liza also remarked that the non-smoker girls in the group are not considered strong members of her group owing to the fact that they do not smoke. ‘We [the smokers] do not mix with them that much’. Yet, as she noted, these non-smoker girls would like to be perceived as members of the group since, ‘When they are with us, we do not pay any attention to them and they still hang around with us. This means that they want to be our friends’. She also assumed that these girls could have bonded more closely with the group if they smoked, ‘Then, my friends [the smokers] would have been friendlier to them’ 77. I asked her to clarify what these girls do not share with the other members of the group. As she explained, their non-smoking behaviour portrayed certain self and/or life-style images, which were not acceptable to the rest of the group.

- ‘Their image when they are with us is not good. It is not suitable. [pause] Girls who do not do what we all do [pause] they do not fit. They differ from us.’
- ‘...the fact that they are not smokers means that they have been conservative at something. They are more held back at certain points.’

According to her, they are excluded since they are ‘quiet’, ‘conservative’ and therefore not like herself and her ‘cool’ smoker friends who enjoy doing silly and risky things such as ‘beating people up’ or ‘driving the family car, without knowing how to drive and going for a spin and then driving it back home’. By smoking, they could confirm that they are risky and crazy as well: group characteristics, which she shared with the other smokers and considered fundamental for the group. As she explained, smoking is one of these activities that can promote shared experiences and solidarity within a group.

‘Smoking makes you feel better amongst your friends, doing what the others do [pause] If you are with a group, you should be doing the things the rest are doing. You cannot just watch them do things without participating.’

77 At this point, it should be stressed that this is an idea expressed by Liza who related her smoking behaviour to the establishment of a close relationship with her peers. It would have been interesting to find out how these non-smoker girls perceive their non-smoking behaviour in relation to their interactions with their friends: a situation that has not been investigated through this research project.
By the word ‘participating’, she did not only imply the practice of smoking and her active inclusion in the group of friends by following their ‘habits’; participation also mirrored their shared self- and/or life- style images. Correspondingly, not smoking reflected exclusion from both the practices and the self- and/or life- style images of the group.

At this point, it is interesting to note how smoking behaviour, as a means of depicting characteristics of a personality, functions in other types of relationships. Specifically, Panagiwta and Liza, the two female participants that I mentioned above, informed me that their ex-boyfriends tried to make them stop smoking. Again, the smoking behaviour, as a signification of a ‘crazy’ or ‘rebellious’ activity, acted as a resource for their emotional relationships. Liza raised this issue by saying that her ex-boyfriend was not accepted in her peer group since, ‘He is very reserved, very serious and a non-smoker’. When I asked her what the opposites are in him in relation to her peer group she responded as follows: ‘If he did smoke, he would not have been the way he is now. He would have been doing crazy things. Smoking makes you a more lively person’. The others, therefore, do not accept him, ‘Because he will not be able to do silly things, like we [her and her friends] do’. Despite the fact that he is not accepted by her group of friends, his non-smoking attitude was not treated as being a problematic one. This is because non-smoking represents his ‘kind character’ and ‘polite ways’. Moreover, she perceived her boyfriend’s personal attempts to make her stop smoking portraying his ‘true interest’ in her. Again, smoking is treated as a mechanism which regulates the type of relationships between young people. The fact that smoking projects certain self- and/or life- style images that are open for an evaluation by others, means that it is employed constructively by young people in their personal relationships.

The interviewees repeatedly associated the eating choices with their peer relationships. They raised the fact that the others may misunderstand a specific eating choice. Here, the misunderstanding concerns the internal personal characteristics, which are projected through a certain dish. Natalia (15), for instance, admitted that she had hamburger Diana with mushroom, and not vegetables - a healthy dish that she preferred - when she was with her friends. She stated, ‘I did not make my feelings apparent, because then they would criticise me. I felt uncomfortable and frustrated
having to eat what they liked’. The problem was the danger of being culturally
differentiated from her friends. By contrast, if she had been with her parents she would
have chosen what she liked to eat. As she explained, a healthy dish represents ‘a dumb
person’ whereas, ‘the person who prefers the burgers and pizzas is the one who goes
out the most [pause] the one who is more cool and modern’. Since her eating choices
projected aspects of her personality, she always took into consideration ‘what her
friends would say’. Therefore, the choice of a hamburger instead of a healthy dish
emerged as a vehicle for securing her status with her group of friends.

The participants frequently reported the refusal by young people to express their eating
preferences in front of their friends. The fact that pulses sounded ‘ridiculous’ for a
young person, could permit other group members to make personal evaluations, which
place the ones who have pulses in danger of being culturally excluded from the group.
For instance, Liza (15) commented about some of her friends who like vegetables and
pulses, ‘There are some who will be biased by what some of us prefer to eat, even
though in reality, they like those foods. They think that they might be ridiculed if they
say it’. In opposition to these friends, she stated, ‘I might say that I like that particular
food, but I will not eat it there. I just do not like to eat something that the others who
are with me are not having’. The problem derives from the cultural evaluations, which
carry a danger of being neglected or rejected from the group. When I challenged her
with the idea of having the same dish with her friends, regardless of what the dish
might be, Liza’s accounts were revealing in terms of the consumer symbols of the
chosen dish. It was not seen as a problem if someone was the only one who had a
hamburger, but it mattered if he/she was the only one who had a soup. Eating a
hamburger, as a young behaviour was thoroughly accepted by the other members of
the group, whereas eating soup was not, since it could project ‘negative’ self- and/or
life- style images. Soup could therefore emerge as a problem since these projected
images were judged as undesirable by the peers. As she explained, ‘It might be more
cool if you are having a hamburger’. Thus, someone could argue that another issue
concerning the eating practice as a means to support peer relationships relates to the
degree that each choice enacts shared cultural values of the group.

In relation to exercise, the participants treated cultural inclusion in a group of friends
in a slightly different way. The emphasis here is on the time the young people spend
with their co-sport friends as a period in which they construct their own cultural codes. These codes distinguish them from other groups of people and thereby strengthen their own friendship. Stelios considered sports as one of the most powerful ways of making friends since you ‘understand these people better’. He then highlighted the common way of dressing, listening to music and making jokes.

Q ‘Has it been influential in other aspects in your life?’
A ‘Yes, greatly. Or you influence others. Skating is linked with the way you dress and what kind of music you listen to.’
Q ‘How?’
A ‘Skating for instance, is linked with Rock and Rap and a bit with heavy metal music. In relation to the clothes I wear, they consist of two types: Stretch or baggie jeans. It gives you a bit of style which most people in Cyprus do not possess. I can’t think of anything else.’
Q ‘Do your friends care about their [interruption]?’
A ‘Basically, I made good friends. Roller-blading keeps us together because we have something in common. We make our own jokes and we have our own language, vocabulary as well. When we are somewhere and we are bored we make jokes, talk.’ (Stelios, 16)

Here, the participant talked about the development of a self-style through an interactive relationship with other skateboarders: he influences, and is being influenced by, their own habits. As a consequence, they built up their own self- and/or life- style through which they communicate and they also experience their participation within this group of people. Rock and Rap music, jeans stretch or baggie and their own type of humour have been constructively developed and are shared among them as common interests or cultural tastes. These common themes include the experience of strengthening social bonds with the other members through sports, which acted also as distinguishing signs from other groups of friends. Likewise Healey (1991), by eliciting memories of sports, found that sports are associated with people’s close relationships and the most meaningful moments in their lives. This research project supports this association by demonstrating that young people who regularly practice a sport, exchange self- and/or life- style images as a way of securing their involvements in a group of friends - sharing self-confidence, distinction and commonality.
'Peer groups' occupy an extensive focus throughout the literature of young people as being of more importance for children and adolescents than for any other age group (Coleman, 1999). In view of that, a significant literature has been developed within health promotion, which concentrates on documenting the social influence of peers with regards to health-related behaviours (Hopkins, 1994). As expected, by taking into account the influences of health logic within the field, the notion 'peer pressure' as a risk factor for the onset of unhealthy behaviours conveys primarily negative denotations (Lupton, 1995; Holland et al., 1996). Correspondingly, young people who follow the 'unhealthy' habits of their peer groups are understood as weak people: lacking mature autonomy, being emotionally dependent on their interpersonal relationships, and thereby easily conforming to the views and behaviours of other 'stronger' individuals (Hopkins, 1994). Based on my data analysis in this section, regarding the act of health-related behaviours as a rite of passage into peer groups, I would like to make two points about the idea of 'peer pressure' in respect of health-related behaviours.

Firstly, this present study argues about the key significance of the cultural manifestations of health-related behaviours as underpinning the occurrence of what is conventionally labelled as 'peer pressure'. In the examples given above, young people would not follow one or other direction – to smoke or not to smoke, to eat or not to eat a certain dish – if these behaviours were not endowed with consumer meanings in accordance with the group identity. For instance, I argue that the association between smoking behaviour and best friend (Lloyd and Lucas, 1998) lies in the cultural manifestation of smoking and its significance for the strength of the bond of friendship. Behaviours such as how much salt one puts in one's food, might be employed by a best friend. However it may not be influential in view of the fact that they are not attributed with meanings important for a friendship. The argument here is that certain health-related choices emerge as influential in people's choices, mainly because of their cultural manifestations, and can act as regulating factors in someone's inclusion or exclusion in a group of friends. Not all behaviours have this capacity.

Secondly, the perception of 'peer pressure' as a negative factor forcing unhealthy choices (Lupton, 1995), underplays young people's creative meaning-making activities in which they engage in the processes of choosing. In the examples above, the
participants demonstrated considerable knowledge of their group culture and the meanings attached to particular behaviours within these groups. They also made decisions about whether a health-related choice as a consumer activity is congruent with, and expressive of, their group identities. They also showed awareness that the same sort of behaviour may be rejected by other groups of people because of the contrasting between this style of consumption and that of these other groups. Therefore, it can be argued, that ‘peer pressure’ entails much more than conformity to the groups’ normative contents. It can also, as shown in the examples above, include collective processes of sharing experiences within their groups and creating their group cultures.

Lastly and as corollary of the above, I would like to challenge the negative connotation of the peer group in the context of health promotion. As Lupton (1995, p.149) argues, ‘peer group pressure is viewed as a negative forcing people to do things that are not good for them, whereas it may equally act as a restraint on behaviours’. Likewise, Lloyd and Lucas (1998) state that peer norms can also have a protective effect on these behaviours (smoking, alcohol consumption and drug use), depending on the shared social representations of the group.

In this study, a shared group of self and style of living image appeared in some cases to discourage ‘unhealthy’ or encourage ‘healthy’ choices. Characteristically, the young people justified their adoption or rejection of a certain health-related behaviour by exposing the prevailing ideas of their own group of friends. Panagiwta (16), who recently changed her friends, had tried to stop smoking.

‘... they are nice people [pause] no-one likes smoking or drinking. We simply go out to eat, to parties [pause] my friends do not think of smoking as being something special. When they see others smoking they explain to them that is bad for their health.’

Katerina (16), explained how she and her friends do not have any problem with eating pulses, despite the fact that the majority of young people labelled pulse, as a ‘non-cool’ food choice. Conversely, she stated about her friends: ‘We consider it [eating pulses] as being something normal [pause] we are all aware that none of us has a problem with eating this kind of food’. Therefore, ‘There were beans on the menu of
that family, that day, and our friend’s mum asked us whether we would stay for dinner, and we accepted’. It is also worth noting the way she responded when I asked her whether eating pulses might become fashionable because it is different from other foods. ‘Yes it might be possible. You might, in the end, become cool if you eat pulses.’

In this section, I highlighted the significance of the symbolic meanings inscribed in certain health-related behaviours in the process of making or rejecting friends. Smoking, eating, drinking alcohol and exercise occur as message systems, indicating to oneself and others, the type of image one should have in order to fit in a group. The symbolic (see section 5.2), and the elemental role categories (see section 6.3), occur as essential elements in the capacity of these four behaviours to ‘regulate’ the cultural inclusion of someone to a group of friends.

6.5: The role of context in the role categories

In section 5.3 I illuminated the relationship between the context and the symbolic categories. I demonstrated how smoking, eating, drinking alcohol, and exercise might be subjected to different consumer traits under different circumstances, such as the type of people who are present and the place where health-related behaviours are practised. In this section, I continue my analysis concerning the significance of context by highlighting its consequences upon the elemental and relational role categories from the perspective of my participants. Where, when and who is present, while someone practises a certain behaviour, are the most frequently mentioned contextual circumstances which regulate the manifestation of the role categories.

The first point discussed, concerns the relationship between the role categories with the presence of certain types of people. Given that a health-related behaviour is utilised as an image, a suitable context for it to be projected appeared as an essential presupposition. For instance, a number of the interviewees argued that the majority of young people smoke only in the presence of other young people. This gives emphasis on the role of the ‘others’ as a means to project a desirable image. As Dimitra (17) noted, ‘I know someone [girl], who smokes lights only when she is out, just to show
that she smokes. She does not smoke because she is addicted to it'. In other cases, the interviewees talked about instances when the projection of a self- and/or life-style image depended on the type of people who are around. For instance, Panagwita (16) explained that she would not like to be perceived as a smoker by adults, since they tend to 'perceive young people who smoke as being losers'. Likewise, Maria explained that she did not have a cigarette after the volley-ball match the day before as follows:

‘If I lit a cigarette, the others would think of me as being too young to smoke and gossip. I would not have felt comfortable smoking in the presence of thirty year-old women. They would think that I was trying to look cool’.

