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New directions in health lifestyle research

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The papers in this special issue of IJPH on risk behavior reflect the increasing interest in health lifestyle research (Tountas et al. 2007; Galani & Schneider 2007; Tzormpatzakis & Sleap 2007; Galani et al. 2007; Rehm et al. 2007; Momeni et al. 2007). Health lifestyles are collective patterns of health-related behavior based on choices from options available to people according to their life chances. Such lifestyles can be viewed as consistent health-related behaviors like smoking that are enabled or constrained by a person's social situation and living conditions. The epidemiological transition from acute to chronic diseases as the leading cause of mortality has made the study of health lifestyles especially important at this time in history. Medicine cannot cure chronic diseases and a person's lifestyle practices can either cause or prevent them. Consequently, health has become regarded as an achievement – a goal people are expected to work for or risk losing. Typically they accomplish this through positive health lifestyle practices. These practices include avoiding smoking, eating properly, moderating alcohol use, exercising, and similar health-promoting behaviors. Conversely, unhealthy practices like smoking tobacco, high-fat diets, excessive alcohol consumption, a lack of exercise, and similar negative health habits are underlying causal factors for many chronic diseases.

There has been a victim-blaming approach in public health in which researchers have viewed risk behavior in terms of individual responsibility. That is, rather than considering such behaviors in a broad social context that includes the life situations promoting the behavior, poor health lifestyles are attributed largely to choices made by individuals. Typically research is focused on individuals who are subsequently targeted to change their behavior through the public health campaigns, the media, and educational programs consistent with psychological models that dominate these approaches.

The idea that a person's health lifestyle practices are matters of individual choice, however, overlooks the significance of structural conditions in determining those choices. We know, for example, that persons living in socially disadvantaged circumstances are drawn to poor health habits, but the types of social situations and conditions that promote this behavior often go uninvestigated. People can only choose from what is available and society typically provides the range of options from which they can choose and the rank order of those options. Socially and economically disadvantaged persons have fewer choices and those choices typically are of lessened quality because of their social position. Public health measures that concentrate solely on influencing individual health behavior fail to address the causal qualities inherent in social structures and living conditions. This is the case even though these structures may ultimately be responsible for causing the health problem.

An increasing number of studies on class inequality, living conditions, neighborhood characteristics, and social capital are finding that structural conditions can be causal factors for both health and disease in the United States and Great Britain (Cockerham 2007). Class position, for example, influences multiple diseases in multiple ways and the relationship has endured for centuries. The impact of structural variables on intervention programs is also becoming apparent. One example is smoking cessation. Efforts to educate individuals in the United States to give up smoking achieved some results, but the most effective measure was banning smoking in public places that ultimately had the effect of labeling smokers as social outcasts and deviants. This disapproval became normative for society at-large, thereby creating an adverse social attitude toward smokers that functioned beyond their control. As Sweat and Dennison (1995) found, antismoking laws, social isolation, and stigma significantly increased smoking

cessation "far beyond the results of purely individualistic approaches."
Research determining the effects of social structural variables on health is gaining momentum. Such research has been handicapped in the past by an inability to determine the direct effects of social structures on individuals because of the possible role of other variables that may intervene in the relationship. However, recent developments in statistics for estimating hierarchical linear models now exist that provide efficient estimations for a wider range of applications than previously possible. Hierarchical linear modeling (HLM) makes it feasible to test hypotheses about relationships occurring at different levels and assess the amount of variation explained at each level (Raudenbush & Bryk 2002). HLM tests the strength of the interaction between variables that describe individuals at one level (level one), structural entities (like households) at the next level (level two), and sequentially higher levels (e.g., communities, social classes, nations), depending on the variable's conceptual position in a structural hierarchy. By comparing changes in the regression equations, the relative effects of each level of variables on health outcomes can be simultaneously determined. We are now able to test hierarchal models that better reflect the layers of social structures that exist in a person's life and affect their health. This approach to the study of risk behavior and health lifestyles is the likely future direction of research in the field.

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References

Cockerham WC (2007). Social Causes of Health and Disease. Cambridge: Polity.

Galani C, Schneider H (2007). Prevention and treatment of obesity with lifestyle interventions: review and meta-analysis. Int J Public Health 52*(6)*: 342–359.

Galani C, Schneider H, Rutten FFH (2007). Modelling the lifetime costs and health effects of lifestyle intervention in the prevention and treatment of obesity in Switzerland. Int J Public Health 52*(6)*: 372–382.

Momeni A, Hartmann T, Born C, Heinzel-Gutenbrunner, Pieper K (2007). Association of caries experience in adolescents with different preventive measures. Int J Public Health 52*(6)*: 393–401.

Raudenbush SW, Bryk AS (2002). Hierarchical Linear Models: Applications and Data Analysis. 2nd ed. Thousand Oaks: Sage.

Rehm J, Taylor B, Roerecke M, Patra J (2007). Alcohol consumption and alcohol-attributable burden of disease in Switzerland, 2002. Int J Public Health 52*(6)*: 383–392.

Sweat MD, Denison JA (1995). Reducing HIV Incidence in Developing Countries with Structural and Environmental Interventions. AIDS *9*: S251–7.

Tountas Y, Manios Y, Tzavara C, Dimitrakaki C (2007). Relationship between basic protective health behaviours and health related quality of life. Int J Public Health 52*(6)*: 341–347.

Tzormpatzakis N, Sleap M (2007). Participation in physical activity and exercise in Greece: a systematic literature review. Int J Public Health 52*(6)*: 360–371.

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