

Lifestyle, Charismatic Ideology and a Praxis Aesthetic

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“A pure aesthetic expresses, in rationalized form, the ethos of a cultured elite or, in other words, of the dominated fraction of the dominant class. As such, it is a misrecognized social relationship. ‘The denial of lower, coarse, vulgar, venal, servile - in a word, natural - enjoyment, which constitute the sacred sphere of culture, implies an affirmation of the superiority of those who can be satisfied with the sublimated, refined, disinterested, gratuitous, distinguished pleasures forever closed to the profane. That is why art and cultural consumption are predisposed, consciously, and deliberately or not, to fulfil a social function of legitimating social differences.’”

Randal Johnson quoting Pierre Bourdieu (1993:25)

The main impulse for this chapter came to me from a variety of sources. These sources where incidents taken from daily life and, although they are anecdotal, indicate the difficulties that we face when we talk about health and the practices that are used to maintain and promote health. Indeed, one of the significant points of this chapter will be that health is heterogeneous and that such ideas come out of the practice of daily living rather than being homogenous and based upon a rationalist unified theory. Such a demand for consistency may be a misleading. (Kirmayer 1994) and hide the discrepancies between varying forms of knowledge. While the above quote is made with regard to art and literature as cultural processes, I shall be arguing that health too is a cultural process and can be similarly subjected to an aesthetic critique.



I want to use a few introductory anecdotes for two reasons. First we see how health is a complex set of ideas, and second, that we need to consider the day to day narratives of individuals as they talk about health. This latter point is not new in terms of health care research and qualitative methods (Milburn 1996; Radley & Billig 1996) , but what I will also be suggesting is that most research makes an assumption that health and illness are opposing poles of a continuum. My proposal is that health and illness may be so constructed by health care professionals trained to think in such a way, but such an ideology may not be reflected in the everyday lives of other people. Perhaps the realm of health and illness are quite separate in practice? Rather than being oppositional they are competing discourses (McRobbie 1996)

relevant for making sense of particular situations.

The first incident is one that occurred at one of the Copenhagen meetings: Following the usual presentations about health and various approaches to medicine, we duly retired to eat and then to the bar where several colleagues ordered their drinks and smoked cigarettes. For most of the day we had been sitting in a centrally heated room and had taken part in no strenuous activities other than disagreeing with each other in a mild sort of way and occasionally moving our chairs to let others get by. From some perspectives of health care activity, we were behaving quite irresponsibly; smoking, drinking both coffee and alcohol, pursuing sedentary activities and no doubt eating fatty foods. However, those of us partaking in such activities seemed to be paying little attention to “health” as such and were generally getting on with the day to day business of living, part of which was actively pleasurable. As such this is a rejection of an aesthetics of Kantian ‘pure’ taste and an embracing of a Bourdieuan ‘vulgar’ taste that returns to the senses. And it is this notion of sensuousness that is at the heart of the original meaning of aesthetic in that it springs from the lower animal passions, a matter of literal taste.

One of the burdens, or joys, of being a conference delegate is that one has to take part in social activities. It so happened that I was invited to the German beer festival in Munich, and not wanting to offend my hosts, I duly took part. The festival takes place in a huge park complete with fairground activities that are replete with noise and activity, and charged with the electricity of human

beings having fun. Within the festival grounds there are huge barns where people go to be entertained. The group I was with were duly led to such a barn and as the doors opened I was immediately reminded many of the things my mother had told me not to do as a boy and which seemed enjoyable as a man. From out of the open doors came a billow of smoke, gales of laughter, squalls of music from a German “oompah” band and the wonderful breezy beery odours of the hall. All the perils of enjoyment captured together in a storm of experience. It will be my own fault if I do not make it to old age. And here lies the crux of the argument, most of the health care debates are moralistic and ignore a profound factor in human existence, repeated from the first example, and that is the simple activity of pleasure.