In opposition, according to her estimations, when she was among other young people of her age, she was not subjected to such types of evaluation: a young person who tries to look ‘cool’.

Elena acknowledged how her presence obstructed the possibility for her smoker friends to ‘show off’. When I asked her about the smoking behaviour among her close friends she responded:

‘Yes. We are five girls in the group and three of us have tried it. Despite the fact that they found it horrible the first time, they tried it again. They do not smoke regularly. They know of my views about it, so they do not show off in my presence. I think that, even when they are on their own they do not smoke’. (Elena, 16)

Apparently, if her friends smoked in front of her, they would not be able to share the experience of smoking with her. They preferred to share the style of smoking among other young people who are more likely to agree with the consumer traits in relation to smoking. As she added subsequently, ‘They do not want to subject me to the sight of them smoking. They know that I do not like seeing girls smoke’. Therefore, it can be argued, that if these young people smoke in order to ‘to project’ or ‘to experience’ a certain self- and/or life-style image, they should also ‘choose’ the type of people who are present.
The interviewees made similar statements about eating practices. For instance, Nausika said:

‘When I am with my friends I put three spoons of sugar in my tea, whereas when I am with people who I meet for the first time I take only one spoon of sugar. I do not want them to perceive me as greedy or ill-mannered’. (Nausika, 17)

In the presence of her friend, the capacity of the number of spoons of sugar she had in her tea to project a certain self- and/or life-style image is nonexistent. Her friends know her well and therefore her personal ritual concerning sugar cannot function as a mechanism ‘to project’ or for her friends ‘to evaluate’ her personality. Consequently, when she meets her friends, she has three spoon of sugar in her tea since she prefers her tea sweet. By contrast, when she is with people who she meets for the first time, she has only one spoon of sugar. In this case, the number of spoons of sugar she decides to have is not regulated by her taste preferences but by the projected self-image: she does not want others to perceive her as greedy or ill-mannered. This example highlights the importance of who happens to be there for a health-related behaviour choice regarding the two elemental role categories to be activated: ‘to project’ and ‘to evaluate’.

The social space of the health-related incidents as consumer activities can also be responsible if and how, the role categories of health-related behaviours may occur. Drinking alcohol in the Factory club was associated with showing off, whereas in the Enallax, it was seen simply as an entertaining activity:

‘The atmosphere in Factory is very different than the one in Enallax. Enallax is a place for more mature people compared to Factory where younger people go, and show off by drinking. The young people who go to Factory have alcohol, just to show that they can take it. When we go to Enallax, might not even drink at times. The reasons for drinking are different. The grown ups have it because they like it. Factory is a completely different place. When you go there, on a Saturday, you are expected to dance and drink. In Factory you go to have fun, so they combine having fun with drinking. On the other hand, Enallax has a similar atmosphere to a concert. You do not need to drink at a concert, in order to have fun. The music, itself will make it happen, because is live and you actively participate. It is not necessary to drink in
Enallax. At other places like Factory, drinking is considered more necessary to be cool’. (Katerina, 16)

Therefore, the projection of a ‘cool’ style through alcohol consumption, which can take place in the Factory, is not available in the Enallax club. These remarks illuminate the role of social space in relation to the activation of the elemental role categories through alcohol consumption.78

Lastly, I elaborate the case of time, regarding the manifestation of an elemental role category of health-related behaviours as consumer activities. The issue of time was, in most of the cases, associated with previous years of the young people: when they were younger. Some of the activities, which used to be chosen as vehicles to either project or experience self- and/or life-style images, do not have the same effects for the participants at the present time.

Alexandros (17), who started smoking three years earlier, explained how smoking was important for him during the third grade of the secondary school (aged 14). It showed that

‘... you are a macho and tough guy. It makes you feel that you are a grown-up. When you are at the third grade of secondary school and smoke, the girls watch you and think that you are cool’.

He then added when I asked him whether it was a positive image:

‘In those days, yes. We were young then, as well. That is how we thought. It showed that you are independent, mature. That is how we thought when we were younger. Now things are different’.

Things were found to be different for him at the time of the interview. Talking about himself and his other smoker friends he noted:

78 In section 5.3 I discussed the different symbolic attributions that health-related behaviours may receive within different spaces. In particular, I compared the inscribed self-images between the Enallax and Factory Club. In the Enallax club a smoker can experience himself or herself as a sophisticated type of person whereas in the Factory as a ‘modern’ or a ‘cool’ one (see p.146-147). In this section, I highlight the role of the space in permitting role categories to be manifested. For this purpose I used the accounts of the same participant about the potentials of each place for letting someone using the elemental role categories with respect to alcohol consumption.
'We have passed the stage when it was cool to smoke and whatever it was [pause] is now finished. We have shown the image we wanted and we do not need to do that any more'.

Later - at the time of the interview - he found the problem of addiction to be the main factor which made him continue smoking. The capacity to smoke, in order to show that he is a ‘macho’ guy, and to feel as a ‘grown up’, is not valid among his ‘older’ friends. The significance of time was raised in respect of his personal way of experiencing smoking as a cultural activity; to show a macho image. It was also stressed, how smoking was perceived by the girls whose cultural evaluations were significantly stimulating.

Q ‘Let us say that you never had the problem of addiction and you quit. Do you think that there would have been something missing whilst out with your friends?’
A ‘No. I am mature now. I do not think like that any more.’
Q ‘I am referring to the image of someone at your age.’
A ‘I do not think that my image would be different if I smoked or not. I think that a guy portray a better image in the eyes of a girl if he is not a smoker. It is better.’

Here, he acknowledged a number of types of changes in relation to the image of smoking and its functions. First, as noted above, he did not need smoking in order to project a ‘grown-up’ personality. Moreover, according to his estimations, girls do not evaluate smoking as a positive self-image as it used to be, ‘… in the eyes of a girl if he is not a smoker. It is better’.

Similar types of ideas were also expressed in relation to take-away food. In many cases, the participants explained how fast food used to portray attractive self- and/or life-style images at earlier stages of their lives. Nausika’s (17) comparable comments were revealing. She indicated how fast food, which they used ‘to project’ or ‘to evaluate’ a self- and/or life-style image, are now interpreted as a matter of practicality among her friends who are at the same age as her. In terms of a younger age, she mentioned.
‘It was characteristic of our age to order a pizza or anything ready-made to eat. That is how you think when you are at that age.’

‘They would have thought that it was weird, but they might even have liked the idea of home-made food. No-one was daring enough to do it though. To have or at least announce that he/she had home-made food.’

When I asked her how she saw someone of her age having fast food, she stressed the practicality of fast food for the current circumstances of her friends, rather than focusing on their cultural manifestation:

‘If the only things he was doing were having a pizza and then going home I would not be against it. Most of my friends are now in the army and when we go see them, they ask us for McDonald’s or KFC. I do not think that it is so important what anyone eats or where he goes for his food’.

Apparently, the strength of fast food to represent a self- and/or life-style image has both altered and diminished. The symbolic manifestation of fast food has altered since, at the age of seventeen, a fast food choice was interpreted as ‘weird’ behaviour if it happens regularly, whereas a couple of years ago, ‘eating at a restaurant’ or ‘having candle-lit dinner’ was seen as not suitable since ‘people of that age are not so mature’.

Nevertheless, eating fast food did not portray self- and/or life-style images to her as strongly as they used to do in the past. The change of the self and/or life-style presentations via fast food, for seventeen-year old young people, diminished at the same time as its capacity to project, and also to be evaluated, as cultural activities. As shown above, Nausika talked about fast food as a practical eating habit. Moreover, while she and her close friends ‘still eat casual food like pizza’, she stated that they ‘have a better time by going out to a restaurant for some chicken or a steak’. As she added afterwards, eating at the restaurant is considered as a more ‘substantial thing to do’, which, ‘shows maturity and being older’. It could, therefore, be suggested that the symbolic importance of fast food has been transferred to ‘eating at the restaurant’ as a more sophisticated activity, promoting communication, sharing same values and norms and entering in a different social field compared to the adolescents’ one. To sum up, the example above aimed to indicate how ‘time’ – when the incidence of a health-
related behaviour occurred – can transform the degree of the manifestation of the role categories.

6.6 Conclusion

In this chapter, I drew attention to the roles, addressed by the participants, of the self-and/or life-style images associated with health-related behaviours in accomplishing young people’s lives. I classified them into two broad categories: ‘elemental’ and ‘relational’. The elemental category, reflecting the basic ‘raw’ roles of the inscribed consumer traits, includes ‘projecting’, ‘experiencing’ and ‘evaluating’ a self- and/or life-style image. The relational category refers to the utilisation of the three elemental categories for ‘attracting attention’, ‘being similar to or different from a group of people’ and ‘joining a group of friends’. These roles give a perspective to young people’s experiences and demonstrate how these attributed consumer traits in health-related behaviours, which communicate certain self- and/or life-style images, fit in their everyday lives. Consumption or non-consumption of health-related behaviours may be seen as forming a part of the available resources to communicate meanings to significant others. Moreover, I illuminated how the communication of certain self-and/or life-style images is affected by the social contexts and the changes taking place in young people’s lives.

This chapter enriches the argument made earlier in relation to the health promotion area, which tends to provide little qualitative insight into a combined focus on young people’s spoken voices and lived experiences (see section 3.5.2, p.73-76). This combined focus expresses the consumer perspective approach as outlined in chapter 3, which moves beyond the potential cause-effect function that consumer traits may have on health-related choices. The data generated here drew attention to the roles of the ascribed consumer traits at the level of everyday experience. In this research project, young people had the opportunity to talk about the benefits gained through the consumer meanings of health-related behaviours in terms of coping with their social lives. They explained how these meanings affect their own self-image and their relationship with others, particularly their peers. They talked about health-related
behaviours as notoriously cultural activities among young people and the role of the ‘significant others’ who receive whatever is communicated. They also highlighted the malleable character of the context with respect to roles upon which the meaning-exchanges are based. The value of this chapter is that it foregrounds young people’s experiences of health-related behaviours. It addresses this little explored aspect of young people’s perspectives, of how meanings attached to particular behaviour provide forms of experiencing.

So far, in chapter 5 and chapter 6 I concentrated on health-related behaviours. I indicated the symbolic and the functional categories of health-related behaviours as cultural activities. In the following chapter, I concentrate on the participants. In particular, I explore their ideas of how young people reflect on the cultural manifestation of health-related behaviours. Is it a phenomenon that they are obligated to follow or resist? Do the young people experience themselves as mere dupes or active consumers? Do they think that young people actively use consumption in constructive ways or not? So far, these sorts of questions were answered by indicating via the respondents’ accounts of the symbolic and functional occurrences of health-related behaviours. My intention to focus on the participants’ opinions led me to identify two types of attitudes towards the cultural manifestations of health-related behaviours - these are explored in chapter 7.
Chapter 7

Reflective Categories

7.1 Introduction

The preceding analytical categories focus on the way the participants make sense of the symbolic content (Symbolic Categories - chapter, 5) and role (Role Categories - chapter 6) of the consumer meanings of health-related behaviours in young people’s everyday lives. The focus here is on the way that participants talked about their personal reflections with respect to the symbolic (category A) and the related roles (category B) of health-related behaviours as consumer activities (see section 4.4.2, p.117-119). The emerging categories – different ways the participants viewed their personal standpoint with regard to health-related behaviours as consumer activities – are labelled as reflective.

This chapter consists of four main sections. In the first, I elaborate the analytical concepts and strategies used for the third category of analysis (section 7.2). In the following two sections I demonstrate, through case studies, the two main sub-categories that emerged within the third category of analysis. These are first, the ‘engagement’ (section 7.3) and secondly, the ‘disengagement’ (section 7.4) with the consumer meanings of health-related behaviours. In the fifth final section of the chapter I elaborate the value of reflective categories of analysis with respect to health promotion (section 7.5).

7.2 The analytical concepts and procedures for the reflective categories

In this section, I clarify the analytical concepts and procedures used for the third category of analysis. Firstly, I describe the analytical process used for the
identification of the reflective categories examined here. Then I discuss the use of ‘case studies’ in order to present the main reflective categories.

The analysis so far has not taken into consideration the personal position of young people regarding the consumer meanings of health-related behaviours. Rather, I used the accounts of the young people in order to disclose the invested symbols and roles of health-related behaviours as consumer activities. Here the analysis is based on a position which focuses upon the young people’s reflections on the health-related behaviours as consumer activities and thereby examines, to some degree, their agency. The term ‘agency’ refers to the capacity of the participants to acknowledge and reflect upon the way they appropriate health-related behaviours as consumer activities. The term ‘to appropriate’, as it is used here, refers to the active contribution of the young people as consumers to ‘register’ their own standpoint with respect to health-related behaviours as consumer activities. Correspondingly, the term ‘agency’ does not refer to the extent in which the participants can make free-standing choices or not. The focus is on the way that the participants struggle, criticise and apply their own experience within the consumer meanings of health-related behaviours; a process which shows how they make sense of themselves as active consumers according to their relative position within the consumer context. The recognition of young people’s agency was methodological refashioned through the ways that the young people were encouraged to talk within the interviewing process (see section 4.3.2.3.2, p.97-98, section 4.3.4.2, p.103-104).

