

Nursing and adolescent health promotion: An inquiry following the philosophical oeuvre
of Michel Foucault

by

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B.N., Dalhousie University, 1989
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A Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of

DOCTOR OF PHILOSOPHY

in the School of Nursing

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University of Victoria

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Supervisory Committee

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Abstract

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Following the philosophical oeuvre of Michel Foucault, I locate and discuss how the discursive formulation of *adolescent health promotion* defines the conceptual possibilities and determines the boundaries of nurses' thinking and practices as they are written about in nursing texts.

From my archaeological work, I locate and name two confident nursing practices within the context of young people and their health: "reducing risk" and "promoting well becoming" and go on to locate those practices within two broader theoretical discourses within human science: the biological view and the social constructionist view.

From my genealogical work, I consider how the management of the adolescent body has become a matter that situates biological life (puberty) as a political event and situates the nurse within governing practices of pastoral power. I question the ways in which adolescent health may be shaped through political interests of economy and social order and question: When is an adolescent ever deemed responsible in matters pertaining to their health?

I offer an alternative view of responsibility and argue for a shift in established binary thinking that allows for the consideration of co-responsibility.

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Acknowledgments

The many ways that I received encouragement, guidance, support and love as I journeyed along the path to a doctorate degree are too numerous to mention. May this page be read as an acknowledgement and heartfelt 'Thank You!' to everyone.

Dedication

To my three beautiful children Deirdre Anne Ryan-Morissette, Fiona Arianne Ryan-Morissette, and Nolan Kerr Charles Ryan-Morissette. You have taught me more than any text or inquiry work about the ‘response ability’ of young people.

Chapter 1

In North America today, young people may be assumed to be generally (physiologically) healthy. If I turn to contemporary nursing and health literature, I read that the majority of their health problems are attributed to environmental stressors, risky behaviours, and psychosocial needs (Tonkin, Murphy, Lee, Saewyc et. al, 2005; WHO, 2005). Moreover, I discover that research by nurses and others interested in young peoples' health often describes adolescent behaviours that risk their immediate health and/or are predicted to compromise their adult health (Compass, 2004; Steward et al, 1999; Williams, Holnbeck & Greenly, 2002). Thus, I can summarize extant adolescent health research as focussing on the dire implications of young peoples' smoking, drug and alcohol use, sexual activity, aggressive and violent behaviours, lack of physical exercise and poor dietary habits. Yet this appears a narrow view into young peoples' health for, although such research provides an understanding of the effect of risk behaviours on young peoples' immediate health (Ahern & Keihl, 2006; Coleman & Cater, 2005; Hulton, 2001; Marsh, McGee, Nada-Raja & Currey, 2007; Williams, Holnbeck, & Greenly, 2002), it operates from an assumption that all young people are inclined to risk their health. Thus, it seems contradictory to conclude that young people are generally physically healthy while, at the same time, engaging in behaviours that pose a serious risk to their health. Moreover, it appears that the in response to this risk oriented construction of adolescents' health, contemporary nursing practices as they are written about describe an established tradition of screening for and promoting healthy lifestyle choices in their practices with young people.

My interest in developing the project on which this dissertation reports began when I stopped to think about repetitive language in nursing texts describing how nurses engage with young people and their health (e.g. *adolescent at 'risk' and adolescent health promotion*). For example, young people appeared to be the focus of numerous public problems including youth violence, teenage pregnancy, and participation in risk behaviours. Curiosity aroused, I wondered about the origin and continued support for this stereotypical characterization of young people. I thought about what might be the impact of such characterizations on nursing health promoting practices. I wondered if I could identify and interrogate language that held such confident characterizations within nursing texts. Questions that came to my mind included; under what circumstances is such a language or discourse of adolescent risk and adolescent health promotion useful in nursing thinking and nursing practice? Under what circumstances might this discourse suggest problematic thinking about young people in nursing thinking and nursing practices? What might be the benefit of further inquiry into present day nursing thinking and acting in the context of young people and their health? From these questions, a philosophical inquiry unfolded.

The starting point for my philosophical inquiry is to locate taken for granted truths inherent in nursing practices about young people such as the 'at risk' adolescent that requires adolescent health promotion. I describe how these 'truths' developed. I question how such truths influence nursing understanding of young peoples' health and, as a result, constitute and legitimate a role for nursing in the health promotion of young people. I do this by moving back and forth between the present and the past.

Methodology

The idea of moving between past and present described as a ‘history of the present’ (Foucault, 1984e) is an approach that opens up, for question, nursing language-in-use and described practices toward young people and their health. Moreover, the discourses that shape disciplines and inform a discipline’s actions may be called into question: What discourses are of influence and how do they influence the development of nursing disciplinary knowledge about young people’s health and, in turn, constitute nursing professional thinking and actions concerning young people’s health?

The central idea of this methodology is the interrogation of the relationship between language and action. For example, by locating a ‘truth’ in nursing language about young peoples’ health, for example, the ‘at risk’ adolescent, I may then critically question how such an idea shapes nursing practices with young people in the present. Moreover, in undertaking a history of the present by locating present day truth statements in nursing texts that describe nursing thinking and acting toward young people and their health, I may further locate and interrogate those knowledges or discourses that generate unquestioned ‘truths’ about young people and health, in particular adolescence and health promotion as they emerged in history.

Statement of purpose

The methodological approach used in this project involves two steps and serves two purposes. The first step, comprises an archaeology of language in use through which I isolate particular statements in nursing texts that reveal one way nursing *thinks* and *acts* toward young people and their health. In the second step, a genealogical analysis allows me to consider the possibilities and restrictions of contemporary ‘adolescent health

promotion' discourses on nursing thinking about professional relationships with young people. In the first half of the project on which this dissertation reports, I undertake an archaeological dig into present day "truths" excavated from nursing texts, which reflect nurses' thinking and acting in the context of adolescent health promotion; in the later half I interrogate the constitutive effects of such discourses on the discipline of nursing's thinking and actions.

Research Questions

A Foucauldian approach to archaeology and genealogy suggests that contemporary questions and answers are the starting point for historical research. The following questions framed my work:

- What interests and forces effected the creation of governing practices in health promotion in Canada within the 1970-1990 period?
- What nursing thinking and practices in adolescent health promotion came into being alongside political ideas of health promotion?
- Why might some nursing thinking and practices directed toward adolescent health promotion be resistant to critique and change?
- What elements of current nursing practices might change if we were to think and practice with young people differently?

Contributions of this study

In this project, I describe the political implications of nursing thinking and acting within a domain of health promotion directed toward young people. This political interpretation of nursing adolescent health promotion practices is important to the discipline for several reasons. First it offers an alternative to two predominant yet similar

conceptualizations of adolescent health promotion practice that influence nursing thinking; the biological view, which I will argue informs a practice of risk reduction, and the social constructionist view which informs a practice of promoting well-becoming.

I offer an alternative theoretical understanding of nursing health promotion practices with young people that questions the knowledge and practices constituting nursing adolescent health promotion activities. In particular, a genealogy guided by the writing of Michel Foucault allows me to examine the systems of reasoning that operate in nursing adolescent health promotion practices, situate that reasoning within social and political spaces and scholarly knowledge, and expose the limitations of this perspective.

By shifting my focus to systems of reasoning, I direct my analysis to a history of discourses, for example the ways in which nursing texts reflect particular understandings about young people and health promotion. My analysis of discourses focuses upon terms, categories, and techniques (Foucault, 1966/1994). My inquiry into young people's health and nursing health promotion directs the reader's attention to the terms and categories that shift nursing thinking and practice away from the individual young person and his or her health to the health promotion needs of *adolescence*. From this perspective, I demonstrate how *adolescent health promotion* is part of a broad network of knowledge, policy, and reason that may neglect both the individual and his or her health.

In my analysis, I also challenge the assumption of progress that supports the development of nursing approaches to young people's health. A history of the present approach to understanding knowledge development calls into question the assumption that the creation of new knowledges and new practices are necessarily the result of progressive thinking. Foucault (1975/1995) cautions us that our belief in the expansion of

our knowledge often results in enhanced bureaucracy. Our freedom to name and expand our knowledge about observable physiological growth in people (e.g. puberty) has shaped our thinking and doing in relation to our ways of managing and administering the conduct of young people. In the following example, we see how a clinical tool designed to collect information about physiological changes in male and female bodies from childhood to adulthood provides data for the continued measurement and regulation of young peoples' bodies.

In a Canadian longitudinal study of young people (7977 participants aged 10 to 17 years over a four year period), the data serves to inform us about the pubertal development of Canadian young people (Arim, Shapka, Dahinten & Willms, 2007). The tool used by the researchers to determine the range of normal pubertal development, the Tanner scale or stages (Tanner, 1962; Marshall & Tanner, 1969), provides a standard assessment of development based on external primary and secondary sex characteristics such as the size of breasts and the development of pubic hair. The Tanner stages do not match with chronological age rather the stages suggest the onset of and progression of normal pubertal development and its variations. Recently, this tool has been translated into self-assessment scales for young people (Schmitz et. al, 2004).