Another scene occurred in a restaurant. My wife and I had decided to take an early Spring walk, the weather was fine and after a gentle stroll we arrived at a hotel in time for lunch, as planned I might add. During the meal, a number of middle aged women came to sit at the next table. The first topic of conversation was their health and each woman took turns to talk about her current ailments. In doing so she introduced various connected topics like the state of her family, the well-being of her husband, the relative benefits of being mature, where she had been shopping recently and a general philosophy and outlook on life. While we might as professionals be tempted to look at this as a health care narrative, health being the chosen topic of introduction, we would be missing a valuable point. Health was used as a springboard for a wide ranging conversation that did not itself remain focused on health. Like the

stereotypical greeting “Hello, how are you”? rarely intends to elicit a conversation about the persons state of health, health as a subject of naturally occurring narratives plays only a minor role. All too often we consider health as if it was the peak of a unified pyramid of rational consonant understandings rather than a topic in a constellation of understandings some of which may be dissonant. It is knowing the relationships between elements of such a constellation that might help us to understand health as part of daily living, as praxis.

When I was a small boy my grandfather took me to the local park where he sat with his cronies, and I played. To give himself some respite from me, he would suggest that I ran around the bowling green. He would either time me, to see how fast I could run, or he would count how many times I had completed the circuit. This was play and I would imagine myself to be some athletic hero of the day like Chris Brasher or Emil Zatopek. Such play became a sport as I grew up and started cross-country running. In my twenties I played other sports and ran, not only for the simple fun of it, because I wanted to improve my fitness. Fitness to play sport that is, not as a health activity. In my thirties, I started to study again and as an aid to preparing for my examinations began to run everyday after studying. In my forties, my father had his first heart attack and I began running again, not this time for enjoyment, but as a hedge against angina. However, I soon stopped as there was no pleasure in such activity and I was picking up more minor injuries “jogging” than going for my daily walk. If we take the same activity, in this case running, we can infer differing attributes to it and the

benefits that it may have brought for my health. Biddle (Biddle 1995) refers to this as the “feel good factor”. Indeed, people had seen my running in my thirties and thought I was doing it for my health. This was quite false. I did it for the sheer pleasure of running like a boy and as a practical activity that would enable me to enjoy playing. Only later did the same activity gain overtones of a health care activity. It is precisely this aspect of understanding such an activity in relationship to a broader field of understandings and activities that is important.

As a final example I would like to refer again to the element of pleasure and how it is ignored in health care thinking. A current debate has been about the implication of cholesterol in coronary heart disease (Evans, Barer, & Marmor 1994) where eating a fatty diet is seen to be an unhealthy behaviour. A favourable way of eating has been proposed as the “Mediterranean diet” that includes less fats, less meat, more fruit and vegetables and carbohydrate like breads and pastas. Again, in the spirit of academic benevolence, I have eaten in the Mediterranean and holidayed on a Greek island. Apart from the incidence of cigarette smoking that accompanied such meals, there were several cultural factors rarely mentioned in health care directives about diet that might play a significant role. First, the meals were slow affairs often partaken within a large family group that occurred late in the evening. Cultural setting seems to be conveniently forgotten in health care descriptions of diet. Second, the food was enjoyed as an activity amongst a series of activities that might include dancing or going for a stroll outside to take the evening air. Yet

the palpable enjoyment of the food as an eating activity and as a social occasion had little to do with the seeming narrow aspect of nutrition. Perhaps the reason for the failing inducements to change dietary habits (Meillier, Lund, & Kok 1996; Nguyen, Otis, & Potvin 1996) are simply that such inducements demonstrate a poverty of understanding concerning the human activity of eating together as a pleasurable activity and the previously mentioned constellation of activities that make health part of a complex praxis aesthetic. Hamilton et al (Hamilton et al. 1995) refer to vegetarians as eating from a moral menu and it is this virtuous aspect of acceptable conduct that appears to pervade health care arguments. The dispute of the primacy of reason over sensuousness is not a new argument in European thought and appears also to have ramifications in Chinese political thinking (Gu 1996).

Health as identity

In modern times, health is no longer a state of not being sick. Individuals are choosing to become healthy and, in some cases, declare themselves as pursuing the activity of being well. This change, from attributing the status “being sick” to engaging in the activity of “becoming well”, is a reflection of a modern trend whereby individuals are taking the definition of themselves into their own hands rather relying upon an identity being imposed by another. Being recognized as a “healthy” person is, for some, an important feature of a modern identity. While personal active involvement has always been present in health care maintenance and prevention, in that people have strategies of distress management (Aldridge 1994), a new development appears to be that being a

“healthy”, “creative”, “musical” or “spiritual” person are considered to be significant factors in the composition of an individual’s “lifestyle”. Rather than strategies of personal health management in response to sickness, we see an assemblage of activities designed to promote health and prevent sickness. These activities are incorporated under the rubric of “lifestyle” and sometimes refer to the pursuit of “emotional well-being” (Furnham 1994). Furthermore, such a lifestyle is intimately bound up with how a person chooses to define him or herself.