In the light of these observations, it is worth noting that within the present category I do not attempt to answer critical questions in relation to consumer culture regarding agency and structure. Rather, I focus on how the participants explained their lifestyles and talked about aspects of agency and structure, as a resource provided through the forms of consumption, including health-related behaviours. I explore the experiences, reported by the participants, with health-related behaviours as components of their consumer lifestyles rather than as evidence of the ‘proportional’ relationship between structure and agency. Therefore, by looking at participants’ accounts regarding their own standpoint, I uncovered some of the layers of personal values that prevail in their conceptions of their own reflective relationship with respect to the consumer manifestation of health-related behaviours.
For the purposes of the final category of analysis, I embarked into another journey through the participants’ accounts and sought to identify statements in which they referred to a particular way of responding on the consumer traits and the roles of these traits in the context of their everyday lives. In this category of analysis I concentrated on the data set of each participant as compared to the preceding categories, where I handled the data as a whole. I complete the picture of the young people’s consumer meanings of health-related behaviours by clarifying the different types of reflections as generated throughout the interviewing process. It gives a more pragmatic picture of the development of the interviewing process and the prevailing critical stance of the participants with respect to health-related behaviours as components of the consumer culture. I concluded with two different ‘ways of seeing’ their reflective encounter with health-related behaviours as consumer activities:

1 As engaging with the consumer meanings of health-related behaviours (section 7.3)
   1.1 Through a positive perspective (section 7.3.1)
   1.2 Through a negative perspective (section 7.3.2)

2 As disengaging from the consumer meanings of health-related behaviours (section 7.4)

These two primary types of reflections on consumer symbols and their role of health-related behaviours emerge in this study. The first (section 7.3), ‘engaging with the consumer meanings of health-related behaviours’ refers to the cases where the participants presented themselves as active users of the consumer meanings of health-related behaviours; they engage with the consumer meanings and they make their own choices in accordance. At these moments, the participants presented themselves as supporters of the symbolic and role categories of health-related behaviours. They viewed their practices as strongly affected by their engagement with consumer traits and the role of health-related behaviours in the context of their everyday lives. While some of them referred to the power of consumer meanings as forms of manipulation, they concentrated on the everyday benefits that these meanings provide them. In this category, I elaborate two types of reflections; when they talked about their engagement with the consumer meanings of health-related behaviours through a positive perspective (section 7.3.1) or a negative (section 7.3.2) perspective.
In a different manner, there were instances where the young people perceived themselves as consciously aware of the threats and dangers of the prevailing consumer meanings. Here, consumer meanings were considered as a repressive force, which can prevent people from following their 'real' needs. In these cases, the consumer framework of health-related behaviours was conceptualised and acted upon as a target for resistance; as a conscious process of disengaging. Correspondingly, the main concern of the participants was to consciously avoid, through their choices, the potential of consumer products to manipulate people’s needs and desires (section 7.4). Here the negativity does not refer to the participants’ feelings with respect to their ‘perceived’ passive choices (as in section 7.3.2). By contrast, the participants claimed that their own choices are independent from the consumer meanings that tended to be invested in health-related behaviours.

What connects both reflective categories is the way participants used the consumer meanings of health-related behaviours as a framework in order to talk about their own choices. Understanding health-related behaviours, either as a medium for cultural communication (category 1 see p.201) or as targets for resistance (category 2 see p.201) constitutes a frame of reference. The point here is that consumption, seen either as a form of empowerment, or resistance, still constitutes an arena for the participants to make sense of their health-related choices. The following analysis seeks to show how consumption provides a context - a set of parameters for both types of reflections as listed above - within which young people understand and talk about their health-related choices.

For the presentation of the analysis I concentrate on certain participants who tended to position themselves strongly in one of the above categories and sub-categories. These cases studies79 were not used as a methodological choice but as a choice of studying the practice of reflection within my participants. This sort of presentation enables me to present examples of my subjects and the way they talked throughout the interviewing process. It also reflects the third category of analysis in which I tried to

79 Here the term case study is used in accordance with Stake (1998) who defined it as ‘not a methodological choice, but a choice of object to be studied’ (Stake, 1998, p.86).
make sense of the way that each participant understood his/her own way of coping with the consumer meanings of health-related behaviours. These case studies enable me to justify more effectively the arguments accompanying each type of reflection developed by the participants. They are ‘intrinsic’ and ‘ideal typical’ which I explain below.

According to Stake (1998, p.88), an intrinsic case study is used because ‘it illustrates a particular trait of the problem’. In the present study, these case studies are ‘intrinsic’ in the sense that they concentrated on the participants’ understandings of their own reflections regarding the consumer manifestation of health-related behaviours. My descriptions do not aim to demonstrate all the issues that emerged in each individual case. Rather, I concentrate on how each of these chosen participants talked about their own reflections with the consumer meanings of health-related behaviours. They are ‘ideal typical’ because they do not represent a large collection of cases within the sample. I could not classify each participant strictly to each reflective category as demonstrated above. The young people’s reflections regarding the consumer meanings of health-related behaviours were inconsistent throughout the interviewing process. Nearly all the participants adopted all types of reflections at least once during the interview. Therefore very few of them can be restricted to just one of these reflective categories. The inconsistency in their responses forced me as shown above, to refer to different kinds of reflections rather than to different groups of people within my sample. Hence, the case studies presented below are ideal typical, in the sense that the individuals examined in each case study, unlike the majority, tend to be more consistent in their accounts of one type of reflection. Moreover, these chosen participants are the ones who articulated in greater depth one of the reflective categories also shared by other participants. Thus, I decided to choose these ideal individual cases, as I believe they advance our understanding of the phenomenon across the range of the participants in this study.

The presentation of the case studies is based on the participants’ vocabulary of issues relevant to the consumer meanings of health-related behaviours. As shown in the analysis below, the young people frequently used concepts or ideas that were expressed by cultural theorists regarding consumer culture. For instance, almost all the participants explained their own standpoint based on polarisations such as ‘real’ and
'fictional' needs, desires or self-representations. These sorts of ideas, which were mainly developed by cultural theorists of the 1950s and 1960s (section 3.2, p.56 and section 3.4.1, p.63), emerged as part of the participants’ descriptions of their own standpoint regarding the consumer meanings of health-related behaviours. My reference to these types of concepts or ideas is strictly connected with my attempt to describe the participants’ viewpoint. What is stressed here is that I do not ‘borrow’ these sorts of ideas from cultural theorists in order to analyse my participants’ standpoints. Rather, these ideas are used primarily as the young participants expressed them.

7.3 Engaging with the consumer meanings of health-related behaviours

The first reflective category refers to those moments during the interview that the participants acknowledged the significance of the consumer traits in their own health-related choices. Many examples were given in the preceding analytical category (chapter, 6), in which I elaborated how the participants talked about the roles of the inscribed symbolic attributes of health-related behaviours in people’s everyday lives. In the present section, I choose to explore the way that three participants judged their active involvement with consumer meanings of health-related behaviours. Specifically, I found two ways of approaching their active engagement with health-related behaviours as consumer activities. Firstly, I present two participants, who perceived their choices as mediations of their self- and/or life-style status (section 7.3.1). These are the participants, who tended to speak positively about their health-related choices as consumer ones. Secondly, I discuss the reflections of one of the participants who engaged in the consumer manifestation of health-related behaviours with some sort of dissatisfaction (section 7.3.2). Accordingly, I name the perspective in which the engagement with the consumer meanings of health-related behaviours is viewed as positive and negative.

80 Along the same lines, Nava (1992) argued that the image that circulates most frequently concerning young people and advertising, is deeply influenced by the polarisations suggested by cultural theorists of the 1950s and 1960s such as the creation of false needs as an inherent aspect of consumer capitalism (ideas expressed by Marcuse, 1964).
7.3.1 Through a positive perspective

Below, I elucidate the accounts of Despina (aged 15) and Nausika (aged 17) who expressed some level of satisfaction with respect to the consumer meanings of health-related behaviours. Both cases are explored in further detail below. Nearly all the participants adopted similar types of reflections at least once during the interviews.

Despina treated her engagement with the consumer meanings of health-related behaviours as a ‘requirement’ of the contemporary way of living and thinking. In her accounts, she identified her ‘self’ as a young person who, like other people of her age, considered the cultural manifestation of her own practices (including the choice of certain health-related behaviours) as components of the dominant youth lifestyle. She made it clear that the behaviours, which are invested with consumer traits, exist as an integral aspect of contemporary self- and/or life- style presentation. Accordingly, she engaged with the creation or presentation of her own style in order to live in parallel with contemporary beliefs. Correspondingly, she justified her own choices as expressions of how a young person thinks and acts in our times.

Her process of weighing up self- and/or life- style images of health-related behaviours is found, at many points in the interview, to be connected with her evaluations of potential consequences for her own self-image. She classified her eating and dressing patterns as the most significant choices with respect to style projection, ‘... the two basic things, which are food and fashion, represent almost all young people’. Eating choices are seen to be equivalent with choice of clothes; choices, which can actively contribute to the self- and/or life- stylisation for a young person. She perceived eating and clothes choices not only as features of young people’s modern life but also as ‘requirements’ of being young. As ‘a follower of today’s beliefs’ she feels uncomfortable to announce that she has beans or boiled potatoes since they are ‘not agreeable’ to young people and a ‘no no for our times’. She preferred fast food since ‘young people believe in Pizza Hut and Hamburgers’. As she explained, these sorts of selections enabled her to ‘belong in the cool group of people’ and not to ‘be cut-off from the rest’.
Likewise, she acknowledged that some people smoke and go to the gym in order to attract attention, to give a positive impression, or to make friends. She associated the engagement with these two practices by other people with the functions of the projected 'trendy' images. Correspondingly, she justified her refusal to follow the contemporary smoking and gym trends due to the projected images because 'they are not appealing to me'. Equally, she did not move beyond her inscribed consumer traits associated with going to the gym or smoking in order to justify her refusal. For instance, she did not mention any practical, health or moral issues concerning smoking or going to the gym. Her refusal to adopt one or other behaviour was justified through her perceived cultural irrelevance with her own style.

Her accounts reflected the idea that self- and/or life-style images are seen as part of contemporary youth culture; the way that young people think and act. It is worth noting that at moments in the interviewing process she presented young people, including herself, as 'victims' of the contemporary trends: 'we just ended up going with the flow following the masses'; and 'my opinion is affected by what the others think and I am only copying them'. These sorts of statements were made when she was trying to justify her obsession with delivered food and her preference not to admit that she had home-made food. She also acknowledged the role of advertising in the establishment of a strong fast food preference among young people, 'maybe it is because of the way these foods are advertised, or maybe is because everyone else eats delivery foods'. Nevertheless, she did not necessarily consider the 'victimization' of young people negatively. Conversely, she mentioned it as an inevitable social phenomenon, which gives her the opportunity to live with the present times. Although, she recognised that she 'follows the sheep' - 'I do not know how I ended up having this mentality myself but I guess I am only adapting to the others' way of thinking.' - she perceived her choices as ways of living according to the 'current beliefs'. To copy others and others' way of thinking or to present someone’s personality via certain health-related behaviours was regarded as an outcome of the contemporary way of thinking and acting, ‘this is the way young people of nowadays think and I would not like to be the odd one out’.

81 Despina used the term 'victims'.
Nausika also treated the cultural manifestation of daily practices as a fruitful source for young people to play with the development of their own self- and/or life-style. Nevertheless, she devoted considerable energy and attention to the ‘correct’ health-related choices as representations of the self. Her positive notions of the use of self- and/or life-style images via daily choices seemed to depend on some kind of internal correlation between the ‘fictional’ and ‘real’ self. This polarisation between ‘real’ and ‘fictional’ self repeatedly emerged in Nausika’s accounts. She referred to a ‘real’ self by using terms such as ‘genuine’, ‘authenticity’ and ‘personality’. On the contrary, for her a ‘fictional’ self does not represent someone’s ‘real personality’ with ‘authenticity’, rather it is a ‘projected self’. In the discussion that follows, I use this type of distinction as suggested by Nausika.

Throughout the interview she constantly negotiated a significant difference between experiencing the ‘real self’ as a positive practice, and projecting - if you are someone else - as a negative one. This tension was evident, for example, in the pursuit of a behaviour, which failed to portray the ‘real’ self through the invested consumer meanings. Her position is summarised in the following extract.

Q ‘So, do you think that even the choice of the type of cigarettes someone smokes has a lot to do with his/her personality?’

A ‘Yes. When the choice that is made, is made truthfully it portrays someone’s personality and that is acceptable by me. If someone, for instance, is smoking slim-line cigarettes, and she realises that it suits her and it is adding to her personality.’

Q ‘Explain to me what do you mean by “she realises that it suits her”.’

A ‘Someone realises that she is smoking that type of cigarette, not to show something which is not real for her. She might realise that smoking that certain brand of cigarette, shows that is advancing her personality to a higher level. She is not doing it though to prove a point to others, but because it felt natural for her to do it in the first place.’

These sorts of ideas occurred throughout the interview with Nausika. Her positive outlook regarding young people’s choices was regulated by the extent that these choices could match their ‘personalities’. She characteristically appraised the smoking behaviour of a girl as follows:
‘If any girl of my age smokes and it suits her, I would admire her. If she does it, though, just to be able to be part of a group, or because her friend smokes, I would think she has no personality of her own and I would pity her’.

The same type of reflections occurred when I challenged her to discuss a healthy selection of a meal by someone who joined the same club as herself:

‘It depends which person will say that [pause] If someone becomes obsessed with healthy eating, I would say that he does it only to show off... If his actions are for staying healthy are genuine and not superficial, he will be admired by me’.