While the intent of the Tanner scale is to describe normal pubertal development, and increase our collective knowledge about the physical changes to the male and female body as it progressed from childhood to adulthood, our increased knowledge about pubertal development frames the larger social and political concern about young peoples' conduct and how to manage it particularly their engagement with substance use and sexual activity (see Arim et. al). This connection between pubertal development and

engagement with health risk behaviours provides a space for health care professionals to continue measurement and interventions that inform regulation of adolescent bodies (e.g. the determination of when a young person may legally ingest substances such as alcohol and nicotine or engage in sexual relations).

I argue that the nursing may overlook how professional practices are legislated into who, what, when, where and how nurses might engage with young people about their health decisions. Thus, I call attention to how political power and authority influences nursing practice with young people. Taking up Foucault's ideas, I question to what purpose there is now a practice tradition in adolescent health promotion that makes 'objectivist knowledge' the classifying criteria through which adolescents are disciplined and self-regulated. I do this by tracing the emergence of such knowledge, and question how this knowledge maintains power and influences nursing adolescent health promotion.

I propose that if nurses are to practice differently with young people and health, we must recognize the ways that contemporary nursing texts represent how some nurses currently think, and act toward young people as well as the political implications of these practices. I suggest that nursing has in some way(s) 'de-politicized' health promotion, and as a result, nurses' thinking and current practices with young people as they are represented in contemporary texts are often at odds with the values purported by the discipline. I offer my work as an opportunity to reflect on the usefulness of contemporary nursing adolescent health promotion practices through a historical critique of the political powers that have defined and sanctioned those practices.

Limitations

The project on which this dissertation reports, is a partial view into nursing health practices directed toward youth, specifically focussing on health promotion practices. Further investigation into the past and a broader look at contemporary practices I will describe later as productive areas for my future work.

I recognize that a textual analysis is one view into the health promotion practices of nurses and may not reflect all nurses' thinking and practice in adolescent health promotion. However, a Foucauldian approach to understanding knowledge development allows me to examine language as practice. Thus, the project on which this dissertation reports is a particular place to engage in a critical exploration of a very large topic.

I note that my focus on systems of reasoning or discourses downplays the particular understandings and experiences of identifiable embodied youth and/or nurses who are either recipients or providers of nursing health promotion practices. My analysis does not capture the personal accounts of either nurses and adolescents. However, in response to this limitation, I call attention to how systems of reasoning about adolescent health promotion help to produce particular subjective experiences among nurses and youth. My inquiry directs the reader's attention to the language that shifts nursing thinking and practice from the young person and health to the health promotion needs of *adolescence* as a stage of life. Furthermore, a history of the present of the discourses that shape how we understand *adolescence* and *health promotion* provides a space for me to locate and question particular knowledges that generate unquestioned 'truths' about young people and health.

Finally, I recognize that my project is located in a North American context of nursing and health promotion practice.

Overview of the Chapters

In Chapter 1, I introduce the reader into the intent of this philosophical inquiry, the parameters of the project and the ideas that my inquiry offers to the discipline of nursing.

In Chapter 2, I describe my methodological plan, a discourse analysis informed by the assumptions within Foucault's archaeology and genealogy. I explore Foucault's introduction of several interrelated concepts that contribute to how we might understand and study knowledge. The concepts *savoir*, *connaissance*, discursive formation, problematization, bio-power, bio-politics, and governmentality are located within two approaches to philosophical inquiry, archaeology, and genealogy. I discuss how those concepts contribute to my 'discursive analytic' (Graham, 2005) or the construction of an interpretive framework for this project.

In Chapter 3, I present an archaeology of nursing health promotion practices in adolescent health promotion as they are represented in nursing texts between the years 2000-2010 in Canada and the United States. In this first chapter of my archaeological work I am guided by a broad question: what truth statements appear to shape contemporary nursing professional thinking and actions concerning young people's health? I locate truth statements that may be traced to a discursive formation *adolescent health promotion* and problematize the ways it shapes particular nursing thinking and practices with young people in the context of their health.

In Chapter 4, I continue the archaeological work I began in Chapter 3 by locating and critically examining the origin of the discursive formation known as health promotion in Canada. Specifically, I will address the first question I posed in Chapter 1; what interests and forces effected the creation of health promotion in Canada within the 1970-1990 period. I begin with the introduction of the Lalonde report (1976) and locate truth statements that may be traced to the discursive formation health promotion. I critically interrogate the ways in which thinking and acting toward peoples' health are shaped as a result of a politically sanctioned view of health promotion.

In Chapter 5, I extend the archaeological work from Chapter 4 now focusing on an examination of the ways the discursive formation health promotion can be shown to have influenced nursing thinking and actions toward people and their health. I will address the second question I posed in Chapter 1: What nursing thinking and actions came into being alongside of the political ideas of health promotion? In the latter half of the chapter, from my textual analysis, I put forth that there is evidence to suggest that within nursing, some nurses adopted a politically legitimized health promotion ideology and began to modify it to the discipline's own ends. Moreover, I demonstrate via quotes from nursing texts how the conceptualization of health promotion sanctioned by government was argued and absorbed into routine professional nursing practices, beginning with the repetitive claim that health promotion 'belonged' with nursing.

In Chapter 6, I provide the genealogical analysis necessary to continue to address the third question I posed in Chapter 1: Why might some nursing practices directed toward young people be resistant to critique and change? As a result of archaeological work in Chapter 3, 4 & 5, I am now able to locate and name two confident nursing

practices within the context of young people and their health that are represented in contemporary nursing texts: “reducing risk” and “promoting well-becoming”. I argue that confident practices serve to inform nursing what is important and enduring in adolescent health promotion and may be located within two broader theoretical discourses about young people and their health within human science: the biological view and social constructionist view. I locate those confident practices in Foucauldian thinking as acts of surveillance and clinical examination guided by normalizing judgment. I argue that if we locate ‘reducing risk’ and ‘promoting well-becoming’ within the idea of governmentality, we see that in doing adolescent health promotion nursing practices reflect a position of ‘pastoral power’ (Foucault) to both survey and supervise young people in matters pertaining to their health such as acts of screening for risk.

In Chapter 7, I raise the final question introduced in Chapter 1, what elements of nursing current practices might change if they were to think and practice with young people differently? I review my analysis as a permission to question the ways in which an interest in health, shaped through political interests of economy and social order, impose limits on nursing thinking and practices in their work with young people. I present and defend a view of the notion of responsibility, an argument outlining what the benefit of such change would be to the discipline (nursing) as well as the well being of young people.

Chapter 2

Introduction

Philosophical inquiry affords an opportunity to call into question our understanding of what nurses know by offering a means to understand the political nature of the discipline of nursing's knowledge development (Pesut & Johnson, 2007).

Beginning with the critical questioning of 'taken for granted' truths in our nursing practices, philosophical inquiry suggests a systematic analysis of the presuppositions or principles that contribute to statements about what is believed to be true for instance, about people and their health and nursing's role in the context of peoples' health.

Philosophical analysis is, however, an interpretive act, always contingent, and always a version or reading from some theoretical, epistemological or ethical standpoint (Wetherall, Taylor & Yates, 2001). My intent in this chapter is to develop what might be called a 'discursive analytic' (Graham, 2005), an approach to philosophical analysis informed by and consistent with the work of Michel Foucault.

The philosophies of Foucault challenge the notion that modern human sciences (biological, psychological, social) offer universal scientific truths about human nature (Gutting, 1989). Rather, Foucault suggests that what human sciences reflect are expressions of ethical and political commitment within a particular society and at a particular point in that society's history. An approach to analysis that draws upon Foucault's thinking is one that examines the function of truth statements in discourses that work to (re)secure dominant relations of power as well as to form particular domains of thought and objects of thought. A Foucauldian discourse analysis offers me a method

to gain insight into the ethical and political nature of nursing knowledges or the domains of thought that guide nursing practice. According to Michel Foucault truth statements can be located in texts that describe how we ‘think’ and ‘do’ nursing. In the project on which this dissertation reports, I will locate truth statements located in texts about nursing and young peoples’ health. Moreover, I will provide the reader with insight into the ways particular political and ethical thought contribute to the formation of truth statements and shape nurses’ thinking and practice within a context of young people and their health.

Methodological assumptions

Discourse analysis informed by Foucault’s philosophies serves to disrupt a practice of inquiry that seeks to substitute one truth for another recognizing that there can be no universal truths or absolute ethical positions (Graham, 2005). My personal approach to philosophical work is one where I do not seek to contribute to arguments that debate the ‘truth’ of adolescence and health promotion discourse nor do I claim that ‘adolescent health risk’ is purely a social construct. Rather, I align myself with Foucault’s (1969/2005) thinking that it is not necessary to engage in debate about the philosophical presuppositions that form a truth or the epistemological foundations that may legitimate it. I interrogate the construction of otherness and differential treatment of young people through nursing acts of health promotion as they are written in contemporary nursing texts to interrupt the stability of truths that inform those acts.