Thus I am arguing here that post-modern identities are constructed, and although these identities are bound up with cultural values, they focus primarily on the body. What we need to take heed of as health care professionals is that this “body work”, this embodiment of culture (Kirmayer 1994; Lewis 1995; Starrett 1995; Turner 1995), this corporeality of expression, is a pleasurable activity, often recreational and simply not medical. Bodies are done, they become the material aspect of a both the individual and the culture in which he or she is embodied. The presentation of symptoms by a patient, for example, have an articulacy that is based upon the body and its needs. The naming of the entities to which those symptoms refer by the medical practitioner are based upon a different articulacy that is based in language and reason. The somatic has an aesthetic based upon the senses, while diagnosis has an ethic based upon naming (Khushf 1996). For the patient, the process of naming, putting words to a private somatic sensation and communicating that sensation within a context of reason, the medical encounter, changes the

experience of that sensation (Cioffi 1996).

The definition of health, who is to define what health is and who is to be involved in healing is not a new activity. Such issues are raised at times of transformation when the old order is being challenged (Aldridge 1991) . In post-modern society, orthodoxies are challenged, and as truth is regarded as relative with few fixed authorities to turn to, identities can be composed from a palette of cultural alternatives.

Health is also appearing in modern society as a commodity. Far from being a simple object, health is concerned with social relationships representing personal worth, market values, existential principles and theological niceties. However, the location of health in modern terms is often within the body (Charmaz 1995; Kelly & Field 1996; Wallulis 1994) . People are demanding recognition that they play an active role in their own health care, and that some can act as lay health-care practitioners. Indeed, before we ask a doctor or any licensed practitioner we have been through varying cycles of self-care, asking family and friends or just hoping that the problem will go away. This shift away from authority and orthodoxy towards democratisation and choice reflects a change from a belief in the certainties of science and religion to a relativist position where people literally “make up” their own minds and work on their bodies; that is, we construct our own identities.

As a consequence of challenges to traditional authority, and the collapse of State socialism, here in Europe, there is no longer a possibility for some

individuals to relate to a given social order. In the writings of many health care practitioners, particularly in alternative medicine, there are few references to health-care as being a social product for the benefit of communities. Instead, rather than a communal argument being voiced, there appears to be an argument for the individual located in an ecological context; the “green” politic of environmental liberalism. Such a perspective ignores the notion of population and health and the pervading fact that morbidity is correlated with the distribution of wealth (Evans, Barer, & Marmor 1994; Vågerö 1994) .

Individuals are seeking to treat themselves with a long term eclectic health strategy that includes a palette of activities with the support of chosen, albeit diverse, informed advisers who can fulfil the role of facilitator. Health care consumers are blurring the role between the traditional health care services delivered at times of crisis, with those of preventive strategies based on consumerism. The idea of community health in these descriptions may be alluded to as an ecological context, but there is little reference to an immediate social or communal context. This is a reflection of the Romantic notion of the individual related directly with the cosmos (Tsouyopoulos 1984) .

Medicines as charismatic ideologies

My principal criticism of health care arguments as presented by conventional medicine, and many complementary medical initiatives, is that these approaches are founded upon a charismatic ideology; that is, health is pursued for health's sake. While this may be relevant for religion - life for a divine

being's sake -, or for art - arts for art's sake -, health will be always undermined by the reality of the body. Health, religion and art are presented as metaphysical activities - they are above the physical realm. But, like the body of work in terms of art products, the individual body in terms of physical health is subject to temporality and is not above the substantial plane of existence. Health is temporal and locally corporeal. We may be better advised to defer from the charismatic ideology of "C" medicines; that is, conventional and complementary, and seek a functional aesthetic relating to the performed body. To be accepted as a performance, a habitus (Bourdieu 1993) .there must be an audience and that returns us to a cultural and social field.