Apparently, the same sort of reflections applied with regard to the roles of health-related behaviours as consumer activities. As demonstrated in the preceding quotations, she referred to three roles of smoking and eating healthy food as consumer activities: ‘To be part of a group’ (see section 6.4.3), ‘to show off’ (see section 6.3.1) and ‘it suits’ (see section 6.3.2). She expressed an antipathy to the first two roles since she considered them as indications of an ‘artificial’ choice: a choice which is not made ‘sincerely’. Conversely, she was positive about the third one, ‘it suits’ since smoking represents the ‘real’ self.

A similar sort of reaction was reported about her own choices. Nausika did not indicate any particular problem with her active engagement in health-related behaviours as consumer activities. Rather, she appeared to enjoy the mediation of self- and/or lifestyle images via her choices since they express ‘authentically’ her personality. Correspondingly, with respect to the preceding category of analysis (Role categories - chapter 6), Nausika is one of the participants who frequently suggested that the consumer meanings invested in health-related behaviours enabled her to ‘feel’ rather than to ‘project’ a certain self- and/or lifestyle image. She frequently justified her own choices as being ‘according to my personality’ rather than using any other sort of criteria. For instance, regarding the selection of an alcoholic drink, she emphasized the relationship between the inscribed images and her ‘personality’ rather than her aesthetic taste: ‘You have a certain drink not because you like the taste of it or to join your friends, but because it suits your personality’. Therefore, as she noted, she is not offended with any accusations about ‘peer pressure’ since her drinking choices are not
'pretentious' but 'genuine' in regards to her 'personality'. Moreover, in order to prove her 'authentic' choice she acknowledged the social construction of her own current alcohol taste; a taste, which is straightforwardly associated with her family backgrounds and current friendships: 'Your friends or family have been the key influence on your personality development and that is the main reason why you drink a certain drink'.

In a similar way, she talked about the fact that she does not drink excessively or smoke. Excessive drinking and smoking were rejected as incorrect expressions of her personality and lifestyle. She is not a drinking or a smoking person, which at the same time means that she does not have an autonomous life away from her parents. Consequently, her friends received the equivalent 'real' self-representations about her: as a person who does not drink and smoke and is therefore a steady friend. These ideas are illustrated in the following extract.

Q  ‘Do you think that every person’s personality has something to do with the choices they make in life?’
A  ‘If my friends understood me as a person who liked drinking and smoking I would have been treated differently. I showed from the early stages of our friendship that I do not like doing those things. Even at home, I never said to my parents: “I am going out now and I will come back whenever I feel like”. My friends realised that I was the steady kind of friend.’

These sorts of reflections did not only have a bearing on health-related choices. Similar ideas were expressed in the interview process about her ‘going out’ choices and clothes. She estimated her choice of a high-class club as a ‘natural thing to do’ since she is always ‘welcomed’ as if she ‘belongs there’. Moreover, this specific club, like the alcohol selection noted above, not only expressed her established personality but also her family origins:

‘Where you end up going out to have fun, depends on the personality you acquire, because of the people you hang out with and the sort of family you were born into. The places you go to, at the age of seventeen eighteen are the ones that express your personality and your style’.
Nausika also pointed out that she could not very easily go to a ‘simple’ coffee shop since she did not have the appropriate clothing, ‘...then the selection of my clothing would have been different as well. It would have been difficult for me to find proper clothes to go to a café’. Her clothes, which were also treated as ‘real’ representations of her personality, could not be matched with certain outgoing places such as simple coffee shops where students go and play games.

Lastly, Nausika’s ideas, concerning the consumer meanings of young people’s choices as a fruitful source for the realistic expression of personality, surfaced when she compared her current experience – at the age of 17 – with a few years ago, at the age of 15. The inability of someone to choose a truthful representation of the ‘self’ declared for her, a ‘lack of personality’ like the ‘people at the age of 15/16 who do not posses an all round personality’. Yet, she recognised that the consumer meanings of daily choices could be utilised, particularly by a young person as accessible routes for discovering his/her personality.

‘At younger ages you try various different places to discover which one suits you best and your personality is being processed in that way. Personalities at that age change in a period as short as one month’.

Despina and Nausika demonstrated, through their accounts, a positive perspective regarding the consumer meanings of health-related behaviours. What distinguished them is the way they judged their positive position in relation to the phenomenon of health-related behaviours as consumer activities. Despina perceived it as a new form of identification which young people are called on to adopt in order to live in accordance with the contemporary world. Nausika naturalised her health-related choices as outcomes of her own established self- and/or life- style. In the next section, I present a case when the participant reported a negative feeling regarding their engagement with the consumer meanings of health-related behaviours.

7.3.2 Through a negative perspective

As opposed to the preceding category, I now deal with the case when the participants expressed an uneasiness in behaving according to the inscribed consumer meanings of
health-related behaviours, particularly in the presence of other young people. While they ‘admit’ their engagement with the consumer meanings of their own practices – this is the reason I still include this sort of reflection in the ‘engagement with the consumer meanings of health-related behaviours’ category – they expressed some level of dissatisfaction. Even though the vast majority of the participants, at certain points within the interview, raised this sort of feeling, nobody used it as a constant underlying presumption of their health-related descriptions. Possibly, it is difficult for anyone to admit to him/herself at first, and secondly to the interviewer, choosing something which does not fall in with his/her desires or does not correspond with his/her way of thinking. Next, I concentrate on Natalia’s accounts since she seemed to be one of the participants who most frequently criticised her own choices negatively but still preferred to act according to the consumer traits ‘stored’ in them.

Natalia (aged 15), very early in the interviewing process stressed the tendency of young people to make their choices according to a set of youthful desirable cultural attributes; to be ‘modern’, ‘fashionable’, ‘cool’ and ‘in’. She also identified the role of these self- and/or life- style images in young people’s lives, such as: to join a group of people; to project an identity; to be evaluated; or to evaluate others (examples of which are given in chapter 6). The self- and/or life- style images and their roles were reiterated in her justifications of young people’s health-related choices. Correspondingly, she included herself as a young person who employs a similar way of thinking and acting. She noted this about fast food, ‘... these kinds of food have now been established as the food most young people eat. The same applies to me’. It is also worth noting that when she justified her own choices she used the pronoun ‘we’ implying that she behaved like all young people: ‘We all do the same things. When we go out, we go to a place everyone else does... If we are hungry, we will have a hamburger [pause] which everyone else does’.

While she justified her own options in terms of the inscribed consumer meanings shared by other young people, she constantly expressed some sort of frustration. When I asked her whether ‘she feels more comfortable when she portray herself as “modern” and “cool” via her eating choices’ she responded, ‘On the surface, yes. Inside of me, though, when I think about it later on, I know that they manipulate me’. Two primary
reasons appeared to underlie her negative feelings regarding her engagement with the consumer meanings of health-related behaviours.

Firstly, she experienced some sort of uneasiness since the consumer meanings directed her choices. For instance, according to her own suggestions, she was forced to make certain eating choices which were not in accordance with her 'real\textsuperscript{82}' eating desires, 'I felt uncomfortable and frustrated with having to eat what they [surrounding young people] liked'. In addition she explained, she wants to try smoking because she felt 'embarrassed... not to dare', and smoking is viewed as a sign of independence and bravery with respect to parents. She also mentioned that she would never have dared to admit that she like boiled potatoes, 'I would never say that', or healthy food, 'Whoever inclines towards healthy living is more dumb than the others and subsequently he will not be wanted in their group'.

Although recognising that she prioritised her 'non-real' needs\textsuperscript{83}, at the same time, she appeared dissatisfied with her own actions. She would have preferred to be freer to choose her 'real' desires rather than her cultural ones. It could be argued that her dissatisfaction derives from devaluing the consumer meanings of young people's choices as a phenomenon. At some point, she questioned this phenomenon with respect to the idea that certain types of food are considered as fashionable. 'If you really think about it though, the food itself is not in or cool.' While she recognised that the cultural classification of food as fashionable influenced her eating choices, she still found it incomprehensible. Nevertheless, she then added, 'we young people are only saying it to show off amongst the rest'.

Another source of her negative feelings derives from the view of young people as consumer sheep. 'It is the majority who has the say in what all young people do. Young people are influenced, get carried away, by what the majority is doing.' According to her understanding, this sort of mentality intervenes in young people's choices; they are forced to make certain choices. Likewise, in order to avoid the danger of feeling 'an outcast' she followed young people's communal preferences

\textsuperscript{82} Here, I refer to a distinction suggested by Natalia between 'real' and 'for image reasons' choices.

\textsuperscript{83} Here I refer to her own polarisation between 'non-real' and 'real' needs. By this distinction, she seemed to regard cultural needs as non-real.
even if they are not in accordance with her wants. Although she appraised this phenomenon as ‘stupid’, she still followed the prescribed choices, ‘I am embarrassed to say that I want something different’.

Unlike Despina - a case, which has been described in section 7.3.1 – Natalia disliked the fact that young people copy each other. According to her suggestions, ‘the copying mentality’ involves the danger of forcing young people to do something against their own desires. ‘Now that we are young, we do things we might not even want to, but because the majority does it.’ The power of communal attitudes not only obstructs the expression of difference among young people, it also indicates a lack of ‘personality’. ‘We do not posses individual personalities and we do what the others do.’ What is fundamentally important is that an underlying contradiction can be identified between the idea that young people do not possess a personality and the personal characteristics attached to their choices. On the one hand, young people are constrained to select certain choices in order to project certain self- and/or life- style images. On the other hand, she considered this phenomenon as a lack of personality. Again, this shows that she experienced the symbolic manifestation of young people’s practices in general, and health-related behaviours in particular as a ‘fictional’ phenomenon.

Natalia’s decision to follow young people’s choices does not only derive from the ‘manipulative power of the masses’ as performed via the inscribed consumer meanings of daily practices. At certain points in the interview, she disclosed her positive feelings regarding young people’s lifestyles in comparisons with adult lifestyles. According to her, young people manage to have a variety of experiences, a situation which was assessed positively as demonstrated in the following extract.

‘I like it. I do not think that an old person will be able to eat hamburgers and pizzas, go out, drink Frappe and smoke. These things are for people of a young age. If we did what the older people do, it would have been like a routine. It is more enjoyable if every age group has its own way of living.’

She also seemed to accept the failure of young people as opposed to older people to consider the consequences of their current practices.
Young people who smoke a packet of cigarettes a day and drink a bottle of alcohol every week they go out, do not think that they are actually damaging their health. An old person thinks of this, for sure. Having lived through a lot in his life, he will think of the consequences of his present actions.’

In a similar way to the case of Despina (see section 7.3.1, p.205-208), she considered her active involvement with her ‘imagined’ mainstream youth culture, as a passport to live in accordance to her age group. Although she constantly criticised youth-related choices, she simultaneously perceived them as the only resource to live her present stage of life. Thus, she preferred to engage with the consumer meanings of health-related behaviours rather than to neglect them, since they enabled her to have a more enjoyable and youthful way of living.

To sum up, ‘engaging with the consumer meanings of health-related behaviours’ as a type of reflection, incorporates the consumer meanings of health-related behaviours as choices that permit young people to actively create their own self- and/or life- style images. In all cases, the participants talked about the way that these behaviours can become valuable cultural resources in their lives. They all stressed the materiality of the symbolic in their everyday lives and how these intangible cultural symbols provide them with the sense of identity, purpose and creativity. Despina and Natalia explained how the selection of certain types of health-related behaviours enabled them to live in a modern contemporary way, and for Nausika to express her ‘personality’. Although they referred to a ‘manipulative power’ of consumer meanings, they still preferred to actively engage and use them for their own benefits. The focus here is, what is rewarding and rational about the meanings that health-related behaviours as consumer activities produce.

7.4 Disengaging from the consumer meanings of health-related behaviours

This section deals with the second main reflective category: disengaging from the consumer meanings of health-related behaviours (category 2 see p.201). It illustrates the participants’ resistance towards the penetration of the meanings associated with consumption into the culture of everyday life. Nearly all the participants, at least at one
point in their accounts, talked about their practices as being 'uncontaminated' by consumer meanings. This reflective category is demonstrated through a deep exploration of the accounts of two of the participants (Nicos, aged 16 and Athina aged 17), who strongly argued that their practices were not dominated by self- and/or lifestyle images. My choice of these two case studies was purposeful in the sense that these participants constantly suggested that their choices were unaffected by the invested consumer meanings. In other cases, similar sorts of reflections have emerged with less consistency compared with these chosen participants.

I start the analysis by unravelling the main position which prevailed in the way that these two participants talked about the consumer meanings of young people's practices. A theme that reoccurs in their accounts concerns their 'disgust' regarding the dominance of self- and/or lifestyle images as motives in young people's choices. Conversely, they regarded consumer meanings as forms of manipulation and governance of young people's minds. People 'who deal with images' do not choose but the choices are made for them by the power of a 'capitalistic society'. Nicos clarified vividly the dangers of consumer culture as a form of manipulation of people's needs. A particular comment by him illustrates this point well. It was raised when I asked him to justify his claim that young people desire to adopt an adult image via smoking.

Q  'Why do you think they want to have this image?'

