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The application of humanization theory to health-promoting practice

Abstract

It has been identified that if public health interventions do not account for what it means to be human they are likely to fail. The aim of this paper is to introduce humanization theory and to show how it can be applied to health-promoting practice. Health promotion can feature humanizing and dehumanizing elements and these appear to impact on how people may (or may not) engage with interventions. The primary prevention of skin cancer with young people is an illustration of this. The practice implications of applying humanization theory to health promotion are potentially vast and complex however it is proposed that considering the dimensions of humanization may be a useful activity to inform the early stages of health promotion intervention designs. Further, developing the qualitative research evidence base about peoples' experiences of humanizing dimensions of health promotion would also be a valuable step towards ensuring that interventions account for the 'human dimension'. Applying humanization theory to the specific example of skin

cancer prevention with young people has been a new venture but based on work so far, suggestions for humanizing principles for skin cancer prevention would be to be inclusive of the needs of young people, to support them and to involve them in research and intervention development.

Introduction

Although the links between humanization theory and public health policy, research and practice have previously been explored in principle and considered in relation to health inequity[1] this paper specifically considers humanization theory and its application to health promotion activity. Hemingway[1] has suggested that public health interventions that do not account for human elements are likely to fail and although this would seem to be an expected and 'common sense' notion in the context of human health improvement, it appears that health promotion may not always acknowledge the 'human dimension'. In this article I will outline humanization theory and explain how humanizing and dehumanizing influences may impact on peoples' engagement with health promotion activity. I will draw on the example of the primary prevention of skin cancer with young people - an area where engagement has been identified as problematic because young people ignore health promotion messages designed to reduce their risk of developing skin cancer.[2-6] I will make suggestions as to why this

might be, based on humanization theory and discuss implications for health promotion practice. Humanized approaches to practice value what it means to be human and qualitative research acts as an underpinning resource because it facilitates exploration of issues from participants' points of view as human beings rather than as research 'subjects' studied in the context of others' theoretical assumptions.[7] In this article I will draw on insights gleaned from a UK based qualitative study designed to understand the reported lack of engagement of young women with skin cancer prevention advice[8] but first, an introduction to humanization theory and its value framework.

Humanization Theory

Humanization reflects a focus on well-being rather than ill health and is about "those things which make us feel more human".[9p.1.] A framework of values about what it means to be human has been developed and includes eight dimensions[7]. Each dimension comprises a continuum reflecting humanizing to dehumanizing elements as follows: insiderness to objectification, agency to passivity, sense-making to loss of meaning, personal journey to loss of personal journey, sense of place to dislocation, an embodiment to reductionist view of the body, uniqueness to homogenization, togetherness to isolation. The first component of each continuum denotes a potentially humanizing concept and the second a dehumanizing one. For example taking the

dimension of insiderness/objectification, the notion of insiderness is humanizing; it acknowledges that we each have a personal sense of our own selves and that only we can know, ourselves as individuals, how things are for us. However it can be dehumanizing when we are perceived as objects and categorised into groups without regard for our 'insider' perspectives (objectification). In relation to the agency/passivity dimension, agency is about our being able to express and experience choices, to act as we wish and to be accountable for our actions. However passivity signifies potentially dehumanizing dependence on others and lack of control over our own health. The sense-making/loss of meaning dimension of humanization indicates that to feel human we need to be able to make sense of our experiences and to understand how elements of our lives fit together. When we are not viewed as human beings holistically and our needs are compartmentalised this can be dehumanizing. The dimension of personal journey/loss of personal journey is about individuals having pasts and futures. It can be dehumanizing when a person is only considered in the present because this demonstrates a lack of regard for their context, past experiences and hopes for the future[7].