While body size and shape are aspects of personal identity, it is how the body is interpreted, the aesthetics of health beliefs that play an important role in forming identity. Such beliefs play an active part in how we recognise illness and what therapy form we choose (Aldridge 1992) . Meanings provides a bridge between cultural and physiological phenomena. The diagnosis of a medical complaint is also a statement about personal identity (Stravynski & O'Connor 1995; van der Geest 1994) and the stigma that may be attached to such an identity (Crossley 1995) . Symbolic meanings are the loci of power whereby illness is explained and controlled. Such loci are now shifting from the educated health professionals, to the increasingly better-educated, and health-conscious, consumers although that relationship is delicate (Dickinson 1995) .

Indeed, in the post-modern era there are ever increasing producers of symbolic goods as related to health. Various

agencies, including consumer groups, now make claims for cultural legitimacy in competition with the orthodoxies of conventional medicine (although it appears sometimes that complementary medical agencies have been incorporated within the body of conventionality). The notion of alternative medicine, consumer groups and self-care groups have struggled to liberate health from the grip of academic control and the monolith of conventional medicine. This has been linked to the development of individual autonomy whereby the health of the individual can be performed as he or she sees fit. Health has the potential of a style and form liberated from a subordination to political and medical interests. To paraphrase Bourdieu:

“ the mass production of works produced by quasi-industrial methods - coincided with the extension of the public, resulting from the expansion of primary education, which turned new classes (including women) into consumers of culture. The development of the system of cultural production is accompanied by a process of differentiation generated by the diversity of the publics at which the different categories of producers aim their products” (Bourdieu 1993:113) .

Definition of health in a cultural context

It is clear that in our modern cultures several belief systems operate in parallel, and can co-exist. Patients have begun to demand that their understandings about health play a role in their care, and practitioners too are seeking complementary understandings. Health itself is a state subject to social and individual definition. What counts as healthy is dependent upon cultural norms.

Health and disease are not fixed entities but concepts used to characterise a process of adaptation to meet the changing demands of life and the changing meanings given to living. Negotiating what counts as healthy is a process we are all involved in, as are the forms of treatment, welfare and care which we choose to accept as adequate or satisfactory (Aldridge 1990, Santiago-Izarry 1996) .

Spickard (Spickard 1994) reminded us that modern people do not merely accept the identities passed down by authorities. Instead, they construct their identities from various sources. Modern identity is eclectic. As in the age of Romanticism, when revolution demanded a new way of being, the primacy of the perceiver is once more being emphasized. Subjectivity becomes paramount, on the one hand reifying the individual, but on the other hand running the risk that the individual will become isolated. Indeed, while post-modernism is perhaps itself characterized by a revolt against authority and tends towards self-referentiality, its very eclecticism, that leaves the individual valued but exhausted of significance - what Gergen (Gergen 1991) refers to as “the saturated self”. This move towards the ability of the individual to control her or himself has led Pinell (Pinell 1996) to refer to the *homo medicus*, the sick person who objectifies her or himself as a medical auxiliary.

Brewster-Smith (Brewster Smith 1994) suggests that the inflated potential for self-hood dislocated from traditional value sources increases the potential for despair, and while individuals may rise to the challenge of pluralism, there are some individuals who will seek to join groups who offer some form of reassurance in a

given orthodoxy of beliefs and actions. The danger in modern Europe is that the romantic notion of individualism, becomes perverted into nationalism, and the dislocated individual seeking to construct his or her own identity, joins a group intent on the limitation of others freedom of self-definition whereby he or she can maintain their own security. Consensus is fragile in a context where individual demands are reified.

If the self in modern society is always being constructed to meet the variety of life's contingencies, then we move away from the model of one generation initiating the next generation into the truths of its own beliefs. Instead there is a pool of experts and advisers to whom we can turn when constructing a system of beliefs within a cultural ecology. Ecological, in the sense that those beliefs are connected, and that the consequences of those beliefs, when acted out in the real-world, are related one to another. In some modern alternative healing approaches, traditional forms of teaching by initiation and learning by discipline, are rejected in favour of an eclecticism that take techniques and locate them within a culture of meanings improvised according to the situation. This action itself is political. Rejecting given orthodoxies, and demanding freedom to engage in the project of realising one's “self” is a “politics of life-decisions concerning life-styles” (Brewster Smith 1994) . And as Hughes (Hughes 1996) suggests, a performative and dramatic approach overrides both traditional and deconstructive notions of causality.