A  'I think is something, which derives from our society. We live in a consumerist society. It constantly produces people who have one value about their selves and lives: what are they going to consume and how much. So, it is very easy for them to consume cigarettes, drinks and anything else. This is in relation to the advertisements that come across. It links with their image. They think that by smoking they will achieve a better image and this clearly links with the way that society functions in such a consumer manner.'

Here, Nicos adopted a negative perspective towards consumer culture. He stressed how consumer society controls its inhabitants by directing their interest towards the achievement of a better image. Accordingly, Nicos regarded young people who 'deal with images' as mere dupes of the society's consumer functions. It is worth mentioning at this point that Nicos justified his exclusions from an image-oriented
world by acknowledging his political position. He perceived himself as a more
informed and critical thinker than other young people since he belongs to the ‘well-
educated’, ‘left communist political party’ and therefore can notice the ‘traps’ of the
‘capitalist societies’. Athina repeatedly stressed the power of advertisements and big
‘capitalistic companies’ to manipulate people’s desires and needs. Regarding the
popularity of the pizza choice among young people she mentioned:

‘It is a matter of habit, it is not their fault they just follow the masses. Whatever is new and is advertised, they have to have it. They will make
out as if it is perfect without tasting it and say “I like it” or “I do not
like it”; The companies have succeeded in advertising the product’.

While both talked about the significance of the consumer meanings and their roles in
young people’s choices (such as to enter in a group of people), they both disapproved of them as a worthwhile resource in satisfying people’s needs or desires. They adopted
Marcuse’s (1964) term of ‘false needs’ in order to stress the useless and fictional character of needs which are shaped by the forces of consumption. They underestimated any human need or desire, which is accomplished by the consumer meanings of a practice: a position that is captured in the following words.

- ‘You do not do it [drink alcohol] because you need it. Simply to show off the image [pause] in order to become acceptable within a group.’ (Athina, 17)
- ‘If you are not addicted you do not want to smoke so whoever smoked once and continues he surely does it not because he likes it but in order to show an image.’ (Nicos, 16)

Although they acknowledged that one’s consumer choices aim to fulfil ones needs and
desires, they still challenged the capacity of these choices for such purposes. The fact that they considered the originality of someone’s needs or desires as a form of
manipulation resulting from the penetration of the contemporary consumer manner, it
is sufficient for them to reject them as ‘non-real’. Like Marcuse, they underestimated
the alternative possibility that people’s identity could be enhanced by commodity possession or use; such as via smoking and alcohol consumption as shown above.
Along the same lines, both of them found the dominance of images responsible for the production of ‘artificial’ people and a meaningless way of living. As they frequently suggested these are the ‘people who deal with images’. Their criticism relied on the power of consumer culture to manipulate people’s choices which is incapable in satisfying people’s needs or desires and thus provide an essential way of living and being. They considered consumer meanings as forms of manipulation and governance of the masses and as responsible for producing artificial selves and meaningless lives. According to them, these sorts of outcomes concern the people who have not managed to overcome the power of consumption and thus, meet their real and not the fictional needs or desires produced by consumer societies. Nicos labelled them as ‘artificial people’ since ‘they portray a self that it is not themselves’. As he also remarked, these ‘artificial’ people may choose a certain place to go or a way to dress that they do not like, but simply because ‘they want to portray a false image of themselves’. He also suggested ‘their lives are without any real essence’. Likewise, Athina emphasised the inability of these people, who are dominated by self- and/or life- style images, to communicate truthfully with their partners since they ‘do not know why they want them’ but simply use them ‘to show their selves off because they have nothing else going for them’. Similarly, she suggested, these people regarded the exchange of ‘cool’ self-images via alcohol consumption as ‘entertainment’; something which is incomprehensible for her.

In opposition, their own choices become meaningful in comparison to the ‘consumer sheep’ – ‘the others’ who follow the consumer society’s fashions. The perceived victimization of the others as consumer dupes gave space for many of the participants to construct their own meanings regarding their health-related choices. A large proportion of their comments aimed to prove how they manage to escape the repressive and manipulating powers of the capitalist consumer culture. Below, I explore through Nicos’s and Athina’s accounts how the disengagement from the imaged-world was seen as a route for achieving ‘truthful’ experiences: a contention which also includes health-related behaviours. The following examples aim to show how the cultural consumption was still employed as a frame of reference for these participants to make sense of their own health-related behaviours. In order to achieve this I explore some of the comparisons that these two participants made between their
choices and the choices of ‘the others’, who follow the sheep: an idea particularly dominated by those who perceive themselves as opponents of the consumer culture.

‘I do it because I like it’ was one of the most dominant discourses, used by many participants as a strategy to distinguish themselves from the dominance of consumer meanings. Whilst talking about their own smoking, eating, drinking alcohol and exercise habits, both of the participants talked very much in terms of their individual material preferences. Yet, when talking about others, they regularly stressed the central role of the cultural significations of their ‘chosen’ preferences. They both appraised their own choices as more ‘real’ since they are not driven from the consumer meanings, a theme reiterated for all four health-related behaviours.

Nicos insisted that he drinks ‘Frappe’ (ice-coffee) only because ‘it is something that keeps me awake’ and not to show that he is a ‘rich kid’ like the others. Regarding alcohol consumption, he noted that he does not feel any oppression in ordering water instead of beer since he does not like the latter. In opposition, he mentioned that he knows someone who ‘does not like drinking and he carries a 7Up in his coat in order to drink because he is ashamed to order it there because people will see what he is going to order’. Likewise, his following comments illustrate the contrast between the originality of his eating choices in comparison with others who are affected by the communication of ‘images’.

- ‘Young people’s minds are dominated by a separation of the places that they are going out to eat. This does not happen to me [pause] I liked it [Epikouros restaurant] but I do not think that it does anything for my image if I go there to eat or not.’
- ‘I do not know what Pizza Hut and a kebab house signifies for someone but for me it does not portray anything in particular.’

Correspondingly, concerning his eating choices, he insisted that ‘the only criterion is what I want. Only what I miss eating...’, unlike others, whose choices are aimed to project an image. In addition, Nicos stated that he does not go to fast food restaurants which ‘are entirely places without personality’ like the other young people. In opposition, he experienced more meaningful moments by going to ‘places where you go and you are simple. It does not matter how you look...’.
Similar types of comparisons occurred in Athina’s comments for all four health-related behaviours. The table (7.1) below illustrates how she justified all her health-related choices in comparison to the ‘others who deal with images’.

Table 7.1: Disengaging from the consumer meanings of health-related behaviours: examples from coded segments of data

<table>
<thead>
<tr>
<th>Behaviours</th>
<th>Athina</th>
<th>Others who deal with images</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking</td>
<td>‘I would have tried to smoke if I wanted. If I liked it I would like it. If I did not like it I would have never tasted it again.’</td>
<td>‘They will smoke, for instance, if someone new comes into their group of friends, or some girls might smoke to show off to a boy. They would not smoke because they are addicted to it but just to appear that they are special.’</td>
</tr>
<tr>
<td>Drinking alcohol</td>
<td>‘If I decide to drink, I will drink because I like the taste. I like drinking because my father always used to drink and also my grandfather… you get used to the taste’</td>
<td>‘They might not know what they are drinking… To show that they are cool they will have shots.’</td>
</tr>
<tr>
<td>Exercise</td>
<td>‘You feel as if your body is rejuvenated. I basically started swimming in February because I like the water.’ ‘I simply did it [running] because I liked it.’</td>
<td>‘Aerobics is something aristocratic. The women who have lovely husbands, [Ironic laugh] whose father built a house or bought a car for them, these kinds of people go to the aerobics classes.’</td>
</tr>
<tr>
<td>Eating</td>
<td>‘I order these types of foods that my grandfather used to order and I like them of course, because if I did not like them I would not order them.’</td>
<td>‘It is a matter of habit, it is not their fault they just follow the masses. Whatever is new and is advertised, they have to have it. They will make out as if is perfect without tasting it and say I like it or I do not like it.’</td>
</tr>
</tbody>
</table>

Throughout the interviewing process, Athina constantly made different interpretations for herself and the others. The others are the ones who smoke, eat certain food, drink alcohol and exercise because of the projected images that inheres in these choices in the public space. In opposition, she labelled her personal choices as more ‘authentic’ and ‘real’ in the sense that they represented her aesthetic tastes and desires as they were established through her childhood, thus not influenced by the consumer images. She is among those participants who attempted to elicit the single truth of her choices.
by escaping the repressive power of consumer images. She rejected smoking as a personal symbolic attribute, but she accepted it as an outcome of an aesthetic taste or a biological addiction. In parallel, she rejected those who smoke, ‘not because they are addicted but to show a self-image’. Similar comments were made in relation to her drinking habits. She maintained that she never drinks for image reasons and she confirmed this position by saying that she might go out and not have an alcohol drink if she does not have the craving for it.

Athina strengthens her standpoint with respect to the ‘authenticity’ of her choices, and thus her resistance to the manipulative forms of consumption, by stressing other significant factors in the construction of her preferences such as family, Cypriot culture and childhood. For instance she argued that she likes going to a tavern, since ‘it brings back memories’ of her grandfather where she would order types of food that they used to eat together. She also regularly talked about the influences of the Cypriot culture on her eating preferences of tavern types of food as opposed to fast foods. ‘I got accustomed to traditional food from a young age. I do not like to eat what Americans sell as food; Again, my choice will be what I grew up with. Tradition, basically.’ She also tried to ‘prove’ her ‘authentic’ preferences by highlighting how her family life plays a pivotal role in establishing her alcohol options. Nausika raised this point as well, she wanted to reassure me about the ‘authentic’ originality of her alcohol choices not as a familiar taste like Athina - but as a ‘genuine’, however still symbolic representation of herself.

The above presentation showed how both Nicos and Athina perceived themselves as being able to sit back and critically reflect on the ‘passive victims of consumption’, those who ‘deal with images’. Nevertheless, they failed to come to terms with the fact that they also conceptualised their own personal choices in reference to their ‘imagined prevailing’ consumer meanings. As shown above, they also constructed their own meanings of the choices partially through the framework that consumption provides. They did not acknowledge that by adopting the opposite style it still represented a

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84 ‘Personal attributes’ was one of the symbolic categories raised in section 5.2.1 (p.133-137).
85 Taverns are local restaurants with a ‘traditional’ decoration where they serve what Cypriots define as ‘traditional food’ such as tzatziki, tahini, kebabs, meat balls and so forth. They do not serve what Cypriots tend to label as ‘western’ or ‘American’ foods such as pizza and hamburgers. It is also unlikely to find young people (aged 15-17) eating at these places unless accompanied by their families.
similar simulation. This inconsistency is well documented by Simmel (1957, p.307); ‘If obedience to fashion consists in imitation of such an example, conscious neglect of fashion represents similar imitation’ (cited in Miles, 2000, p.143).

Although Athina’s comments aimed to give a more critical edge, while illustrating the pervasiveness of consumer culture, she still referred to her own ‘style’. ‘I think my style is more cultural. I like my tradition.’ She therefore classified her eating preferences – going to a tavern and having traditional food - as expressions of her style in a very similar way as ‘the others’. The only difference is that ‘the others’ claimed that they are ‘modern’ and ‘in’ by eating Macdonald’s. In addition, although she regularly accused young people to like or hate certain foods without even trying them, she stated about Macdonald’s, ‘I have not been to Macdonald’s yet. I have not tasted their food yet and I do not even want to taste it’. Apparently, Athina did not address her own choices according to the same criteria. Like ‘the others’, she declined the option of Macdonald’s without even tasting it. Likewise, she declined trying aerobics or going to the gym, since ‘the others’ consider this type of exercise as ‘cool’.

To sum up, I discussed the second reflective category ‘disengaging from the consumer meanings of health-related behaviours’ through Nicos and Athina, who constantly presented their selves and choices as opponents of the consumer culture. They emphasised their agency in which they, far from simply following the latest trends in order to act in accordance, prefer to follow the ‘opposing’ style. Their approach is linked with McRobbie’s (1989) study, which shows how young people play an active part through the creation of their own street fashion, rather than following passively the latest fashions. However, the main point here concerns the use of consumer meanings as a frame of reference in the way they understand their health-related choices. The fact that they consciously attempted to react against the mainstream (according to them) ‘cultural’ options among young people, does not necessarily mean that they abandon them as well. They also construct their meanings of choices partially through the framework that consumption provides.
7.5 Conclusion

The third category of analysis concentrates on those moments that the participants engage in a reflective practice: stand ‘outside’ and explain their own position with regards to the consumer meanings of health-related behaviours. Two key types of reflections were generated, ‘engaging’ and ‘disengaging’, relating to the consumer meanings of health-related behaviours. The first signifies an active appropriation of consumer meanings for the accomplishment of purposes within the context of their everyday lives. The second refers to an active ‘resistance’ to ‘using’ the consumer meanings of health-related behaviours for the satisfaction of needs and desires.

Despite the opposing character of these two reflective categories – engaging and disengaging – the analysis presented in this chapter highlights their shared features. Firstly, forms of consumption, including health-related behaviours, act for both categories as a fundamental frame of reference. Symbolic and role categories form part of the available repertoires, which the participants draw upon to explain a reflective standpoint. Likewise, aspects of structure and agency regarding the forms of consumption, as understood by the participants, were used as a resource for personal reflection. Nearly all participants referred to the manipulating and constraining power of the cultural manifestation of forms of consumption, and also to their capability to think, stand back, reflect and thereby operate in a discourse of choice.