Foucault’s (1969/2005) assertion that language not only produces meaning but also particular kinds of objects and subjects upon whom and through which particular relations of power are realized provides a place for me to reflect upon the constitutive and disciplinary properties of discursive practices within socio-political relations of power,

and specifically in the nurse-adolescent relationship. As a result of this reflection, my approach to philosophical analysis, informed by Foucault, dissects, disrupts and interrogates discourses of true and false within the domain of nursing *adolescent health promotion* and the category *risky adolescents* upon which nursing act.

In the following sections of this chapter, I explore Foucault's introduction of several interrelated concepts that contribute to how nursing might understand and study knowledge. The concepts *savoir*, *connaissance*, discursive formation, problematization, bio-power, bio-politics, and governmentality are located within two approaches to philosophical inquiry, archaeology, and genealogy. I discuss how those concepts contribute to my 'discursive analytic' (Graham, 2005) or the construction of an interpretive framework for this project.

Archaeology

In 1969/2005, Foucault published *The Archaeology of Knowledge*, a methodological exposition that explicated the premise of his archaeological approach.

Foucault proposed:

“in a society, different bodies of learning, philosophical ideas, everyday opinions, but also institutions, commercial practices and police activities, mores—all refer to a certain implicit knowledge [*savoir*] special to this society. This knowledge is profoundly different from the [formal] bodies of learning [*des connaissances*] that one can find in scientific books, philosophical theories and religious justifications, but it [*savoir*] is what makes possible at any given moment the appearance of a theory, an opinion, a practice.”(p 261)

Similarly, Gutting (1989), a Foucauldian scholar, clarifies the differences between knowledges suggesting, “By *connaissance* he [Foucault] means... any particular body of knowledge such as nuclear physics, evolutionary biology, or Freudian psychoanalysis”

(p. 251). In contrast, *savoir*, Gutting continues, “refers to the [broad] discursive conditions that are necessary for the development of *connaissance*” (p.251). Thus, Foucault directs our attention to *savoir* or the ‘conditions of possibility’ of formal knowledge, *connaissance*.

Significant to my work in this project is the notion of *savoir*, which directs me to investigate the importance of understanding those ‘other’ societal discourses about young people and health that in some manner contributed to the establishment of contemporary nursing practices of adolescent health promotion. Foucault suggests that there are other societal discourses that shape disciplinary thinking and these are located “outside “of the history and texts of the discipline. Taking up this thinking allows me to not only trace the historical emergence of nursing’s practices of health promotion with young people within nursing disciplinary texts, or *connaissance*: Foucault’s writing broadens my methodological approach to understanding the *savoir* that made it possible for nursing to take up particular thinking and doing health promotion with young people. In the next paragraph, I will share an example of how Foucault describes the relationship between *savoir* and *connaissance* that I will, in turn, apply to my analytic work in subsequent chapters.

Foucault provides us with an example of how he views the relationship between *savoir* and *connaissance* in his first published text, *The History of Madness in the Classical Age* (1961/2009). While conducting his archival research into historical treatments of the mentally ill, Foucault connected statements such as ‘diseases of the head’ or ‘nervous diseases’ found in seventeenth century medical texts to the emergence of a discipline named ‘psychiatry’ in the eighteenth century. From my reading of this

text, it would seem Foucault proposes that what contributed to the emergence of a discipline of psychiatry was a set of relationships between hospitalization, internment, the conditions and procedures of social exclusion, the rules of jurisprudence, the norms of industrial labour, and bourgeois mentality [*savoir*]... in short a formation of statements that characterized the discursive practice of psychiatry [*connaissance*]. From this analysis, Foucault suggests that psychiatry could appear as a formal discipline, a *connaissance*, as a result of a much broader *savoir* or change in legal texts, in literature, in philosophy, in political decisions, and in the statements made and the opinions expressed in daily life, *savoir*. To support this relationship between two sources of knowledge, Foucault refers to the radically different *discursive formations* about people and the acts they called forth for example, ‘nervous diseases’ that appeared in the 17th century to that of ‘psychiatry’ a formal discipline possessing scientific status that appeared in the 18th century with its own particular language. Foucault challenges our thinking suggesting that formal knowledge or *connaissance* does not emerge solely from a formal and rational scientific discovery following rules of reason and rationality. Foucault suggests that a broader context of politics, institutional practices, and popular opinion also contribute to the formalization of knowledge. In other words, psychiatry did not develop purely from a systematically progressive set of scientific reasonings about the biology of the body and mind. Rather public opinion about normal behaviors and ethical treatment of the ‘not normal’ contributed to the possibility of a psychiatric discipline.

In my work, I take up the notions of *savoir* and *connaissance* to understand nursing knowledge about young people and their health. In particular, I examine

contemporary nursing disciplinary texts about young people and health and locate particular statements within those texts about young peoples' health such as 'risky behaviours' that, in turn, nursing suggests impact health in 'adolescence'. Moreover, nursing thinking about risky behaviours and possible effects on young peoples' health may be traced to specific nursing acts toward young peoples' health for example, 'adolescent screening' and 'adolescent health promotion'. I link such statements to *connaissance*, that is, nursing knowledge about health promotion and adolescence. At the same time, I locate and critically examine broader political and societal discourses about health promotion and adolescence, *savoir*, outside nursing disciplinary texts. This act allows me a place to reflect and discuss the popular opinions that also shape nursing thinking and acting in the context of young peoples' health. I do so by highlighting those statements that contribute to discursive formations, another concept developed by Foucault and significant to his particular understanding of knowledge.

Foucault (1969/2005) alleges that archaeology offers a means to locate knowledge of what is true in the present to particular *discursive formations* that define conceptual possibilities and thus determine the boundaries of thought. From this perspective, Foucault offers a set of ideas about how the examination of discourses framing those formations might facilitate our understanding of the development of particular truths and knowledge.

Discursive formation

Foucault (1969/2005) proposed, "archaeology would be the appropriate methodology of ... analysis of local discursivities" (p.85) and in another text suggests "the analysis of discursive practices [that] made it possible to trace the formation of disciplines (*savoirs*), that is archaeology" (1984a, p.4). In these statements, Foucault is

suggesting that documents or collections of statements might be analyzed as *discursive formations*. Foucault proposes that statements are subject to sets of rules beyond grammar and logic for there exists unspoken rules about what can and can not be said (political correctness) as well as a social currency, or the acceptance and power a statement might hold at a particular time in history. Foucault proposes that locating a repetitive statement within broader discursive formations allows us to understand the effects of knowledge such that the repeated statement reflects a generally accepted or prevalent truth.

Gutting (1989) nicely outlines the four basic elements of a Foucauldian discursive formation as; the objects its statements are about, the kind of authority the discursive formation holds, the concepts that formulate them, and the theoretical viewpoints that they develop. However, he argues that Foucault intended that we recognize that the discursive formation is governed not by content (e.g. the objects to which it refers), but by the political and social rules that govern its deployment. Or as Foucauldian scholars suggest; *discourse* as the ‘limits of acceptable speech or truth’ (Butler, 1990); discourse as the systems of thoughts composed of ideas, attitudes, courses of action, beliefs, and practices that systematically construct subjects and the worlds of which they speak (Lessa, 2006).

Foucault’s interest in the ‘rules’ that govern the deployment of discursive formations led to the development of what Gutting (1989) describes as a classification grid. I present my interpretation of that classification grid in a table (see Table 1).

Table 1

Elements of a Discursive formation (Gutting, 1989)	Foucault's Rules for deployment of a discursive formation (Gutting, 1989).	Questions to guide analysis of the discursive formation 'adolescent health promotion'
Object	<p>Rules governing statements about the formation an object</p> <ol style="list-style-type: none"> 1. Does the statement characterize the subject in a certain way so that the subject is separated off from a social context into the domain of the discursive formation? 2. Who has the authority to decide what subjects belong to what discursive formation? 3. What are the grids of specification whereby discursive formations classify and relate differing subjects so that they are readily and always recognized? 	
Authority	<p>Rules for determining the function of the context from which the statement originates.</p> <ol style="list-style-type: none"> 1. Do the people making the statement have the right to use the language? 2. What institutional site contributed to the development of the language in use? 3. What is the relative position of the person making the statement to the object of the discourse? 	

Concepts	<p data-bbox="544 231 982 304">Rules that govern the formation of concepts.</p> <ol data-bbox="544 346 982 892" style="list-style-type: none"><li data-bbox="544 346 982 493">1. What methodological approaches determine the ways in which statements of a discursive formation relate to each other?<li data-bbox="544 525 982 703">2. How does a statement become accepted, or rejected? What other discourses may be involved in determining whether a statement is valid or legitimate?<li data-bbox="544 777 982 892">3. In what ways may a discursive formation be altered to produce new statements?
Strategy	<p data-bbox="544 997 982 1102">Rules that govern the formation of theories within a discursive formation.</p> <ol data-bbox="544 1144 982 1764" style="list-style-type: none"><li data-bbox="544 1144 982 1249">1. How do theoretical statements guide practice within the discursive formation?<li data-bbox="544 1365 982 1512">2. What is the range of practices permitted as a result of the theoretical statements of the discursive formation?<li data-bbox="544 1627 982 1764">3. What authorities affect the theoretical options allowed within the discursive formation and to what result?