Health as functional aesthetic

The notion of life-style appears to be important in describing modern

approaches to health care use and its delivery. In a Foucaultian sense, the self is not an assemblage of functional components, but a unified style of behaviour (Dreyfus 1987) . However, I am challenging such perspective in this chapter. Rather than there being a human nature, the self-interpreting practice of being human enables us to have varying natures. Our lives have the potential to become a work of art in that our identities are constructed and maintained each day (Aldridge 1989) , thus a performed identity and a functional aesthetic. In this sense the activity of healing is concerned not with restricting us to a one-dimensional sense of being according to an accepted an orthodox world-view, but the possibility for the interpretation of the self as new albeit embedded as an identity within a particular culture.

Individuals then seek to make claims about their personal identity to someone else to whom they matter; that is, in interaction. Claiming to be a healthy, fulfilled, empowered, artistic or spiritual person, is to a way of presenting self that will elicit a response from others. Schwalbe (Schwalbe 1993) interprets this action of deciding which identity to present, and in how we present ourselves, as one of moral agency. In modern descriptions of alternative healing, it is the body that is the stage for the interaction of the self and its interaction with culture.

If the big narratives of modernism are now being replaced by our own personal sets of meaning made locally with those whom we seek to live (Warde 1994) , then we need to understand more about the person that sits before us in our consulting room. How that person creates an identity will be indicative of how that

person will resolve his or her problems. How that person seeks to be identified will guide his or her health care activities. Some will seek medications, other will imbibe herbal preparations, others will seek to be physically manipulated, others will seek to be psychically manipulated, yet others will exchange energies both subtle and cosmic, some will search for the laying on of hands in a ritual way - whether it be from a medical doctor or a spiritual healer (both require their own brands of faith)-, some will sing to relieve their souls, and others will jog for the hearts content. Each of these, the body-builder and the disciple, the artist and the atheist, the athlete and the allopath, will demand a recognition for whom they are as a person, and for that recognition to be included in treatment decisions. Indeed, the route to treatment will be guided by an itinerary pertinent to personal identity. Health is something that is done, a performed art.

What we singularly fail to see is that our current thinking about health is dominated by a medical thinking that ignores much of the reality of the persons we intend to treat and support. Few people, when they are sick, respond by seeking a health care practitioner (Andersen 1995) . Perhaps even fewer consult a health-care practitioner about staying healthy. What we appear to do, outside of an academic life thinking about such lofty matters, is eat, drink, amuse ourselves, love our nearest and dearest, walk the dog, chase pieces of leather across field (both dogs and football players), without thinking of medical consequences. Maybe our health care assumptions are so narrow that they have little relevance for others who do not bow down at the altars of epidemiology and

empiricism. Many lay appraisals of health care activity seem to be based upon holistic considerations that include feelings of mood and vitality (Andersen & Lobel 1995). If changes of mood are ignored, or assessed as potentially pathological by health care practitioners, and the philosophy of vitality is generally regarded as invalid in modern scientific medicine, then we should not wonder that few people come to us for help. If, as in traditional Chinese medicine, for example, health seeking becomes a pleasure, that sequesters “a body that can not only taste sweetness but be sweet, not only report painful symptoms, but also dwell on and cultivate the quiet comforts of health” (Farquhar 1999: 493) then maybe we can understand that the seeking of a positive identity in a post-modern world is an activity that can be enjoyed without experts and the grand narratives of science and medicine. We may indeed have to learn to seek out those personal and local truths that our patients are themselves choosing to embody.

It may appear that self and society are being presented as opposing realities. However, in the field of health promotion we know that to choose only one approach would be limited. In this century major changes in health status have occurred as results of improvements in living conditions - clean water, improved sanitation and adequate nutrition. There is also evidence that income plays an important role in maintaining standards of health, that poverty is not only a social burden, for the individual it has consequences for personal health. The field of health influences as they are played out in the community manifest themselves in the bodies of individual persons.