Secondly, both reflective categories demonstrated the active ways in which the participants negotiate with the consumer meanings of health-related behaviours in the course of their everyday lives. These active ways were expressed through both types of reflections: as a conscious appropriation of (reflective category 1) or a conscious resistance to (reflective category 2) the hegemonic consumer meanings attributed to health-related behaviours. In both cases, the participants demonstrated themselves as operating in a discourse of choice and exposed somehow their own private logic which guided them towards one or the other choice.

These similarities between the reflective categories can be best exemplified by highlighting the parallel types of arguments used for both types of reflections. For
instance, both the idea of ‘consumer sheep’, and the polarisation between the ‘fictional’ and ‘real’ character of self- and/or life-style images, were employed for demonstrating an autonomous choice. Nevertheless, these points were filtered differently in each reflective category. As shown above, Nausika used both ideas in order to distinguish herself from the ‘consumer sheep’ who according to her are those who choose a self-image which is not an ‘authentic’ representation of themselves. Natalia and Despina also used the idea of the ‘consumer sheep’ by suggesting that collective youthful activities can be experienced not only as an oppressive situation, but also as the correct rite for a contemporary and a desirable youthful way of living. Nicos and Athina referred to the ‘consumer sheep’ as people who ‘deal with images’ in order to celebrate their own power to escape from the fictional realities of consumption. It is worth noting that I did not come across any participant who either perceived him/herself ‘fictional’ or conformed to the profile of ‘consumer sheep’. Both seem to be ideas, which prevail in the participants’ accounts, as a frame of reference for their own practices.

With respect to health promotion, the reflective categories are significant for two main reasons. Firstly, what the value of health-related behaviours says about one person becomes even more complicated when the reflective categories are also taken into account. The recognition of types of consumer traits (Symbolic categories) and the related-roles (Role categories) of health-related behaviours does not necessarily imply a straightforward and unthinking use. This analytical stage demonstrated that young people’s agendas could not be fully obtained by sticking merely on the inscribed consumer meanings ‘stored’ in health-related behaviours. It demonstrated that meanings communicated through all or any health-related behaviours have been or will be accepted by all young people. These meanings were ‘consumed’ or ‘non-consumed’ by young people only if, through a reflective practice, they decided that these meanings give expression to their own style of living. Therefore, it is pointless for a health promotion intervention to reinforce or weaken a particular set of consumer meanings of health-related behaviours by approaching young people in general. Rather, health promotion should be sensitive towards the different cultural reflections and provide a custom-made intervention.
Secondly, this analytical category is significant for health promotion, in the sense that it concerns the active process of thinking, employed by the participants, related to the consumer meanings of health-related behaviours. The young people in this study did not act entirely in ignorance of the consumer manifestation of health-related behaviours. Their decisions, as demonstrated in this chapter, involved a conscious choice to engage or not in an activity. That is not to suggest that consumer choices are independent of, or necessarily resistant to, the structural determinants of young people’s lives. Rather, it demonstrated those cases where the participants made critical judgments and arrived ‘consciously’ at certain decisions. As argued in chapter 3, consumption, as an active meaning-making activity for young people, is relatively concealed within the field of health promotion. Yet, recognition of agency is important in health promotion and consistent within the context of the rhetoric about empowerment.

The examples given in this chapter demonstrated that the participants do have at least some degree of critical distance from the phenomenon of the consumer manifestation of health-related behaviours. The exploration of the participants’ descriptions of their reflections, brought to bear their sophisticated critical skills and their active part in creating their own styles. If Nava (1992) argued about the sophistication of young people in de-coding advertisements, I similarly indicate their skills in de-coding their and others’ choices. The critical thinking of the participants is directed by the consumer meanings of health-related behaviours and not by the health discourses. Thus, the material presented in this chapter challenges the claim that young people lack the skills of empowerment as a reason of their failure to make the ‘right’ choice. The problem seems to be that the direction of the young people’s decision-making skill is towards the consumer meanings rather than to health meanings. These behaviours were not seen as a preventative way of resisting disease and promoting health, but as ways of projecting or hiding a self- and/or life- style image. As shown, the ‘right’ choice of the participants was not always the healthy one and neither was seen as a passive one.
Chapter 8

Conclusion

8.1 Introduction

This research study began with an acknowledgment of the difficulties within the field of health promotion of conceptualising the meanings young people inscribe on health-related behaviours in their everyday lives. In the literature review, I argued that the empirical and conceptual approaches to health-related behaviours have been hindered by a tendency to concentrate on the final choice, or by structurally loaded discussions of ‘problematic’ behaviours and meanings: attempts which have limited relevance to young people’s self-conceptions of the role of these practices in their everyday lives (chapter 2 and chapter 3). Subsequently, I proposed that health promoters need also to address what young people say about their everyday lives as well as the processes of interpretation that give meaning to health-related behaviours. How young people talked about the way that the consumer meanings of health-related behaviours fit in the context of their everyday life was identified as being a particularly important focus in this respect.

In this chapter, I bring together my empirical findings together with the conceptual debates I raised in chapter 2 and chapter 3. In section 8.2, I highlight the importance of escaping from health logic in order to retrieve young people’s ways of seeing the everyday role of smoking, eating, drinking alcohol and exercise as consumer practices. Hereafter, I go on to elaborate the implications of the data generated for future research by highlighting apparent limitations and proposing different research questions (section 8.3 and section 8.4). Finally, I explore, in a broader manner, the implication of the study concerning the relationship of consumer culture and health promotion (section 8.5).
8.2 Exploring health-related behaviours as consumer activities

The two main elements of the research design – focusing on consumer meanings of health-related behaviours and bypassing health logic – constitute the distinctive area that this research study occupies within the field of health promotion. The combination of these two research elements reflect my ambition to capture the perspectives of the participants on the consumer meanings of smoking, eating, drinking alcohol and exercise as embedded in their everyday lives. In both empirical processes (interviewing and analysing), I concentrated on young people’s self-perspectives and their everyday lives. This arose out of my choice of themes to explore, and, in relation to the analysis, bring to bear on the participants’ perspectives without classifying them as conducive or not to a healthy choice. Rather, my emphasis was on how the consumer meanings attached to particular behaviour provide forms for experiencing everyday life. In this section, I discuss the empirical value of both research elements, in comparison with the main tendencies characterising the field of health promotion.

In chapter 2, I developed the notion of the health logic through which I elaborated the main critique of the thesis which concerns the ‘judgemental’ and cause-effect logic applied to the way that these four behaviours, along with their social and cultural manifestations, are generally approached. This health logic is also reflected in the empirical studies generated in relation to the consumer manifestation of these four behaviours within the field of health promotion, an area which has not yet adequately explored within the field. The emphasis is placed on explaining the compliance (or not) of individuals towards certain choices as outcomes of the symbolic manifestation of consumer products and activities. As discussed in chapter 3, health promoters tend to be influenced by theories and empirical approaches which have emerged in the field of consumer culture and which aim at explaining the construction of the choice rather than at exploring how consumers make sense of their own experiences. In effect, the role of the consumer meanings of these four behaviours (smoking, eating, drinking alcohol and exercise) and their role in young people’s daily lives are unsurprisingly neglected and treated as irrelevant to health matters in general.
Accordingly this research study, located within the field of health promotion, is distinctive by virtue of employing something of the overall orientation of cultural studies in exploring health-related behaviours as consumer activities, thereby decisively breaking with health logic. This was reflected at both stages – during the interviewing process and analysis of data. The participants were not asked to judge these four lifestyle choices with respect to health as such. Rather, they were encouraged to discuss their everyday experiences generated by the consumer manifestation of these behaviours. Likewise, the data analysis prioritised the young people’s perspectives on their consumer experiences, thus moving beyond a classification of their accounts as rational, irrational, positive or negative from the point of view of health logic. The significance of this empirical approach is elaborated below.

Health-oriented judgments were revealed in the pilot study, something which obstructed my participants to talk about the role of these behaviours in their everyday lives (see section 4.3.1). Conversely, by encouraging the participants to discuss the consumer meanings of these four behaviours within the context of their everyday lives - without ‘obligating’ them directly or indirectly to judge these behaviours with respect to health - the health relevance of these activities did not appear in their account, standing alone and above other dimensions of these behaviours (see section 4.3.2.4.3 and section 4.4.3.1). These four behaviours as health-related were taken up but were just as often resisted, ignored or negotiated in relation to other meanings and roles experienced. The participants’ positive or negative attributions concerning these behaviours were largely in accordance with the embedded self- and/or life-style images in their everyday life experiences. Thus I managed to escape from the judgemental character of health, with respect to the role of the individual in health matters, and capture how the participants talked about health-related behaviours primarily as consumer activities. This is not to suggest that health notions are irrelevant to young people’s experiences of their behaviours but, as noted above, they do not leave space for other kinds of considerations to occur which are relevant to these choices and their everyday lives.

The data analysis concentrated on the consumer meanings of health-related behaviours as background knowledge held by the young people. The unique element of the
findings concerns the way that the sort of background knowledge chosen – the consumer meanings of health-related behaviours – was analysed, by focusing on the young people’s perspectives on their everyday lives. The analysis of the data moved beyond the ‘evaluation’ of the young people’s accounts in terms of the adoption, or not, of a healthy choice. Rather, I disclosed how the young people talked about the consumer significance of health-related behaviours with respect to their everyday lives. The merits of the findings as developed in the three analytical categories are elaborated below.

Firstly, I sketched out the embedded symbolic traits (e.g. ‘cool’ – see Symbolic Categories - chapter 5) that were connected primarily with self- and/or life-style images, rather than with any sort of inherent use value or health quality (in the biomedical sense). Moreover, I demonstrated how health could be desirable or undesirable for young people, not only as a medically defined state of well being, but also as a cultural product. The health relevance of these four behaviours was found to also signify self- and/or life-style images. These types of self- and/or life-style attributions led me to propose placing health-related behaviours in the arena of consumption. Among other consumer products or activities such as clothes and music (e.g. Miles, 1998), health-related behaviours were also seen as a mode of being and articulating self- and/or life-style images.

The study of health-related behaviours as consumer activities was reinforced in the second category of analysis (Role Categories) through which I addressed how my participants talked about the role of the symbolic categories within the context of their everyday lives (chapter 6). As discussed in section 3.5, health promotion has had little tangible success in coming to terms with the role of health-related behaviours as consumer activities in the context of everyday life. This is because the analysis of the consumer meanings of health-related products or activities is primarily restricted to their impact upon young people’s choices, leaving out the utility of these behaviours in their daily lives. This research project managed to fill the gap in this area of research, by moving beyond the inscribed symbolic traits in health-related behaviours. The second category of analysis, demonstrated how the participants did not only ascribe self- and/or life-style images to health-related behaviours, but also described the everyday solutions or experiences provided to them.
The third category of analysis (Reflective categories – chapter 7) enriches further our understanding of young people’s accounts of health-related behaviours as consumer activities. I explored young people’s reflections on the symbolic traits (first category) and their roles (second category). I showed how the consumer manifestation of health-related behaviours amount to an important resource through which young people evaluate their own standpoint with respect to their choices as self- and/or life-style images. I exemplified, through a number of case studies, how the recognition of the constraining and manipulating aspects of health-related consumer choices was seen as a resource for personal reflection and articulation of the cultural occurrence of health-related behaviours, with respect to the participants’ own and others’ standpoint.

With respect to health promotion, the third category is significant in the sense that it generated an active process of thinking employed by the participants concerning the consumer meanings of health-related behaviours. While the field of health promotion has developed few empirical projects which focus on the way that people make sense of their choices as active consumers, it conceptually relies on the empowerment of the individual in health-related choices (see section 3.5.2, p.73-76). This paradox, which characterises the area of health promotion, is partly addressed through the third category of analysis which uncovered the active process of thinking employed by the participants. It also challenged the assumed lack of empowering skills possessed by young people as a reason for their failure in selecting the ‘right’ choice. As was demonstrated, the participants did not view the ‘right’ choice as either healthy nor passive.

The overwhelming indication gleaned through these three categories is that the young people’s consumer meanings constitute an invaluable source for playing with their self- and/or life-style images. Therefore, it can be argued, health-related behaviour meanings are culturally constructed and they constitute an important resource through which young people can communicate and interact with one another.

In view of the findings of this study, I propose consumer culture as an interpretive perspective for analysing young people’s accounts of health-related behaviours. The conception of health-related behaviours as consumer activities highlights their cultural
significance and their role in young people’s lived experiences. What is viewed as a paradox in young people’s understanding, in relation to their health behaviours with reference to good health, could be rationalised from the perspective of consumer culture. The notion of lifestyle, when it is seen through a consumer culture perspective (see chapter 1 p.11), is not restricted merely to the health discourses but incorporates self- and/or life- style expressions of health-related behaviours. To sum up, the conception of health-related behaviours as consumer activities enables health promoters to escape, at least empirically, from the notions of ‘good health’ and to place these four activities within a broader consumer framework which characterises contemporary urban living.

8.3 Limitations of the study

Every step of this research process was accompanied by a number of decisions and every decision was linked to a number of possibilities and potential limitations. In the preceding section, I have drawn out the potentials of these decisions by demonstrating the links between the aims of the study and the main findings. I elaborate on these decisions by highlighting themes that have not been systematically addressed.