In this table, I locate the four elements of a discursive formation (Gutting, 1989) in the left column and the rules that govern the deployment of the discursive formation (Gutting, 1989 citing Foucault 1984a) in the center column. The third column (on the right) remains empty until the end of this chapter where I present Table 3. Throughout the remainder of this chapter as I continue to examine the ideas of Foucault, I will develop the questions that inform my own discursive analytic so that my thinking becomes explicit and easily traced back to the ideas of Foucault and Gutting. My discursive analytic seeks to critically interrogate and disrupt the discursive formation ‘adolescent health promotion’ that I have located in the statements nursing texts contain describing young people and their health. In my ‘literature review’ in Chapter 3, I locate statements nursing texts hold about nurses’ practices and young peoples’ health promotion from 2000 to 2010 and as a result of my application of the completed grid (Table 3), I situate those statements within the discursive formation ‘adolescent health promotion’. In the next section, I describe how my philosophical analysis of the located discursive formations will unfold.

Problematization

Foucault and Faubion (2000) described problematization as the work that the historian does to interrupt the stability of ‘truths’ in the present in order to show those truths to be problematic in some crucial sense. For instance, Foucault offered the “problematization of a present” as “the questioning by the philosopher of this present to which he belongs and in relation to which he has to situate himself” (p.88). In another instance, Foucault (1984a/1990) described his work as ‘the history of problematization’ such that his historical inquiries would aim less to problematize present practices and instead be focused on the way in which certain people and practices have been subjected

to problematization in history. He describes himself as analyzing “the problematizations through which being offers itself to be, necessarily, thought—and the practices on the basis of which these problematizations are formed” (p.11). Foucault goes on to clarify that he is not so much problematizing concepts by writing their histories as he is writing the histories of those concepts that have been problematized (e.g., madness or crime as problematized in the eighteenth and nineteenth centuries or sexuality as problematized in Stoicism and early Christianity).

In the project on which this dissertation reports, I have taken up problematization in the first sense... that of problematizing contemporary nursing practices through the interrogation of the truths that inform those practices. However, as a result of locating the discursive formation that contributes to the thinking and doing of nursing practices with young people and their health, or in other words, the truth statements within the discursive formation known as adolescent health promotion, my work has also entailed writing about a history of the concepts that have been problematized such as adolescence and health promotion. It seems to me that both approaches to problematization are asking the same questions of statements within discursive formations; who is making this statement? Who is he or she making it for? Why is this statement being made here, now? Whom does this statement benefit? Whom does it harm?

Foucault outlines three classifications of problematizations as discursive, governmental, and ethical (Foucault, 1984e) and the act of problematizing through questioning is reflected in the questions I developed in the third column of Table 2 and 3. The classifications direct our gaze to the contexts in which a concept may be problematized within historical understandings and/or the ways in which our thinking and

doing is unquestioned. For example, discursive practices that problematize *epistemes of thought* (Foucault) suggest to me that an examination of nursing's epistemological premise(s) might assist me in critically analyzing nursing discourse around the production of knowledge about young people and health promotion. For Foucault the notion of *episteme* refers to those systems of thinking or strategies that inform us what may or may not be accepted within a field of scientificity, for example, nursing adolescent health promotion and those statements that nursing characterize as scientific truth when referring to the idea of adolescent health promotion. In the project on which this dissertation reports, I intend to interrogate nursing's disciplinary understandings about how knowledge of young people and health is known, and what language describes the knowledge. In my work, I access nursing epistemes of thought by examining scholarly publications about nurses' theorizing and practices directed toward young people and health promotion (*connaissance*).

In addition, governmental practices may problematize certain objects of knowledge (Foucault, 1984e). Moving outside the disciplinary discourses of nursing, I question what other discourses may contribute to nurses' knowledge of young people and their health (*savoir*). For example, questioning the influences of governing practices within the discursive formation of adolescent health promotion, particularly the political power of such a discursive formation over the young person's body. I begin by asking the questions, how did thinking about the young person shift over time to that of how we know it today (adolescent), and, how did becoming an adolescent become problematized as a risk to public health and social order?

Similarly, ethical practices problematize the formation of the self within certain knowledges. For Foucault, the self is determined by what is prohibited, banned or prevented...what is renounced, rejected or denied ...and what self control is necessary to live 'a good life' (Foucault, 1984e). For example, as my work evolves I find myself asking questions about how nursing health promotion practices might categorize a subject, the adolescent, and what are possible effects of such a categorization. In particular, I draw attention to how a governing practice, that of health promotion, was taken up into the disciplinary discourse of nursing and modified as an ethical practice for nurses. At the same time, I plan to consider those alternative discourses that are rejected or denied, prevented or banned in how nursing thinks about young people and their health. To assist me in this process is Foucault's notion of genealogy.

Foucault (1984a) argues that "...archaeology be the appropriate methodology of this analysis of local discursivities and genealogy would be the tactics whereby, on the basis of these local discursivities, the subjected knowledges which were thus released would be brought into play" (p 85). Foucault's genealogy, seeks to account for how particular discursive formations obtain and maintain power.

Genealogy

In *The History of Sexuality: the use of pleasure* Foucault (1984a/1990) discusses the theoretical shifts that he makes as he studies 'games of truth'. He refers to his analysis of discursive processes that made it possible to trace the formation of disciplines (*savoir*), and names this archaeology. He broadened his thinking to consider power relations and their technologies that regulate, and refers to this analytic approach as genealogy. And his third shift in thinking narrows again to consider the forms within

which individuals are able, and perhaps even obliged to recognize themselves as subjects so that ‘the care of self’ reflects a political investment in the body. As I understand Foucault, he treats genealogy as a further means of thinking about the location of discursive formations in archaeology so that we might reflect on the ways in which the power of those discursive formations take hold.

According to Foucauldian scholars Scheurich and McKenzie (2005), a genealogist “critique[s] the pursuit of origins by showing they are fabrications...show[s] that the body is imprinted by history...describe[s] systems of subjection and the endlessly repeated play of domination...in short an effective history” (p 853). Foucault presents the idea of effective history as differing from a traditional understanding of history where real events and real people are investigated and, as a result, truths are discovered. In contrast, a genealogical approach to understanding the past through effective history begins by adopting an analytic stance that takes the present as a “fiction”, and then seeks to discover the ways in which “truth” is created. As a result, the genealogist is able to destabilize truth through a critical examination of legitimized knowledge; interrupt the ‘taken for granted’ understandings of, for example, adolescence and health promotion.

In his fifth book, *Discipline and Punish; the birth of the prison* (1975/1995), Foucault outlines his intent in this text as being “to study the metamorphosis of punitive methods on the basis of a political technology of the body (*technologie politique du corps*) in which might be read a common history of power relations and object relations” (p 24). With this statement Foucault is introducing the notion that the body is “imprinted by history” “subjected” and dominated. A reading of this text offers an example of how Foucault’s ‘general rules’ for a genealogical study are applied to the ideas of discipline.

In Table 2, I summarize those general rules in column one, provide quotes and exemplars from Foucault's work in *Discipline and Punish* in column two, and introduce how I plan to conduct my genealogical analysis (in Chapters 7) in column three.

Table 2

Elements of a Genealogy (Scheurich & McKenzie, 2005)	Foucault's (1975/1995) rules for genealogical study.	Questions to guide my genealogical discussion of the discursive formation 'adolescent health promotion'
To challenge the pursuit of the origin	Look beyond the obvious repressive effects of punishment to examine the possible positive effects. For example, Foucault links the positive effect of a new penal regime as the normalization of appropriate behaviour among the general population.	I will question how does adolescence and health promotion discourse constrain and enable in nursing practice.
Expose a body imprinted by history.	Analyze punitive methods as techniques possessing their own specificity in the general field of ways of exercising power. Regard punishment as a political tactic.	My analysis locates adolescent health promotion methods as techniques of political power.
Describe the various systems of subjection and the endlessly repeated play of domination.	Look for the common matrix or single process of 'epistemologico-judicial' formation; make the technology of power the principle of both the humanization of the penal system and of the knowledge of man.	I will locate nursing practices in adolescent health promotion within a single process of 'epistemologico-medical' formation. I will discuss how technologies of power spread and are enacted within public institutions and human sciences.
Write an effective history.	Try to study the metamorphosis of punitive methods on the basis of a political technology of the body in which might be read a common history of power relations and object relations. Discuss how the shift in thinking occurs from that the criminals do but also on what they are, will be, may be.	I will ask the question, How do epistemologico-medical' formations shift our thinking from techniques of power that seek to control behaviours of young people (what they do) at the same shift our thinking toward what future possibilities e.g. what will be, may be.

In addition, there are three concepts introduced by Foucault when discussing genealogy, which call our attention to the ways that discursive formations hold power. They are important to my analysis for they allow me to locate particular nursing actions (e.g. adolescent screening) and thinking (e.g. how nursing came to view the young person as foremost an adolescent). These concepts been subsequently taken up and broadened through discussion by Foucauldian scholars such as Nikolas Rose. They also hold currency in critical nursing publications (e.g. Holmes & Gastaldo, 2002; Perron, Fleuter & Holmes, 2005; Purkis, 1997). They are bio-power, bio-politics, and governmentality and I introduce them in the following paragraphs.