To feel human involves us in feeling secure and familiar with our surroundings not only in terms of physical place but in other ways, for example culturally. Feelings of security and familiarity are located at the 'sense of place-end' of the sense of place/dislocation

dimension of the humanization framework. When our sense of place is removed this is referred to as ‘dislocation’ and can be dehumanizing because it can make us feel insecure and like strangers. The dimension of humanization related to embodiment and reductionist views of the body suggests that at the dehumanizing end of this spectrum the body is considered to be a biological entity and almost as something mechanical to be maintained. However at the humanizing end of the spectrum ‘embodiment’ recognises that a person’s well-being is influenced by other factors such as their socio-cultural context. [7]

Two remaining dimensions of the humanization framework - uniqueness/homogenization and togetherness/isolation are presented in detail next. They are considered in an applied way to specifically illustrate how health promotion may feature humanizing and dehumanizing elements. The specific example of skin cancer prevention with young people will be used to illustrate and implications for health promoting practice will be discussed. Applying humanization theory to the issue of skin cancer prevention with young people is a new venture and work in progress but suggestions for how we might account for 'individuality' and 'togetherness' in health promotion will be offered along with principles for humanizing practice.

The nature of the dimension of uniqueness /homogenization and application to health promotion

In a humanizing context the uniqueness element of this dimension is at the fore, reflecting that 'feeling human' involves display of individuality. The dehumanizing 'end' of the continuum features homogenization, which is characterised by emphasis on people being part of a homogeneous group rather than being unique. It involves an expectation that people will behave in homogeneous ways as part of that group.[7] How this dimension relates to health promotion will be considered next, drawing on the example of skin cancer prevention with young people.

Skin cancer is believed to be a preventable condition because exposure to ultraviolet radiation is the main risk factor in its development.[4] Primary prevention measures are designed to prevent a health problem before it occurs[10] and current skin cancer prevention advice comprises guidance for people to limit their time in the midday sun, to use shade, wear protective clothing, use sunscreen SPF 15+, heed the ultraviolet index and to avoid use of sun lamps and tanning parlours.[11] Although young people are expected to comply with these sun safety messages the evidence internationally is that

they do not.[2,4] Drawing on humanization theory a reason for this may be that their individuality and uniqueness has been overlooked. Treating them as part of an homogeneous group is potentially dehumanizing and they may not all perceive sun safety to be relevant to them. In the qualitative study cited above[8] a key finding was that young women do not comprise an homogeneous group in terms of their sun-related experiences; they are they are indeed unique as indicated by one participant in the study who was aged 15:

Ann (pseudonym): ... *Different people feel differently about the sun.*
Researcher: Yeah.
Ann: So you can't say 'our age group' 'cos not all of our age group are the same.

Further, according to humanization theory "*… No matter how much we are part of larger influences and contexts, there is something unique in space and time about this particular person in this particular moment that characterises their particular individuality".* [7p.71] Such uniqueness in space and time was evident in the study cited above.[8] In addition to interpersonal differences in terms of participants' own personal preferences and issues related to being in the sun, another layer of 'uniqueness' emerged and this was manifest on a moment-by-moment basis because individuals' 'selves' were transient according to their social contexts and the people around them at any one time.

As a consequence each did not have one, consistent ‘adolescent’ way of behaving, instead they could assume the role of child, adolescent or adult according to their ever-changing social circumstances. This affected sun-related activities for example when they were with younger children participants assumed a protective, adult role and in the company of adults, they themselves took the role of dependent child. This role was characterised by their conformity with adults’ requirements to wear sunscreen, to cover up and to protect themselves from burning. Individuals adopted more independent ‘adolescent’ roles when they were with peers and as others have also found[12] on these occasions they were vulnerable because the sun-protection equipment and reminders that adults provided were lacking. Further, their peers did not necessarily encourage protection measures as the following illustrates:

Researcher: So what would happen if you didn't fit in with them (parents) *'nd what they thought?*

Isabel (pseudonym): They'd start naggin'.

Researcher: Yeah.

Helen: (pseudonym) (mimicking a high pitched voice)*: Oh, you'll get* ***burnt!*** (giggling). *That's what they keep doin'.* (All laughing)… *your friends aren't gonna say ' you'll get burnt put some cream on again'. They don't really care* (all laughing).