The first point is concerned with the process of analysis which approaches young people as a homogeneous group. Although in the sampling process I tried to include multiple backgrounds of young people, in the process of the analysis which followed, I have not systematically reported those differences. The diversity of background enabled me to generate the various and contested perspectives on health-related behaviours as consumer activities. Yet, a multiple understanding of consumer meanings of health-related behaviours was not explored in depth with respect to parameters such as class, gender, age or location of residence. Therefore, how these activities acquire meaning at the level of groups, can be seen as a limitation of the study. My decision here is justified by the focus of this present study. I did not intend to identify differences or similarities between the meanings employed by the various groups of young people, such as young men or young women. These sorts of classifications –which are difficult to make in a small sample - over-emphasise the
social influences on young people’s perspectives: a direction which tends to underplay young people’s voices regarding the role of the consumer meanings within the context of their everyday lives.

A dominant effect on the emerging direction of the research findings was: the limitation of the sample; the specific age group approached (young people aged between 15-17). This specific age group, located at a key stage of life, where young people are preoccupied with representations and meanings and try to relate with others through consumer choices expressing self-images. This is not to underestimate this capacity in other age groups or their need to represent and reflect a self-image through consumer practices. Here it is exactly where the limitation appears. A different age group for example, a more mature group of people, a youth club, a sample of university students or even ex-students, could provide different insights.

The design and the evolution of the open interviewing process were sufficiently loose to allow the respondents to choose to talk about their own particular experiences. I did not specify the types of consumer products or activities, such as eating certain products like Pizza Hut or McDonalds, or smoking specific brands like Marlboro or Silk Cut Light, and then ask the participants to comment on these specific issues. Since the participants did not talk about the same specific issues the possibilities for making comparisons between the different issues raised were limited. In many cases I found it difficult to identify whether young people ascribed similar or different symbolic traits to different aspects of health-related behaviours. Themes were generated from the participants’ localities regarding consumption relationships instead of being pre-defined by the researcher, as these were expressed in the everyday media discourses. An empirical concentration on certain mainstream symbolic associations, such as Marlboro smokers, might equate with a ‘macho’ representation, could have brought to light new aspects of studying health-related behaviours as consumer practices. However, my concern was to prioritise the participants’ accounts by giving them space to talk about their own process of interpretation of health-related behaviours that give meanings to their everyday lives.

Another theme that I did not expand on in great depth was the issue of the slimming body which is clearly related with gender and a female body (Bartky, 1997), and the
possible effects of the ways that young people understand fundamental issues and choices around the materialisation of the body. Fruitful analysis here would contribute to the debate about the triple relationship between ‘beauty’, ‘health’ and ‘youth’ (Lupton 1996). The technologies of the body beautiful, the sexed body, the anorexic body are extensively theorised (Shilling, 1993; Macsween, 1993) my aspiration was to recognise these discourses in relation to the materialisation of the body and its disciplinary regimes but integrate them into other aspects of the research. The way I integrated these issues was more or less by seeing the body and its materiality as it was understood and seen by the participants’ localities, rather than highlighting a ready made agenda provided by the disciplines of the body. In particular, it was an active decision not to explore the processes, such as dieting, that some of the participants mentioned in order to construct a desirable body. Rather, I focused on how health-related behaviours such as dieting and going to the gym were used symbolically in order to highlight features of the body.86

Health-related behaviours as consumer activities provide a means, or a resource, through which the participants appeared to play with issues concerning self-images and lifestyles. Health-related behaviours, as they are experienced within the symbolic domain of consumption, represent an important ingredient in this process in that they can be used as a means for projecting, experiencing or evaluating self- and/or lifestyle images. Nevertheless, the extent to which these behaviours enable young people to construct their own identities and lifestyles has not been explored in this study. The relationship between consumption and identity is a complex issue and cannot be merely established through the participants’ accounts of their everyday experiences. Such complexities can only be understood if the impact of these consumer meanings is considered in routine social settings. Issues concerning structure and agency and other sources of constructing identity need to be taken into consideration. Nevertheless, the orientation of the study was in the health promotion field and as such, the focus remains on how the participants interpreted health-related behaviours as consumer activities.

86 See section 4.4.3.2, p.123, section 5.3, p.145, section 5.4, p.152, section 6.3.1, p164, section 6.4.1, p.180
Finally, the Cypriot context itself could be a limitation since a different cultural space is associated with different cultural particularities. A researcher who explores his/her own cultural background can always work with the possibility of a better understanding or it could amount to a research weakness (see section 4.3.2.2.1, p.89). My involvement in this research agenda could be seen as one of a limited number of research projects, with respect to the Cypriot context and health, which could inspire other people to take this research insight further, as well as researching from other cultural milieu to apply similar research in their own context. This leads to the following discussion for future possibilities.

8.4 Possibilities for future health promotion research

In the light of the above issues regarding the strength and limiting aspects of this research study, I discuss implications for health promotion practice and suggest possibilities for further research directions.

Following on from the particular orientation of this present study, other researchers in Cyprus, and elsewhere, might research health and consumer meanings from a different perspective. Future research could use other methodological choices such as participant observation, or triangulation, in order to explore the impact of certain consumer meanings on the construction of identities in modern Cyprus. More explicitly, a future research agenda could explore how and why certain binaries are reinforced in the eating habits of young Cypriots, such as the dislike of pulses or the fashionable status of fast food. Certain cultural imperatives of what is regarded as ‘tasty’, ‘cool’ or ‘fashionable’ could be studied in combination with psychoanalytic tools like, for example, concept of desire and identification. Why certain eating behaviours are privileged while others are underprivileged? According to this logic the construction of masculine or feminine subjectivities in Cyprus could be studied in combination with the four health-related behaviours. Moreover, an empirical attempt could be made in order to address the impact of the historical changes that emerged on the island after 1974 (when the island was divided because of the national conflict between the Greek Cypriots and the Turkish Cypriots) upon the symbolic...
manifestation of certain health or consumer behaviours. A theorization which took this into account could contribute to a better understanding of the contested and multiple constructions of subjectivities.

With respect to health promotion, this present study can be used as a valuable source for the construction of health education programmes. Future research could concentrate on the impact of a school programme which is fundamentally based on the impact of consumer meanings upon young people’s everyday lives. I imagine a set of activities in which the young people could actively engage in exploring and at the same time developing their own critical stance regarding the role of consumer meanings in their everyday lives. This process of articulating consumer meanings, as I personally experienced it through the young people’s active participation in the interviewing process, was a learning one and, as such, it deserves some kind of exploration from an educational perspective. How do young people react to health education programmes which focus on their own daily concerns of health-related behaviours as symbolic activities? Could it be a fruitful process which weakens the compliance culture of health and enhances young people’s awareness of choosing? Could it diminish the ‘victim blaming’ which is directed at individuals in health matters? These sorts of questions need to be explored within an educational setting in which the young people would be able to report their experiences. These issues are of particular importance for Cyprus, where the construction of health education programmes remains largely confined to the medical perspectives on health.

8.5 Consumer culture and health promotion

The process of ‘finalizing’ the research allows space for reflection, giving the opportunity for researchers to develop ideas beyond those of summarizing. What I suggest in the following section is not the results that were produced from the research as a highlighted frame, nor a final statement, but rather to discuss the significance of what has emerged through critical and reflective thinking about health-related behaviours as consumer activities.
Health-related behaviours, as routine daily practices, constitute the intersection between consumer culture and health promotion. This study demonstrates the interaction between health promotion and ‘health-related’ consumer culture through the participants’ accounts of smoking, eating, drinking alcohol and exercise within the context of their everyday lives. They intimately included these four behaviours not only as routine activities, but also as ‘health enhancing’ or ‘health damaging’ activities in the symbolic domain of consumer culture. This present study elaborated empirically, within its own specificities, the relationship between health promotion and consumer culture: an area that remains largely at the level of theoretical abstractions.

The relationship between health promotion and consumer culture, as expressed in this study, concerns primarily the negotiated consumer meanings inscribed in health-related behaviours that are generated by the participants’ accounts regarding their local everyday context. While this study cannot estimate the extent to which health-related behavioural choices are consumed due to the consumer manifestation, the three analytical categories demonstrated how they inform young people’s understandings of these behaviours. This study was particularly successful in foregrounding the processes of the articulations of consumer meanings by prioritising the participants’ own sense of their everyday experience. It illustrates the significance of consumer culture in young people’s health-related choices not as a powerful meaning-making system, which directs young people towards certain choices and excludes others, but rather as a phenomenon which activates young people to think about their choices in certain ‘consumer’ ways.

Hence, it can be argued, the relationship between the field of health promotion and consumer culture is presented here as an act of thinking and talking about these consumer health-related choices. The cultural dimension of consumption, at the juncture between health promotion and consumer culture, did not appear as a concrete, additional element in these behaviours which can either promote certain choices or exclude others. Consumer meanings appeared as an arena that was actively employed by the young people when they were asked to think and talk about their everyday choices. Correspondingly, the inclusion of health promotion via these four lifestyle behaviours, within the parameters of consumer culture, cannot be seen merely as a
competing meaning system (such as Thorogood, 1992b), but also as an active contribution to the meaning-making mechanisms. In parallel, this study indicated how the participants experience the consumer traits as concrete sets of meanings inscribed in the products and activities, regardless of their own way of thinking and at the same time, how they actively construct their own meanings of their choices.

One way of understanding the relationship between health promotion and consumer culture is by recognising the fact that both areas function as message systems since they inform people about their practices, for instance, ‘what you should do’ as a health conscious person or consume as a young person. This study showed how young people created a distance from both message systems. The participants did not see either of these two systems as persuasive enough to totally determine young people’s choices. While all of them referred to the manipulative element of consumer practices, none of them perceived his/her self as mere consumer dupes, but rather as reflective selves within a situation characterised by contradictory choices and conflicting messages (see chapter 7). In the same way that the participants talked about the manipulative mechanisms of consumer practices under the system of capitalism, they also referred to a cultural imperative that is somehow imposed on young people by health discourses. The participants employed the same distancing towards the imperatives of health. They did not only see themselves as ‘health dupes’ or as ‘health enemies’. Rather they used health meanings like the consumer ones, as resources for constructing their self- and/or life- style images. It can be argued, therefore, that health meanings exist among others in the cultural matrix of consumption, as an arena for the participants to locate themselves and to signify who they are.

In speculating about reasons for why the participants could actively inscribe consumer meanings to health and health-related behaviours, I would say that both fields operate within the logic of choice and individualisation. By legitimising choice and individuality, thus allowing young people to choose what is regarded as appropriate for them, they simultaneously left space for both consumer and health meanings to be contested. By the fact that health promotion is located within a ‘healthy choice’ discourse it simultaneously sets itself up to be contested within other kinds of meanings manifested within the area of consumer culture. The present study indicated, through the participants’ accounts, how health-related meanings are contested with
self- and/or life-style images. When they had to talk about these four behaviours as everyday choices they frequently chose to refer to them as self- and/or life-style images.

Health-related behaviours do not only concern dominant physiological medical discourses, generally divided into binaries of 'what I am' or 'what we are' as bodies (healthy versus unhealthy bodies). A 'healthy' lifestyle is incorporated, at the same time, into a much wider process which does not only include individuals’ roles in health matters but also our individuality as an artistic self-expression project. The young participants did not merely engage in this process of choosing or rejecting health-related products as individuals who have certain capacities for or limitations in choosing the 'right' healthy choice. Rather, they talked about this process as a game of representation - who they are or how they want to be perceived.

In this light, the difference between health promotion and consumer culture is the way choice is conceived. Choice, for both fields, consists of human acts, to choose X rather than Y. However, the crucial difference is the contested rules upon which choice is based for each field. The emphasis in health promotion is the socially constructed capacity of individuals to act 'rationally', in an 'informed' way or 'logically' and therefore select the healthy choice. Health promotion aims at empowering individuals to select the ‘X,’ which is healthy, and reject the ‘Y’, which is unhealthy. Thus, the act of choosing in this context is minimised as one choice (thus no choice), which is objectively defined by health discourses. Conversely, the ‘rules’ for the consumer choice are grounded in the desire of individuals to articulate and express their own sense of identity through clothing, hair-styles, body decoration, music, cars, travel (Bocock, 1992) as well as health-related behaviours. The important element in the consumer context is the role of desire from the point of view of the consumer. Within contemporary consumer culture, consumers demand an increasingly wider range of products thereby making possible greater choice (Featherstone, 1987). Individuals as consumers are expected to select the X or Y, no matter which, as long as these choices express what they desire to signify to themselves and to others who share the same system of symbols. The participants in this research project had the opportunity to talk about health-related behaviours as consumer choices, as a means of establishing, and creating who they desired to be.
There are clearly a great many other directions that the relationship between health promotion and consumer culture can be viewed. The argument here, is that consumer culture does not only play a crucial role in the determination of people’s tastes and preferences, but it also provides a fundamentally important arena in which young people play with their self and lifestyle notions. As discussed in chapter 2, the field of health promotion focuses on the extent to which individuals do or not locate themselves within the ‘healthy choice’. Considering that health-related behaviours are not only health directed behaviours, but also consumer activities, health promotion should also tighten its focus and target health-related behaviours as a category of activities that includes individuality and not merely individuals.