Bio-power

Foucault's genealogical approach directs our attention to the processes by which power inscribes itself onto a body (bio-power). He suggests three primary techniques of bio-power that operate in modern society: hierarchical surveillance, normalizing judgment and the examination.

In *Discipline and Punish: the birth of a prison*, Foucault (1975/1995) proposed that surveillance of the individual body and recognition by the individual that his or her body is being observed compels the individual to reflect on his or her actions. Thus, surveillance simultaneously relates one's body to oneself as a text capable of being read by others and as a text that one must read in order to understand oneself. Foucault concludes that this technique of bio-power contributes to the creation of docile and productive bodies as the individual monitors his or her external behaviours with a view to conforming to the norms of a specific social setting.

Foucault continues to develop his thinking about normalizing judgment in his three-volume history of modern sexuality (see *The History of Sexuality* [1976/1990], *The*

Use of Pleasure [1984a/1990], and *The Care of the Self* [1984b/1990]). In his problematization of *sexuality*, Foucault compared the differences and similarities of statements within discursive formations pertaining to sexuality. According to Foucault, people internalize norms established by scientific thought and monitor themselves against the pre-established norm. Thus, the idea of ‘appearing normal’ is a form of political control that is unquestioned by the individual and may serve to subjugate bodily experience into pre-established categories.

A third aspect of bio-power, the examination, is an example of what Foucault’s (1975/1995) calls power/knowledge for it combines the “development of force and the establishment of truth” (p 184). The examination is recorded in detailed records from which those in control can formulate categories, averages, and norms...and this data becomes knowledge. Therefore, by a process of examination, an individual becomes a case for study, a scientific example, and as a result of the examination may find themselves the recipients of a necessary, caring intervention should they deviate from accepted normal. Thus, one might conclude from a Foucauldian perspective there is a distinct possibility that institutional *caring* might contribute a further opportunity for social control.

Bio-politics

According to Foucault (1984e), bio-politics refers to a practice of mass scale interventions whereby the power of a state or government to govern populations is enacted under the purpose of maximizing life. Foucauldian scholar Nikolas Rose (2001) contributes to the idea of bio-politics suggesting contemporary thinking and acting about ‘risk’ populations reflects bio-politics. Rose suggests the government of ‘risk’ as “a family of ways of thinking and acting involving calculations about possible futures in the

present followed by interventions in order to control that potential future” (p7). In this statement Rose offers me a way to think about how nursing acts purported to promote health and well being in the present might, at the same time, be calculated acts that determine and control possible futures of young peoples’ health. Taking up the notion of bio-politics opens space for me to critically interrogate contemporary nursing thinking and actions about young people and their health through the practice of health promotion. For example, in a subsequent chapter I argue that young people’s well-being is constructed within a particular formulation of risk language that results in a language of well-becoming.

Governmentality

Foucault (1979) defined governmentality as:

“the ensemble formed by institutions, procedures, analyses, and reflections, the calculations and tactics that allow the exercise of this very specific albeit complex form of power, which has as its target population, as its principal form of knowledge, political economy, and its essential technical means, apparatuses of security” (p 20).

According to Foucault, apparatuses of security include diplomatic military techniques, the police, and pastoral power e.g. the act of caring for others. The third apparatus, pastoral power seems most relevant to the discipline of nursing as the care of others through various therapeutic regimes underpins theoretical developments within the discipline. The concept of governmentality encompasses practices of governing and practices of self by calling attention to those practices that shape us or mobilize certain acts through the choices, desires, and needs of the individual and population (Holmes & Gastaldo, 2002).

I critically examine how those therapeutic regimes embedded in the political discourse of health promotion, ultimately shape the self (of the young person and the nurse) so that they fit with an appropriate 'normalized' way of living (Dean, 1999). Normalizing practices set standards and ideals for people, and as a result, impose homogeneity both in the expectation of nursing thinking and acting as well as the expectations of 'normal teenager' thinking and acting.

Summary

A Foucauldian analysis of discursive formations or grids of possibilities, map the ways in which a discursive formation is constructed and consequently recognized within a broader social context of normalizations. Such formations or possibilities are at the same time epistemological and ontological for they create the object category and at the same time legitimize our reasoning for why the object category is recognizable. Of interest in this dissertation is how young people come to be described as 'at risk' within nursing health promotion practices. In order to facilitate an investigation of nursing discourses that construct recognizable (Butler, 1993) 'disordered' objects through statements that define the health risking young person, I have developed a methodological plan to approach the analysis of nursing discourses.

In Chapter 3, I apply my discursive analytic (Table 3) to a substantial and systematic review of literature representing nursing texts describing nursing thinking and practices in young peoples' health promotion from 2000 to 2010.

Table 3

Elements of a Discursive formation (Gutting, 1989)	Foucault's Rules for deployment of a discursive formation (Gutting, 1989).	Questions to guide analysis of the discursive formation 'adolescent health promotion'
Object	Rules governing statements about the formation an object	
	1. Does the statement characterize the subject in a certain way so that the subject is separated off from a social context into the domain of the discursive formation?	1. What statements do nurses' make about young people and their health? What are the effects of those statements on how young people manage their health?
	2. Who has the authority to decide what subjects belong to what discursive formation?	2. By what authority do nurses' make statements about young people and their health, and as a result, regulate young peoples' activities?
	3. What are the grids of specification whereby discursive formations classify and relate differing subjects so that they are readily and always recognized?	3. How do nursing statements about young people and their health relate to other statements that serve to make the young person and young people's health recognizable and distinguishable from other peoples' health? How do these statements legitimize nurses' practice with young people?
Authority	Rules for determining the function of the context from which the statement originates.	
	1. Do the people making the statement have the right to use the language?	1. What is the language utilized by nursing when making statements about young people and their health? To what extent is this language distinct to nursing particularly within their practice with young people?
	2. What institutional site contributed to the development of	2. Can the language used by nurses be located in the institution of

	the language in use?	nursing or another institution?
	3. What is the relative position of the person making the statement to the object of the discourse?	3. What is the position of the nurse in relationship to the young person when making statements about young people's health?
Concepts	Rules that govern the formation of concepts.	
	1. What methodological approaches determine the ways in which statements of a discursive formation relate to each other?	1. What methodological approaches have contributed to nursing understandings of 'adolescent health promotion'?
	2. How does a statement become accepted, or rejected? What other discourses may be involved in determining whether a statement is valid or legitimate?	2. What discourses are involved in the continuance of the discursive formation 'adolescent health promotion'? How are other statements about young people's health considered in relationship to the discursive formation adolescent health promotion?
	3. In what ways may a discursive formation be altered to produce new statements?	3. Are there novel moves that young people can make in their encounters with nurses that result in current statements within the discursive formation, adolescent health promotion, to be altered?
Strategy	Rules that govern the formation of theories within a discursive formation.	
	1. How do theoretical statements guide practice within the discursive formation?	1. What theories about young people and health are located within the discursive formation adolescent health promotion? How do those theories guide nursing practice?
	2. What is the range of practices permitted as a result of the theoretical statements of the discursive formation?	2. How are nursing practices facilitated or constrained as a result of theoretical statements about adolescent health promotion?

3. What authorities affect the theoretical options allowed within the discursive formation and to what result?

3. What are the epistemological tenets that contribute to theories developed by nurses about young people and their health within the discursive formation, adolescent health promotion? What are the results of such tenets?

CHAPTER 3

Introduction

In this chapter I commence the archaeology work necessary to address the four questions introduced in Chapter 1 (p 4) that guide the project on which this dissertation reports. In Chapter 1 (p 3) I introduced archaeology as a history of the present (Foucault, 1984e); an analytic process that provides us with a means to trace knowledge of what is true in the present to particular *discursive formations* that serve to define conceptual possibilities and determine the boundaries of our thinking (Foucault, 1969/2005).

Accordingly, if I wish to understand the discursive formation(s) that constitute contemporary nursing thinking and acting toward young people and their health, I must begin by locating those truth statements that hold currency for nursing about nurses role regarding the health of young people. Thus, in this first chapter of my archaeological work I am guided by a broad question: what truth statements appear to shape contemporary nursing professional thinking and actions concerning young people's health?

I employed the search engine Cumulative Index of Nursing and Allied Health Literature (CINAHL) to locate peer reviewed publications written by nurses that describe nursing thinking and acting in the context of young people and their health. The act of writing for publication requires nurses, unlike almost any other sort of accounting mechanism, to make their thinking and professional practices explicit in ways that, in turn, make nursing thinking and acting accessible for archaeology work. Moreover, nursing peer reviewed publications provide a readily accessed window into the

connaissance of the discipline. The process of peer review encourages authors, in this project, nurse authors, to meet accepted standards of the discipline and is purported to prevent unwarranted claims, unacceptable interpretations and personal views. Thus, it seems reasonable to propose that nursing publications about my topic are legitimized by the discipline. It becomes possible for me then, to infer that texts published within a time period (e.g. 2000-2010) reflect nursing thinking and acting toward young people in the context of their health during that time.