In the last decade of the twentieth century there is a change in relationship between self and society. The individual is becoming disembedded from a traditional commitment to society, a disenchantment with the collective, and a new type of commitment is being seen (Warde 1994). In a liberal ideology, individuals with enough disposable income are becoming personally responsible for their own identity and this is linked to lifestyle as commodity. Individuals are socialised in a post-modern society as consumers with a choice of lifestyles. While on the one hand our autonomy is restricted in the field of employment (if we can find employment), how we choose to define ourselves and with whom we choose to define ourselves is a matter of personal freedom. An anomaly of this situation is that personal perceptions of health, their own well-being and life satisfaction may be at odds with a health professional's assessment of that individual's health status (Albrecht 1994). The danger of this individual health lifestyle approach, when it assumes that health is the opposing pole of a health-illness construct, is that individuals too can be held as responsible for the causation of their own diseases (Kirkwood & Brown 1995) and lifestyle factors can be seen as the precursors, risk factors, of future illness (Armstrong 1995). Health may then become expressed as a moral debate concerning responsible citizens free from the intervention of doctors. This in turn masks the agenda of restricting access to limited resources. Rather than the sick being labelled as deviant, the sick become labelled as illegitimate users of provision. In England such a situation has occurred whereby advertisements in national

newspapers have been taken out on behalf of a medical association requesting patients only to contact their doctor in an emergency.

Promoting and maintaining our health is one such choice in the plethora of consumer activities intimately related to our identity. The body-builder, eating efficiently for the production of a body mass will consume differently from the computer freak who surfs the Internet and eats fast food for a fast lifestyle. Both these will differ from the jogging yoghurt eater who consumes vegetables to purify his material self, reduce his cholesterol levels and meditates for the salvation of the planet. The young boy who was running for fun in my earlier example, grew up to be the young man running for pleasure, who became the middle-aged man running for his life. While the same activity prevailed through each episode, the needs that were being gratified were different (see also (Montelpare & Kanters 1994; Tinsley & Eldredge 1995) .

The implication of Bourdieu's work (see Randal Johnson in (Bourdieu 1993)) is that any analysis that overlooks the social grounds of aesthetic taste tends to establish as universal aesthetic and cultural practices that are in fact products of privilege. So it is of an universal health practice. A pure aesthetic demands keeping necessity at arms length, and daily life will always subvert such an health aesthetic, thus my call for a functional aesthetic of health understandings based upon the body that legitimates pleasure. Martin (1996:53) urges us to an "understanding of the imagery, language and metaphor operating in our contemporary culture of the body".

Implications for health promotion

I would like to consider three practical areas of health care that relate to the previous arguments. All are subject to the charismatic ideology that assumes a monolithic perspective on health as applied by experts who know that is often based upon an hidden moral agenda.

The first is concerned with AIDS educational campaigns that are concerned with encouraging safe-sex amongst gay men. Such educational material has assumed that there is an homogenous culture to which gay men belong and that behavioural change will follow as a logical consequence from reasoned exhortation. Gold argues otherwise (Gold 1995) There is not a safe sex culture in existence, and the encouragement to have safe sex has missed out on the reality of hedonism involved in sexual contact. As mentioned previously, health care rationale, for the individual, is not necessarily linked to a carefully planned strategy as health-care professionals like to believe. There may be indeed disparities between what people believe and what they do.

For some gay men, the constellation of sexual gratification, recreational pleasure and the maintenance of a particular lifestyle, tied-up as it is with a gay identity, does not have health-care as a principal strategy for living even in a climate of AIDS prevention. Human beings live, with optimism and zest, to enjoy life not necessarily to prevent illness. Any interventions aimed at changing behaviour in gay men to promote a safer-sex culture will need to accept that there are groups of men with differing lifestyles and expectations, some

of who may not be benign and benevolent towards a wider community.