Isabel: They'd say sit there 'nd ***burrrrrn!*** (burrrrn said in a deep and gruff voice)

(Name removed to anonymise the manuscript[8]).

Applied to health promotion practice it seems that one-size-fits-all approaches based on expectations of homogeneity are unlikely to succeed because they do not account for human uniqueness and difference. The question is how can we humanize practice and account for individuality in health promotion? To some extent this question may have been answered in the context of skin cancer prevention (albeit unintentionally) because there are secondary prevention measures in place. Secondary prevention refers to detecting disease early, in order that treatment can be instigated[10] and in the UK, secondary prevention of skin cancer is already an adjunct to primary prevention campaigns. Individuals are encouraged to check their skins for suspect lesions so these can be treated as early as possible (See Cancer Research UK[13]). This secondary prevention strategy may be considered 'humanizing' because to some extent it accounts for interpersonal uniqueness. It is potentially relevant to those who do not subscribe to primary prevention measures - it reflects inclusivity which is proposed here as a humanizing principle for practice with young people.

Drawing on the example above, accounting for intrapersonal uniqueness in space and time may be another way to humanize health promotion. Young people appear to be susceptible to excessive sun exposure when they are in 'adolescent mode' with peers

and lacking the sun protection prompts and products adults provide. Supporting them when vulnerable and most likely to renege on ‘healthy’ behaviour (in this case sun protection) would be humanizing hence ‘support’ is suggested as a humanizing principle. The need for adolescents to be encouraged and helped to carry out sun safe activity has been acknowledged before[12,14] and supportive environments can make healthy behaviours easier to achieve.[15] For example schools are enabling environments when they have education and policies for sun protection[14,16,17] and evidence from Australia suggests that under these conditions sun protection is made easier for adolescents because there are rules about clothing to be worn and resources like shade provided.[4] Given the success of supportive school environments in encouraging healthy behaviours Williams et al[4] have suggested that there is scope for schools to partner councils and sports contexts to make sun protection more widely accessible and an easier option for adolescents. It seems that more could be done in the UK to help young people because here sun protection policy and education does not appear to be a priority. Although Cancer Research UK has produced Sunsmart guidelines to enable healthy environments in secondary schools[18] whether schools adopt them is discretionary. Further, Personal, Social Health and Economic Education (PSHE) is a non-statutory element of the curriculum.[19] It seems that there are opportunities to support young people more consistently and more fully through secondary schools and other contexts. Ideally the means for support would be developed in partnership with

young people themselves because as discussed next their perspectives and conceptions of health impact on the relevance of health promoting activities.

The nature of the dimension of togetherness/isolation and application to health promotion

Human beings need to experience 'togetherness' and in humanization theory the dimension of togetherness/isolation reflects our need for a sense of belonging and to feel part of a community rather than isolated and alone.[7] Social isolation can be detrimental to our health [20,21] and whilst discussing this dimension of togetherness/isolation Todres et al[7] suggest ways that dehumanizing isolation may be countered in health care practice in order to humanize it. Paradoxically it seems that health promotion can make potentially dehumanizing demands on people, for example in the primary prevention of skin cancer as explained next.

Whether we experience belonging can depend on the appearance of our skin as acknowledged in the field of Dermatology. Patients can be stigmatised and shunned because of how their skin looks and this can lead to social isolation (see Ginsburg and Link[20]). Social context defines ideal appearance through cultural influences[22] and a suntanned appearance has been identified as a cultural norm for young people.[23-26] Adolescents are influenced by social norms and attitudes[27] and in the qualitative study

referred to above[8] it was particularly important for some participants to look good in order to feel that they fitted in. To this end they enhanced their appearances through different means including sun tanning. By advising that people should not have a suntan[28] health-promoting messages are arguably advocating a 'dehumanizing' and potentially isolating option against conformity with social contextual norms related to appearance. This lack of focus on humanizing togetherness and indirect advocacy for dehumanizing isolation may explain the lack of engagement with sun safety advice and requirement for some young people to strive for a suntan reported in the literature.