I acknowledge that some nurses may publish outside of this search engine parameter. I also note that not every nurse's thinking and actions are accessible through publications. However, my intent was not to provide an exhaustive description of all nursing thinking and acting toward young people rather access an archive that is understood by those seeking to contribute to the body of nursing knowledge for the purpose of conducting an archaeology.

I began the archaeology on which this dissertation reports by specifically searching for articles published between 2000 and 2010 that contained the terms "nursing" or "nurse" and "young people" (alternatively adolescent or youth or teenager) and "health" or "health promotion". I located seventy-five articles that contained the search terms. I then began my archaeology dig through a process of reading, rereading and critically analysing the texts. An archaeology dig allows us to analyze the ways in which a field of experience or a set of practices is accepted without question or truth or to 'problematize' thinking (Foucault, 1984e). Unquestioned practices, according to Foucault, might be noted in a pattern of repetitive practice both in nursing thinking about

young people and their health (a field of experience) and in nursing actions toward young people and their health (a set of actions).

In this first phase of my archaeology dig, I will argue that the discursive formation, adolescent health promotion, is clearly evident in the literature I have read between 2000 and 2010 about nursing thinking and acting in the context of young peoples' health. Moreover, I believe that further analytic evaluation of how the discursive formation came to be and hold power in nursing *connaissance* will merit additional learning for the discipline. To assist me in the presentation of this initial phase of my archaeological work I have divided the remainder of the chapter into four sections, following the four basic elements of a Foucauldian discursive formation outlined in Table 1; the *objects* its statements are about, the kind of *authority* the discursive formation holds, the *concepts* that formulate them, and the *theoretical viewpoints* that they develop (Gutting, 1989). Within each of the sections, I ask the questions and I developed in Table 3 and as a result locate and present the truth statements evident in nursing texts that support the discursive formation adolescent health promotion. Within each section, I summarize how this particular discursive formation defines the conceptual possibilities and determines the boundaries of nursing thinking and acting toward young people and their health. I then briefly introduce how this problematic thinking and acting sets the groundwork for further archaeological work in subsequent chapters of my dissertation.

Object

What statements do nurses' make about young people and their health?

Statements in nursing texts serve to separate the young person from the older, physically mature and cognitively capable adult. Singleton (2007) demonstrates this theme in nursing thinking stating “adolescents are distinct biologically, cognitively, psychologically and socially” and further suggests that “there are changes which occur during adolescence that are universal including biological, cognitive and psychological changes and social redefinition” (p 140). In another example, Christopherson and Jordan-Marsh (2004) inform us that adolescents “have their own identity as a subculture and share a distinct lifestyle that separates them from the rest of society” (p 101). Indeed, in the 75 articles I reviewed young people are always already distinguishable as adolescents.

In contemporary nursing texts, adolescents are described as “at high risk for the development of problem behaviours that are distressing and socially disruptive” (Bartlett, Holditch-Davis & Belyea, 2007, p 13). The authors encourage their nurse colleagues to separate out those problem behaviours that are deemed to be ‘health risks’ (such as engaging in sexual activity too early and without birth control; smoking cigarettes; ingesting alcohol or other drugs) from other “developmentally appropriate” (p 14) but still problematic behaviours such as decisions to behave in a rowdy manner in public, skip school and lie to parents about their whereabouts. Here we see an example of what might be framed as a moral code being conveyed by nurses to nurses about what is okay and not okay in problematic ‘adolescent’ behaviour or stated another way, what

behaviours nursing may have a duty to intervene with a view to prevent or alleviate the risk to adolescent health.

Similarly, Christopherson and Jordan-Marsh, quoting Perry (2000), suggest that although adolescents appear to be biologically mature they “[lack] the requisite cognitive abilities for adult decisions ...[and as a result]...the tension between social expectations and biological imperatives may contribute to risky behaviours” (p 101). In this example, the argument is put forth that adolescents’ lack an ability to make adult decisions (e.g. consent) and this perceived inability to make autonomous decisions is natural, biologically based, and contributes to risk behaviours. The idea of social expectations about what may or may not be acceptable problematic behaviour appears to create a place in thinking where nursing may separate out those problem behaviours that risk health so that they may act to ensure adolescents are shepherded toward making socially responsible decisions about their health. And while not explicitly stated, again an underlying moral stance may be in operation such that nursing accepts nurses hold a particular knowledge about what are the good and socially responsible choices an adolescent must make about their health.

More often, nursing texts characterize adolescents as “a particularly vulnerable population” (Ahern & Kiehl, 2006, p 12) whose health requires protecting and monitoring (Abrams, 2006; Autra, Hall & Marcy, 2010; Davis, 2005; Jaskiewicz, 2009). In those particular texts we might infer that the idea of protecting and monitoring adolescent health is accepted without question for the authors were not required to expand on this claim in order to publish their thinking and professional practices. It would seem to be a legitimate claim to state that adolescents are vulnerable and in need

of monitoring and protection by nurses. Statements about adolescent vulnerability and need for monitoring and protection illuminate further a moral positioning or code that seems to justify nurses thinking and actions toward young people. The statements seem to imply that not only is it wrong to risk health, there is an implied nursing duty to assist those who are naturally inclined to risk their health (e.g. adolescents).

What are the effects of those statements on how young people manage their health?

In contemporary nursing texts about young people and health, it appears from the statements above, nursing determines young people to be at the same time very likely to risk their health and to be unable to manage their health. Furthermore, health risks if not addressed in adolescence will shape adult health. Rew, Johnson, Jenkins and Torres (2004) contend that “health risk behaviours arise from the intersection of normal growth and development...and their [adolescents’] immediate environment” (p 304). Moreover, Saewyc, Bearinger, McMahon and Evans (2006) inform us that risk behaviour underlying adult health problems, for example smoking, began during adolescence.

As a result of an approach towards young people that questions their ability to responsibly manage their health, nursing assumes a powerful and professional role in regulating healthy lifestyle choices for young people. For example, Ahern and Kiehl (2006) proposes that nursing ought to promote resiliency in adolescents. To do so will, in turn, lead to healthy lifestyle choices by young people and adults. Similarly, Davis (2005) argues for the role of the nurse practitioner as one that will go beyond a general health assessment and provide specialized screening and intervention strategies that will develop adolescent resiliency. Some nurses have developed nursing theories about how to promote the health of adolescents such as the Pender Health Promotion Model (Pender,

Bar-Or, Wilk & Mitchell, 2002; Srof & Velson-Freidrich, 2006). In the preceding examples, nurses are at the same time regulating adolescent health and legitimizing nursing for they argue for the adoption of particular nurse actors (nurse practitioner) and nursing thinking (nursing theory). However, it seems to me that those nurses approach young people already knowing what the health risks are and how those same health risks are to be managed. From the preceding statements in nursing texts, nurses appear to manage a categorization of young people: the adolescent. The concern this raises is that, if this is the case, it may result in the nurse overlooking individual differences amongst young people including recognizing their unique and distinct abilities to manage their own health.

By what authority do nurses' make statements about young people and their health, and as a result, regulate young peoples' activities?

A pattern of thinking can be located in present day texts where nursing takes up extant theories of adolescent development and utilize such thinking to predict age relative characteristics of young people with whom they engage in health related actions. It is from this scientific authority and the associated developmental theories, that nursing makes statements about young peoples' ability to act responsibly and manage their day to day health. These authoritative statements, as a result, contribute to the legitimization of nursing actions in the context of young people and their health. The nurse appears in a position of authority in relation to young peoples' health for he/she has access to specific knowledge apparatuses (developmental theory) that serve to inform the nurse about the character of young people and justify nursing actions in monitoring and intervening in young peoples' management of their day to day health.

At the same time, it would seem that a particular discourse about health, and the promotion of health also serves to shape nursing thinking and legitimize nursing actions toward young people about their health. Discourses on health include the ideas about, and explanations offered for, what health is and what determines it, as well as the particular practices that are produced by these ideas (Roberston, 1998). In contemporary nursing texts about young people and health, it would seem that nursing focuses on the risks associated with adolescent health, particularly those that are thought to impact adult health and subsequently enact particular acts of nursing health promotion to address those risks. Apparently, nursing understands the promotion of health to be a legitimate and effective act, achieved through a process of scientific reasonings, for example epidemiology.

Nursing's seeming moral reasonings that separate out natural inclinations (e.g. to be rebellious) from social pressures (e.g. to smoke) appear shaped by thinking that adolescents are vulnerable and in need of protection and further legitimates power over young people through a reasoning of caring ethic such that nursing as a profession care for those who cannot care for themselves.

How do nurses' statements about young people and their health relate to other statements that serve to make the young person and young people's health recognizable and distinguishable from other peoples' health?