A second example is in the field of dieting and exercise as they are related to body shape. Females in Western industrialised cultures are expressing not only concern about their bodily shapes but are actively engaged in altering how they appear. The female body is the interface between the woman herself, as a person, and her social identity. Feelings about the self are related to feelings about the body, they are not solely located in the body, but are concerned with how that body appears to others. A vast amount of time and money are spent on consumer activities related to this body image in terms of exercise activities, fashion and diet. Slimness has become popularly associated with elegance, self-control, social attractiveness and youth (Furnham, Titman, & Sleeman 1994) . Such descriptions are also the motivating factors associated with the sales pitch of many consumer products. While such personal lifestyles of dieting for fitness and the presentation of a powerful potent body may be health enabling, there is also the paradox that it is these very activities that are involved in the generation of eating disorders. Hartley (1996) argues that the advancement of health education encouraging a diet low in fat and cholesterol has a negative effect and may play a role in eating disorders. The aesthetic of near emaciation in conjunction with the modern moral imperative of eating healthily, that is fat-free, may encourage a lifestyle that is life threatening. Health promotion has a social ecology that is all too easily neglected and this neglect of context may be the cause of high relapse rates

following health promotion interventions (Stokols et al. 1996).

The encouragement of the excessive individualism, while promoting autonomy, may be at the expense of her integrity as a whole person. She is connected to a set of cultural values that threaten to destroy her health when disembedded from the relations that may offer a social meaning to her personal identity. This excessive emphasis on the individual body dislocated from the social body is classically reflected in the egoism explanation in Durkheim's explanation of suicide (Warde 1994) . Food preparation, the choosing of diet, the presentation of the body and the adornment of the body are never fixed and belong to a complex argument related both to individual identity and to the maintenance of a symbolic capital (Rasmussen 1996).

A third example is concerned with cigarette smoking in the young. While there has been a considerable impact on behalf of educational campaigns to curb adult smoking, those campaigns have failed to make any impact on the prevalence of young smokers (Lynch 1995) . Lynch argues that this failure is because educational campaigns singularly fail to understand the reasons why young people smoke. These reasons may not be homogenous, and certainly will not follow the causal sensible logic of most health care professionals. Image is seen as a powerful factor in influencing smoking behaviour, as is the need to be "an individual". Thus campaigns aimed to curb enjoyment, emphasising a sensible conformity to an artificially constructed target group of adolescent smokers falsely assumed to be homogenous, will be doomed to failure.

We see that hedonism, the enjoyment of the body, the maintenance of a self-image and pursuing an active, seemingly healthy, lifestyle can be both health promoting but in some circumstances, deleterious to health. The pursuit of excessive individualism may lead to a disentanglement from social relationships that are vital to bringing some checks and balances to counter extremes of living that may prove to be deleterious. There is no easy reconciliation of this problem.

We must however recognise that our health care endeavours must target small groups and individuals. There are no easy global solutions that can be applied from the top-down. Struggling to understand the individual and those with whom she is bound are vital. If this is central to the practice of health care in the consulting room, then it can surely be extended to our health-care reasoning.

The ramification of all this for health care is that instead of a top-down approach to promoting health care, we must consider targeting interventions aimed at small groups in which individuals are embedded. Even within church groups we know there are small groups of individuals who have differing interpretations and adopt differing lifestyles (Spickard 1994).

We have to understand how people “do” their lives, not simply what they think and say about their lives. It is in the body that individual identity is expressed, and the body is the interface between the individual and society. It is what people do together that binds them together with the groups with whom they perform their lives. This performance will be bound up with lifestyle, exercise and leisure activities (Johnson, Boyle, & Heller 1995;

Montelpare & Kanters 1994; Tinsley & Eldredge 1995) , home decoration (Madigan & Munro 1996) , dieting (Furnham & Boughton 1995; Hamilton et al. 1995; Nguyen, Otis, & Potvin 1996) and dress. In the sense, “lifestyle” is not something that can be read about in books, it is an activity and also subject to change (Træen 1995) . Making sense of the world is an activity achieved through the body. Swimming cannot be learned about by reading about it, or by gathering together a band of expert swimmers together to tell you about their experiences, nor by attending a conference of hydro-physicists. At sometime we have to jump into the water and through experience do it. The body grasps what it needs to do. Having a teacher in the water certainly helps. So too with health and a change in “lifestyle”. If we wish to encourage people to do something differently, we have to understand that it will be intimately connected with their identity as a person and those with whom that identity is validated. Health care professionals are no longer the group with whom our patients wish to identify, and with their rates of suicide, marital disruption and drug abuse, who can blame them. Change is brought about by influencing small groups and understanding their way of being in the world.