Few could reject or ignore the significance of the above points as these take into consideration the ‘consumer life’ of health-related behaviours as it is lived and understood by young people. However, arriving at the conclusion of the thesis I could not resist the temptation to re-consider the health promotion tension which derives from its ultimate goal to promote one choice - the healthy one. The problem here is how we promote one choice within a framework, as suggested above, which needs to accept a broader understanding of the complex consumer meanings inscribed in health-related behaviours. Thus, optimising our awareness regarding these complexities, which feature health-related behaviours as consumer activities, could not be beneficial without suggesting ways of solving such a tension. This statement itself ‘provokes’ us to redefine who ‘we’ are, how ‘we’ theorise and how ‘we’ attempt to give health promotion a more empowered voice and presence.

In light of the above, I take the challenge that health promotion needs to find ways to make its message ‘compete’ more effectively. My response is to simply reform the verb ‘compete’ to ‘co-operate’ which I justify thus. Firstly, I would argue that there is not an absolute status accorded, neither is it something stable or concrete – a set of consumer meanings inscribed in health-related behaviours – which is clearly against health promotion goals and therefore must be competed against. As demonstrated in this study the ways which young people talk about health-related behaviours as consumer activities are governed by multiple and contradictory meanings. Young people’s experiences were found to be highly changeable and contextual. Each of the
health-related behaviours incorporates multiple consumer meanings and roles in young people’s lives. The picture becomes even more complicated if the generation of the different reflections upon these consumer meanings, and their roles in young people’s lives, are taken into account. While some of them regarded health attributes of these behaviours as ‘positive’ self- and/or life- style images, others emerged as ‘enemies’ of their youth status. What emerged from the analysis is a plurality rather than a ‘logical’ coherence regarding young people’s consumer meanings of health-related behaviours; a phenomenon which challenges the possibility of antagonism.

Secondly, ‘competing’ with the consumer manifestations of health-related behaviours entails the danger of health promotion being regarded as in opposition to young people’s lifestyles. In this study, I indicated through my participants’ voices, an increasingly important role that health-related behaviours, as consumer activities, have in young people’s leisure activities. That means if health promotion takes the route of competition it puts itself simultaneously against a vital aspect of young people’s ‘way of life’ - the consumer one. Health promotion needs to come to terms with the routine values and implications of the consumer experience rather than to compete with them. Thus, if health promotion aspires to be grounded and accepted by young people, then the consumer ‘life’ of health-related behaviours should not be neglected, excluded or competed against. When a health promotion intervention does not acknowledge the consumer role of health-related behaviours, its messages become isolated from young people’s lifestyles. One of my participants defined health messages as: ‘irrelevant to our youth culture’; health education as ‘something standard which teachers often say. It is like a tape. It is constantly played’; and young people who consciously care about their health, as ‘saints’ (negative connotation) ‘who do everything they are told, always submit’. What is stressed here is the alienating character of a health message for a young person when health-related behaviours as consumer activities are absent in such interventions.

The complex nature of the boundaries between the consumer and the health dimension of smoking, eating, drinking alcohol and exercise, as I experienced than through my

87 The quotations here are taken by a participant of my pilot study. As noted in section 4.3.1 (p.83-85) in the pilot study I discussed explicitly issues which are relevant within health education in Cyprus.
participants’ accounts, suggests the need for health promotion to co-operate rather than to compete with the consumer dimension of health-related behaviours. Health promotion needs to acknowledge its symbiotic relationship with the consumer manifestations of these behaviours, rather than to compete with them. That should not be interpreted as an acceptance of the unhealthy choice. Rather, I refer to a health promotion activity which concentrates its energies on the way young people interpret and experience events and situations in relation to health-related behaviours. The fact that young people’s consumer meanings arise from their own struggles to make sense of their everyday lives, with contradictory meanings, should help health promoters to realise that an ongoing dialogue between them and the target population is a real necessity. This is a fruitful way for young people to assess whether a cultural analysis fits with their own everyday practices and experiences. An approach like this plays down the role of the health promoter as expert and the knower of ‘what matters’ in young people’s lives, and seeks to incorporate and acknowledge the voices, perceptions and perspectives of the young people whose life and health is at stake.

I simply propose another starting point for interventions in which the target population is asked to reflect on themes or issues similar to the ‘consumer’ analysis of this study. ‘Such a dialogue is an intervention in its own right’ (Krumeich et al., 2001, p128). In such conversations, young people’s voices and everyday lives become central. They can resist, correct or refine health promotion’s interpretations of their lives. As Krumeich et al. (2001, p.127-128) argue ‘such a discussion may result in increased critical consciousness among both the target group and the health promoters about cultural mechanisms that underlie personal experiences with regard to health matters’. This is an approach which is based on ‘the assertion that health promotion’s primary concern should be with helping people to gain control over their lives and their health’ (Tones, 2001, p.3). Dialogue which aims to delve into the thinking and experiences of the young people cannot bring the ‘healthy’ choice on its own. Yet, it is consistent with the three principles of health promotion: choice, empowerment and lifestyle. It is a dialogue about young people’s lifestyles, choices and agency, as all these are linked with aspects of the world within which people live.

This study indicates, through a number of examples, how the transmission of health messages is not a straightforward process and how the complexities of daily life are
rooted in young people’s actual experience of issues related to these four ‘health’ behaviours. That is not to say that ‘health advice’ should cease to be promoted, but that it should not be used as a means to discriminate, evaluate or explain human practices in isolation from their social meaning and their social context. Conversely, health messages should be merely seen as informative resources for what is medically considered ‘healthy’ or ‘unhealthy’. Health Education should be sensitive towards the different cultural resources associated with different groups and tailor interventions accordingly. In conclusion, I suggest that health education programmes could be more meaningful to young people if they had opportunities to critically reflect upon the consumer meanings of ‘health’ behaviours. These types of opportunities are essential if health promoters are to acknowledge the role of young people as active rather than passive consumers of health messages.
## Appendices

### Appendix 1: Description of the sample

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<th>Date of interview</th>
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<th>Gender</th>
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<th>Mother’s occupation</th>
<th>Father’s occupation</th>
<th>Favourite going out area in Nicosia</th>
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### SUMMARY

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**TOTAL: 25**
Appendix 2: Going out places as a criterion for sampling

I divided the ‘going out places’ into three groups according to the participants’ comments. The preferences of the young people are shown in appendix 1

<table>
<thead>
<tr>
<th>Area of Nicosia</th>
<th>‘Going out places’</th>
<th>Participants’ descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engomi</td>
<td>Factory club</td>
<td>‘Engomi is a place for younger people, of the age of fifteen-sixteen.’</td>
</tr>
<tr>
<td></td>
<td>Amarte club</td>
<td>‘Dark from smoke, with people falling all over you’</td>
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<tr>
<td></td>
<td>Agora club</td>
<td>‘They get very drunk and they all drink from the same jar.’</td>
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<tr>
<td></td>
<td>Browns coffee shop</td>
<td>‘When you go there on a Saturday, you expect to dance and drink.’</td>
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<tr>
<td></td>
<td>Four seasons</td>
<td>‘Mini-skirts, high heels’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘Provocative evening wear and heavy make-up’</td>
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<tr>
<td></td>
<td></td>
<td>‘Techno, commercial music’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘Modern pop music’</td>
</tr>
<tr>
<td>Centre</td>
<td>Versus club</td>
<td>‘The age group is between seventeen to twenty-four.’</td>
</tr>
<tr>
<td></td>
<td>Zoo club</td>
<td>‘People who go there are big-headed’</td>
</tr>
<tr>
<td></td>
<td>Le café, Da capo</td>
<td>‘Elegant clothes, knee-length skirts, expensive clothes’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘Smoking expensive brands’</td>
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<tr>
<td></td>
<td></td>
<td>‘Modern music’</td>
</tr>
<tr>
<td>Old city</td>
<td>Enalx club</td>
<td>‘Quality places’</td>
</tr>
<tr>
<td></td>
<td>‘Ithaki club’</td>
<td>‘Places for more mature people’</td>
</tr>
<tr>
<td></td>
<td>‘Kala kathoumena</td>
<td>‘Sitting down and talking about various subjects or playing games such as chess, and cards’</td>
</tr>
<tr>
<td></td>
<td>coffee shop</td>
<td>‘Casual clothes’</td>
</tr>
<tr>
<td></td>
<td>Aigaio tavern</td>
<td>‘Greek quality music’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘Rembetico – traditional songs’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘Live concerts’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘Non commercial music’</td>
</tr>
</tbody>
</table>
Appendix 3: Starting and continuing the interviewing process

Examples of the opening question and the follow-on questions, which are formed on the basis of the preceding comments of the participants

Example 1

Q Talk to me about your holidays in Alona.
A You feel that you are nearer to nature, I can speak to myself, I get the chance to communicate with other people, I like the atmosphere which enabled us to make new friends. It is nice to get the opportunity, during your holidays, to speak with yourself, recall in your mind what have you done the past year, and find solutions to what has been bothering you now there are no more distractions to feel influence by. I believe that this is the appropriate place for me.
Q So, do you think about things?
A Yes. If I want to do it in another way, I will do it through music. I selected a few songs which when listening to them, -no matter how weird might seem- I can speak with myself and find various solutions.
Q For instance?
A Songs by Racintzis.
Q How does this work for you?
A The lyrics of his songs are very near to my soul. It is as if they have been written for me.
Q Which are these lyrics?
A I cannot find a specific one, but there are a few.
Q Do you like music in general?
A Yes. I like listening to music, not creating music.
(Elena, 16)

Example 2

Q What are the main issues that matter to you during this period of your life?
A School is very important. I study hard to get good grades, I try to concentrate on one subject so I eventually follow a career.
Q Does getting good grades at school make your life complete?
A I am not stressed about getting good grades.
Q How do you spend the rest of your time?
A I play handball. I go to practise every day.
Q Where do you play?
A I play for Centro Neotitos Larnacas. I do a bit of painting and go to computer lessons.
Q Tell me about handball. How did you start playing?
A I started in primary school. They brought us a coach to introduce us to the game and I liked it. So the coach suggested to go to Centro Neotitos Larnacas and I have been there for the last four years.
Q Do you enjoy it?
A I might end up to do it professionally.
Q What is good about the experiences you have playing handball?
A It helps you be in a good physical state and exercises your brain because every decision you make in the game might affect the whole outcome.

Q What does playing offer you personally?
A A good experience. I enjoy being involved in teamwork, and the thrill of scoring. It feels me with joy.

Q Do you think is important to feel joy in life?
A Yes.

Q Why?
A You are happy about things.

Q What other things make you happy?
A Painting, going out to discos and café.

(Dimos, 16)

Example 3
Q It seems that you like music, do you?
A First of all, music has a calming effect on me. If, for instance, I am angry, I can very easily calm down with music. Also, I find that it is easier for me to do my homework whilst listening to music. I just like it.

Q Is the fact that you are angry, the reason you are now listening to music?
A No.

Q Which are the other things that are important to you?
A I like to draw, watch the television.

Q Do you draw just for fun?
A Yes.

Q How do you spend your time?
A I first do my homework, I then might go to a neighbour’s house, for a chat or to a friend’s place. I might listen to music or mostly watch television. This is during weekdays. On Fridays I usually go to my cousin’s, once every other Saturday I go to a club and stay at home on Sundays.

Q Where are you now off to?
A My cousin, lives near the Engomy area, so we are going there today. I enjoy people. I am a sociable person.

Q Is it crowded there?
A Yes, very.

Q What age?
A My age and older, like twenty to twenty-five year olds.

Q Where do you go around that area?
A We play on the video games or have a game of pool and chat. During the Christmas period, we mostly play cards, we are gamblers (joking)!!!!

Q Do you ever eat there?
A Sometimes. Things like kebabs or donner kebab.

Q Which clubs do you go to?
A To Factory, Agora [pause] We go there to dance. For no other reason.

Q Just that?
A We dance, chat. That is what you usually do in a club.

(Athos, 15)
Example 4
Q What are the main issues that matter to you during this period of your life?
A I am involved in various activities. I play the piano, play volley-ball and I am learning Italian. I very much like going out with my friends, on Fridays and Saturdays, getting to know new people. My exams are very important to me right now. I do a bit of everything.
Q So, you enjoy extra-curriculum activities?
A Yes.
Q Why?
A It is nice to have something to do which is not about school. I have something else do other than lessons. Those are things which will be useful to me later on. I will have a certificate in piano which might help me at university. If I am unlucky in finding the right job, I will have that certificate which will provide me with immediate employment. I enjoy Italian. Volley-ball is a kind of exercise for me. I would not like to be at home all day.
Q Do you consider volley-ball as an excuse to get out of the house or as a form of exercise?
A I started playing volley, purely by chance. I used to play it at school and Agne suggested to try playing for Olymbiada. I went there and liked it. I do not only play it to exercise. I also enjoy being part of the team, playing a game together.
Q Do you like the fact that at present you are an athlete?
A Yes, I do so a lot. I went to a sports do the other day. Not everyone can join. You get chosen from school, and only athletes are allowed to join. It is nice to know that you are someone who does not laze about, sitting around doing nothing. I exercise my body and mind.
(Dora, 16)

Example 5
Q What are the main issues that matter to you during this period of your life?
A I am very stressed with school, now. I have a good time.
Q What things make you feel ok?
A Stop going to private tuition. I like going out to clubs, café. I would like to go every week. I would like to escape from school.
Q Is going to clubs and cafés important to you?
A Yes, it is something that helps me to forget my problems.
(Natalia, 15)
Bibliography and References


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Morrow, V. (1999). If you were a teacher, it would be harder to talk to you: reflections on qualitative research with children in school. International Journal of Social Research Methodology, 1, 297-313.