Nursing practices of categorizing young people into a distinct group may be aligned to similar statements about young people in popular and scientific texts. Theoretical developments within the disciplines medicine, psychology, education and

nursing reflect a system of reasoning about young people or a discourse of adolescence such that the adolescent is separated from the adult physiologically and socially.

Adolescence discourse builds upon a premise that adolescence begins at puberty and “its essential role as a period beginning with reproductive-function awakening and culminating in sexual maturity characterized by biological, cognitive, emotional and social reorganization with the aim of adapting to cultural expectations of becoming an adult” (Susman & Rogol, 2004, p 15/16). It would seem that the overt signs of sexual development of the body and related changes to a young person’s appearance as the physical body matures signifies a transition period from child to adult known as adolescence. The idea of adolescence as a period of physiological change in and of itself does not suggest problematic thinking. We can ‘see’ the physiological development of people over time.

However, embedded in adolescent discourse are *truths* about the nature of adolescents that suggest, because of these universal physiological changes, all young people exhibit similar traits. For example, in previous sections we see how nursing takes up adolescence discourse to suggest that young people may not be relied upon to think or act responsibly about their health when compared to the adult they will become. Further analysis of adolescence discourse is needed to trace back to when this particular view of young people came into power and how it came to be that nursing aligned with the discourse.

At this time, it is my position that this assumption if unquestioned, it may contribute to problematic thinking and acting toward the young person for it may very well place the nurse or other professional in power position of knowing the young person

better than they know themselves. Moreover, the ability of the young person to contribute to conversations about their health and health related behaviours may be filtered through a grid of classification, such that age signifies what questions and what answers to questions are to be deemed as legitimate concerns of the young person when compared to the pre-established classification.

For example, Singleton (2007) further classifies differences between older and younger adolescents based upon developmental theories (in this example Erickson and Piaget) and informs her colleagues “younger and older adolescents are quite distinct biologically, cognitively, psychologically and socially” (p 140) although she never explicitly states how. However, Singleton does suggest that presentation of symptoms of mental health may appear differently, require different treatment and the adolescent may respond differently to interventions dependant on whether they are younger or older adolescents. Again, Singleton does not clearly articulate what those differences might be. However, she does seem to be suggesting that responses to treatment might be screened through an assessment of a young person’s age and refers to two developmental theories that suggest cognitive ability signified by age. This suggested practice may become problematic in that the nurse might dismiss some young people as immature and unable to actively participate in their treatment.

Along similar lines of thinking, Rew et al. (2004) inform us that it is normal or to be expected that adolescents risk their health and these nurses go on to justify a ‘programmed’ approach to delivering health education information to young people based on that claim. They suggest that all adolescents at a particular age be grouped together and educated about health, and how their behaviours might pose a risk to their

health. In another example, Bartlett et al. (2007) suggest that it is normal for adolescents to lie to their parents about their whereabouts, to be moody, and to challenge authority at the same time suggesting it is not normal to risk their health by smoking cigarettes, ingesting street drugs, drinking alcohol or have sex. Further analysis is needed to discern the basis upon which this division was set up so that risky health behaviours were removed from 'normal' challenges to authority.

How do these statements legitimize nurses' practice with young people?

Nursing statements about young people and their health reflect a general theme. In these accounts, young people, as a result of their age and associated developmental stage, are portrayed as naturally inclined to risk their health thus they require specific acts of regulation such as screening and monitoring and educating.

The contemporary nursing literature reviewed thus far suggests that two discourses are used by nursing to legitimate nursing actions toward young people: A discourse of adolescence as a period preceding full formation of a fully capable adult; discourses of health promotion that legitimate nursing practices of monitoring and regulating adolescent health.

Authority

The authority from which nursing makes statements about young people and health may be traced to alignment with what Foucault proposes to be systems of reasoning. They, in turn, may be accessed through a critical interrogation of the language individual nurses' use to recount their thinking and actions toward young people and their health. In the following paragraphs, I provide examples of nursing language in use as they engage with young people and their health. I demonstrate how such language

reflects nursing alignment with adolescence and health promotion discourse, and, as a result, nursing of young peoples' health is shaped in particular ways.

What is the language utilized by nurses when making statements about young people and their health?

A language of risk behaviours and prevention of risk behaviours seems to frame the majority of thinking and actions by nursing toward young people and their health. Guaio, Blakemore and Wise (2004) argue the "imperative that screening for risk behaviours be the standard of care when an adolescent presents for a physical exam or health visit" (p 56). The act of 'screening' is one where the nurse purposefully asks questions or performs a physical examination to assess for an already presupposed 'health risk' (Davis, 2005). For example, St. Mars and Valdez (2007) inform us that "dating violence in adolescents is a risk factor for continued exposure to violence in adulthood" (p 335) such that "dating violence places the adolescent at higher risk for substance abuse, weight control problems, sexually transmitted diseases, teen pregnancy and depression" (p 336). In this text, the authors are encouraging fellow nurses to screen for dating practices with a view to preventing risks to health. Similarly, Notarianni, Clements, and Tillman (2007) recommend approaches that may assist fellow nurses' in their screening of youth at risk for developing violent behaviours. They provide a list of possible factors that may lead to adolescents acting violently and encourage their nurse colleagues to screen for possible violent adolescents.

Other examples of nursing writing about specific health risks associated with adolescence and how to screen for those risks include; the risks associated with self-harm behaviours (Anderson, Woodward & Armstrong, 2004; Tusaie, Acierto, Murray,

Fitzgerald & Chiu, 2009; Williams, & Bydalek, 2009; Williams, Daley and Iennaco, 2010), and eating disorders (White, 2000), adolescent obesity (Frenn et al., 2003; Hargarty, Schmidt, Bernaix & Clement, 2004; Holcomb, 2004; Zenzen & Kridli, 2009), smoking (Hamilton, O'Connell & Cross, 2004; Pherts et. al., 2006) and depression (Zucherbrot et. al., 2007).

I found it interesting that the majority of nursing texts in the years 2000 to 2010 directed nursing practices of screening the sexual activity of young people with a view to preventing the spread of sexually transmitted infections (Cochran & White, 2002; Fantasia, 2009; Guiao, Blakemore & Wise, 2004; Lugo, 2009; Smith, 2003; Weiss, 2007) and to mitigate the presumed health consequences of adolescent pregnancy (Koniak-Griffin, Anderson, Verzemnieks & Brecht, 2000; Strunk, 2008; Watt, 2001). Moreover, nursing screening acts in sexual health target female adolescents putting forward the argument they are at greater health risk than male adolescents (Callaghan, 2006; Christopherson & Jordan-March, 2004; Guiao & Thompson, 2004; Hulton, 2001; Tusaie, Puskar & Sereika, 2007).

In the preceding examples, nursing texts inform readers (predominantly other nurses) of the prevalence and characteristic of the 'risk' so that it might be readily identified or presumed in the adolescent. Stated another way, nursing educates other nurses about adolescent health risk behaviours and as a result set a particular context for the nurse-young person interaction. Moreover, risk language is utilized to encourage those acts that will 'screen' for risky adolescent behaviours, thus the language shapes the way the nurse relates to the young person, that of health expert screening for particular health risks in an already identified subject.

To what extent is this language distinct to nurses particularly within their practice with young people?

A language of reducing risk is not distinct to nursing and may be located within other professional and governing practices concerned with public health and the prevention of disease. The notion that adolescents risk their health appears to be substantiated by national surveys (e.g. National Longitudinal Study of Adolescent Health), data banks (e.g. Centers for Disease Control) and professional research (e.g. Youth Risk Behaviour Surveillance Survey). In those reports, sophisticated statistical techniques are applied to young peoples' self reported activities and correlations assumed between those identified behaviours that may impact health, for example, having sexual intercourse and possible health consequences in the present and future (Weinstock, Berman & Cates, 2004). This particular approach privileges an empirical view into the young peoples' health. Yet, while the data may provide insight into behaviour trends demonstrated by young people that may very well impact health, for example the numbers of adolescents who have unprotected sex, the data does not always readily report on the day to day lives of those young people, for example the social contexts within which young people make decisions about their sexuality and their health. Further analysis may assist us in understanding if and how it came to be nursing aligned with the discursive formation adolescent health promotion such that nursing understanding about the risks of sexual intercourse at the same time exclude other ways of thinking about young peoples' sexuality.

What is the position of the nurse in relationship to the young person when making statements about young people's health?

Nursing is placed in a powerful position to act when performing nursing actions that aim at modifying risk behaviour and lifestyle choices of young people. Ways in which nursing appears to promote health include educating adolescents about the immediate and long term effects of risk behaviours as well as behaviour modification technologies designed to encourage healthier lifestyle choices. In this section, I provide examples from an article that explicates this patterned thinking and acting in nursing texts. The article may be viewed of an exemplar capturing 'truths' readily accessed in other articles. My example recounts nursing language utilized in thinking and actions in relation to adolescents and sexual health. I chose this example as nurses write extensively and thus have an already established nursing discourse about adolescence sexual health promotion. I will direct our attention to how nurses takes up risk language in particular ways that in turn contributes to nursing knowledge and the resultant practices of a particular technology of health promotion.