One factor that we must take into account is that the serious business of living can also be fun. While we know a lot about health care activities and their impact, we know little about the importance of leisure activities and their ramifications for health. Positive emotions, according to new thinking, influence our health status for the better.

Optimism and a sensual pleasure in everyday activities and situations are valuable for promoting personal health and the absence of symptoms and a sense of enjoyment coupled with a zest for living, appear to play a significant role in the subjective assessment of health (Montelpare & Kanters 1994; Wengler & Rosén 1995). Once more, health is an activity that has sensual ramifications that are also concerned with pleasurable activities that are themselves integrated with an overall sense of “lifestyle” rather than our unilateral exhortations to follow health care prescriptions.

How such optimism and sensual pleasure is passed on to those living in poverty as the urban poor will be the proving ground of the post-modernist argument and its reification of individualism. That the poor may continue to smoke and drink as creature comforts in a harsh world may lend credibility to the argument that sensual pleasures and leisure activities, even when there is no work, are the important arbiters of health care activity as it relates to daily living. The distribution of wealth that has a considerable impact of morbidity is not in the hands of individual but belongs to a broader political process.

At the beginning of this chapter I used a quote from Pierre Bourdieu that separates the pure aesthetic of a dominant class from that of natural vulgar enjoyment. The same situation occurs in the broader medical discourse, whether it be within the suprematist dogma of orthodox medicine, or the moral stricture of complementary medicine as they have both become established in modern Western health care delivery. There is a pure aesthetic of health related to a dominant moral discourse. What I am

arguing for is a vulgar praxis aesthetic that takes health as being done. This reflects both the chthonian mode of knowing (touch and smell) with the Apollonian mode (seeing and being seen) (Bemporad 1996). Rather than separating forms of knowing, perhaps we can turn to a reconciliation that occurs in the practice of everyday life. The body that is done is both seen and smelt in practice. Health care understandings are then heterogeneous combining both sense and reason located in the practice of everyday living. This will have an implication for the methodologies that we use for health care research as we need to incorporate - literally embody - lay knowledge (Aldridge 1990, 1992; Emke 1996; Popay and Williams 1996).

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A person who lives the aesthetic lifestyle is constantly fighting to reach his/hers full physical potential through intense training and an implementation of a clean diet. The individuals who live that way are sponsored by big supplement companies and have a large number of fans who look up to them for advice. Real definition: A life dedicated to the physical and the approval of others. The person who embraces this lifestyle usually has a very hard time understanding the inner self. He/She usually tries to hide insecurities behind a synthetic looking body, cheap talk, and cash. The aesthetic lifestyle is dirtier than it looks. The athletes use drugs to gain muscle mass and lose body fat. They will never admit that to your face in order to protect their contracts with supplement companies. Charismatic people have mastered a complex set of communication skills which give them considerable advantage in work and life. The charisma effect. It turns out, there are a lot of quantifiable benefits to using charismatic behaviour. For instance, when the values a leader stands for overlap with those of the people he or she is trying to influence, a "charismatic effect" can occur. "People will identify with you more, they will want to be more like you, they will be more willing to follow you," says John Antonakis, professor of organisational behaviour at the University of Lausanne. Independent of how attractive you are, if you're more charismatic in a short clip competing for venture capital funding, you're more lik

Aesthetic Experience Is Processual
175-Transience
17B-Artifact and Genesis
17B-The Artwork as Monad and Immanent Analysis
179-Art and Artworks
1B1-History Is Constitutive; "Intelligibility"
1B2-The Necessity of Objectivation and Dissociation
1B3-Unity and Multiplicity
1B6-The Category of Intensity
1B7- "Why a work can rightfully be. For even though students once complained that Adorno had no interest in praxis but was preoccupied only with art, from the book's perspective it will be noticed that the word has completely disappeared from contemporary language, whereas for this book on art, "Praxis would be the ensemble of means for minimizing material necessity, and as such it would be identical with pleasure

Aestheticism (also the Aesthetic Movement) is an intellectual and art movement supporting the emphasis of aesthetic values more than social-political themes for literature, fine art, music and other arts. This meant that art from this particular movement focused more on being beautiful rather than having a deeper meaning "art for art's sake". It was particularly prominent in England during the late 19th century, supported by notable figures such as Walter Pater and Oscar Wilde. The movement started