The significance of the skin's appearance in determining psychosocial health for adolescents does not seem to be taken seriously enough in relation to skin cancer primary prevention. This is paradoxical given that the appearance of the skin is accepted as having a negative effect on psychosocial health and relationships in skin disease and empathy is shown for sufferers (see Ginsburg and Link[20] for example). It leads to the question of how can practice account for togetherness and be humanized? Perhaps the first step is to consider why there has been a lack of focus on humanizing togetherness in the first place. In the context of skin cancer prevention with adolescents the answer appears to lie in the different ways that health can be conceived. The skin cancer prevention agenda is underpinned by epidemiological evidence about the negative effects of ultraviolet radiation and sun exposure as a physical threat; it emphasises

physical health. However young people appear to have more holistic perspectives of health and wellbeing[29] meaning that interventions based on risk and determined by epidemiology may not engage them. Further, health promotion professionals can perceive young people as risky because they do not understand their health motives and agendas.[29] Adolescent behaviours defined by health professionals as 'unhealthy' may be the means for young people to adapt to their social environments (See Crossley[30]) and although perhaps an inconvenient truth, it seems this explains why young people may strive for suntans. If adults develop interventions to promote young people's health without anticipating or heeding the issues affecting them this will impact on their effectiveness. A humanizing principle for health promotion then would be to involve the people the intervention is intended for.

To begin with, a way to involve people would be via research, for example there are gaps in knowledge about adolescents' conceptions of health in their own terms. Research to glean their perspectives to-date has largely been based on dominant discourses of health risk and so further qualitative research work into young peoples' perceptions of health is necessary.[29] Qualitative methodology prioritises and facilitates exploration of participants' issues using their own terms of reference hence qualitative research findings are crucial in informing humanized practice.[7] Understanding the health perspectives of young people would seem to be an important place to start in

humanizing health promotion not only in relation to skin cancer prevention but other areas of practice too.

More generally, the preceding discussions reflect issues that have been recognised in public health before. These are that the health priorities of individuals and the public health agenda may differ, and that the health of the individual is not only determined by their lifestyle and personal health behaviours but also wider, contextual influences[31]. The points raised in this article suggest that these issues can impact on whether health promotion activity is potentially humanizing or dehumanizing. Ways of accounting for individuals' circumstances as well as their broader contexts are called for if health promotion activity is to be relevant and humanizing. According to Stockols[32] the social ecological approach to health promotion has the potential to account for both the individual and contextual factors that influence health. It seems there is scope to explore the potential role of social ecological models in humanizing health promotion.

Conclusions

Humanization theory is relevant to health promotion activity because humanizing and dehumanizing influences appear to impact on how people may (or may not) engage. The implications for health promotion practice are potentially vast and complex however it is proposed that considering the dimensions of humanization may usefully inform the

early stages of health promotion intervention designs. This process may help to identify likely enablers and barriers to interventions and there is scope for research to explore this further. Qualitative research is a key resource for humanized practice given the insights into the ‘human dimension’ that it offers. Based on this, first steps to humanize health promotion could be to develop the qualitative evidence base around peoples’ experiences of related humanizing dimensions. In terms of humanizing health promotion with young people this could be informed by more qualitative research investigating what health is to them and in the context of skin cancer prevention, their experiences of humanizing dimensions of related health promotion practices. Applying humanization theory to the issue of skin cancer prevention with young people has been a new venture but based on the discussions above suggestions for humanizing principles for skin cancer prevention would be to be inclusive of their needs, to support them by providing supportive environments and to involve them in research and developing interventions. More generally, the potential role of social ecological models of health promotion in humanizing health promotion could be explored.

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Conflicts of Interest

The author declares no conflicts of interest.

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