Fantasia (2009) claims, seemingly informed by an adolescent health promotion discursive formation, that young people "are plagued with many issues during adolescence ... and one topic of significant concern within this population is the onset of sexual activity and the potential consequences that follow" (p80). If I compare Fantasia's risk languaging of emergent sexual activity as one that leads to 'consequences' to Sussman and Rogol (2004) who suggest adolescence as a developmental period beginning with reproductive-function awakening and culminating in sexual maturity I see how risk languaging seems to change the meaning of sexual awakening. On one hand, I

am to expect the young person to awaken sexually (the chronological age signifier appears fluid within this thinking). On the other hand, risk language shifts my thinking from a neutral statement (young people awaken sexually and presumably engage in activities that explore that awakening) to a statement that alerts me to the negative consequences of sexual awakening and in some way attempts to control the awakening through a risk to health discourse.

Further reading of Fantasia (2009) reveals how she supports her view of the consequences of sexual awakening by referencing several government reports. In her first reference, Fantasia refers to the Youth Risk Behaviour Surveillance (2006), a public health document that informs us half of the adolescents surveyed reported being sexually active. This is not surprising, given that adolescence discourse frames adolescence as signified by age, the emergence of physiological sexual characteristics, and the successful negotiation of a sexual identity. However, Fantasia's use of the word "plagued" suggests that emerging sexuality is not something to be celebrated in that the word plague typically refers to a deadly disease; one that must be protected against and prevented!

In her second example, Fantasia (2009) draws nursing attention to the Healthy People 2010 project, a national health promotion and disease prevention agenda for improving the health of all people in the United States (US). A review of that document reveals that to ensure responsible sexual behaviour for adolescents, health professionals are encouraged to act with a view to increase the proportion of adolescents who have never had sex (article 25 11a), increase the proportion of adolescents who have not had sex in the past three months (article 25 11 b) and increase condom usage among adolescents who are sexually active (article 25 1c). Fantasia, citing Weinstock, Berman

and Cates (2004), then informs her readers that almost half of reported sexually transmitted infections in the US occur in adolescent and young adult populations. In this example, I see an explicit connection between delaying and preventing sexual awakening in order to decrease the spread of infections (read disease). Yet it would seem that the other half of reported STI's (adult populations) are somewhat less of a concern. At the same time the boundary between adolescent and young adult is blurred leaving me to wonder at what age sexual awakening is safe. Fantasia does not address these points but continues on to seemingly secure a moral role for nursing in adolescent sexual health promotion, one that also appears legitimized through a government agenda.

Fantasia (2009) informs her nurse colleagues that, "monitoring the pregnancy rates and contraception use of adolescents is essential due to the social and financial consequences of adolescent parenting, both for the individual and society as a whole" (p 81). She adds, "adolescent sexual activity, and its potential consequences of STIs and unplanned pregnancy, has a considerable impact on the lives of those involved, society, and the healthcare system" (p 88). Here I note that the impact on the health care system refers to an economic view of health where the costs of what is deemed preventable consequences of individual behaviours also serves to sanction nursing actions to screen for risk behaviours in young people. Further analysis is required to understand how it came to be that nursing aligns with the goal of reducing health care costs through screening and the impact of that particular standpoint.

Fantasia (2009) goes on to outline the following legitimate nursing acts: obtain a detailed sexual history; review with the young person the dangers of sexual activity at every encounter. Fantasia defends this practice by aligning with the discursive formation

adolescent health promotion (again) claiming that, as a result of a particular age or phase in growth and development, adolescents are orientated to the present such that they are unable to think about future consequences. Fantasia suggest from this particular knowledge apparatus that nurses must tailor their education and guidance acts to account for a limited cognitive ability in the young person. She seems to suggest young people do not possess the cognitive skill to successfully negotiate sexual activity that appears at odds with the definition of adolescence as one where a sexual identity is negotiated as a result of physiological changes to the body.

We are left with questions: How do we understand how a discourse can be used to contradict itself? How is it that nurses are asked to adopt a position to discourage sexual activity which indeed is part of negotiating one's sexuality. Moreover, implicit in the prescribed nursing acts is a heteronormative view of young people and their sexuality (and here I am thinking about how the concern is with disease spread through intercourse alongside a concern about pregnancy). There appears to be an assumption operating on two levels. The first, all adolescents are going to awaken as heterosexual or, alternatively, adolescents who awaken as gay, lesbian, transgendered or queer do not risk their health as a result of sexual activity.

In this example, we see how nursing alignment with the discursive formation, adolescent health promotion, legitimates a powerful position in managing the young person to ensure particular sexual health outcomes. And while Fantasia suggested that decreases in numbers of reported teenage pregnancy (Alan Guttmacher Institute, 2004) as evidence that nursing sexual health promotion in adolescence 'works,' a closer scrutiny of her claim suggests that it is not possible to draw that conclusion. The 'fact' may be

that teenage pregnancy rates are decreasing as reported by epidemiology. However, the relationship between sexual health promotion and decreased rates is not causal, it may only be inferred as there are other technologies at play that influence the rate of decrease (e.g. a decrease in the number of adolescents per capita).

From the texts I have reviewed, and as demonstrated in my illustrative exemplar, I see that nursing texts sometimes explicitly, but most often implicitly state that nurses are in possession of knowledge; they already know what risks face adolescents as well as what is needed by adolescents to manage those risks. Furthermore, nursing texts describe how nurses are encouraged to tailor their interactions with young people, acting from specific knowledge apparatuses that inform nursing about the character and ability of the young person. Thus, it would seem that for nursing 'objectivist knowledge' acts as the classifying criteria through which adolescents are disciplined and self-regulated. Critical interrogation of concepts located in the language of nursing may illuminate how objectivist knowledge apparatuses hold power in nursing thinking and acting.

Concepts

A concept may be thought of as a general expression for a phenomenon, for example health. Concepts are shared among people and most often used to impose some sort of coherent meaning in the world; they are words that help us to make sense of a real world and communicate our experiences to each other. Concepts are also useful in providing a system of classification or typology such that we 'know' something when we use the word, for example child, adolescent, adult. While concepts are used in our day to day language with regularity, in research methodologies concepts are used purposefully. In the natural sciences concepts are precisely defined through research methods while the

social sciences recognize concepts as constructions of reality emerging from cultural values and traditions. However, within the concepts adolescent and health promotion I suggest that both empirics and social currency serve to legitimate the continued use of the discursive formation, adolescent health promotion.

In the following section, I continue my archaeological dig by examining the methodologies that inform the concepts *adolescent* and *health promotion* within the discursive formation, adolescent health promotion. We consider the ways in which concepts inform nursing thinking and acting toward young people and health.

What methodological approaches have contributed to nurses' understandings of 'adolescent health promotion'?

Methodologies that place the researcher in an objective observer position compared to the research subject appear to contribute to the discursive formation adolescent health promotion. My analysis thus far demonstrates this as young people are always already categorized into a system of classification, adolescence. In the nursing texts reviewed between 2000 and 2010, two developmental theories were referenced: Erikson's (1964) theory that proposes young people are in the process of reshaping their own identity amid newly forming relationships with friends, family, and society and; Piaget's (1969) theory of cognitive development which suggests adolescence is that time in development when formal operations otherwise defined as the ability to problem solve using a scientific approach to problems is reached. From these two examples of systems of reasoning, is granted an authority to conceptualize young people as adolescent. Moreover, as a result of this authority, nursing texts can claim that adolescents are in a

process of transition so that their identity is not fully formed, and, adolescents are limited in their ability to identify and solve problems.

Methodologies that inform the discursive formation adolescent health promotion are positivist and empiricist. Such a methodological approach begins with set definitions (e.g. adolescent or health), utilizes a deductive approach to understanding reality, makes statements about cause and effect, and is presumed context free. In empirical research, generalizations leading to predictions, explanations and understanding within positivist and empiricist methodologies. I now examine how the human science, epidemiology, appears to inform nursing understanding and continued practices in adolescent health promotion.

Epidemiology may be best summed up as the science of the study of the patterns, causes, and effects of health and disease conditions in defined populations in this example, adolescents. Epidemiologists utilize gathered data and a broad range of biomedical and psychosocial theories in an iterative way to generate or expand theory, to test hypotheses, and to make educated, informed assertions about which relationships are causal. Within a practice of promoting public health, data from epidemiological reports may be utilized to inform policy decisions and evidence based medicine by identifying risk factors for disease and targets for preventative medicine. Earlier in this chapter, I discussed how nursing thinking and acting toward young people as a population was informed by risk language supported by ‘evidence’ from national epidemiological research. Major areas of epidemiological study include disease surveillance and screening. For the project on which this dissertation reports, I argue there is similarity in nursing language particularly the use of disease surveillance and screening.

Epidemiologists rely on other scientific disciplines such as biology to better understand disease processes (e.g. how smoking contributes to poor health outcomes) and statistics to make efficient use of the data and draw appropriate conclusions (e.g. numbers of young people who smoke compared to those who do not) and social sciences. Knowledge gathered from the preceding serve to inform understandings of proximate and distal risk factors or stated another way, why some young people more likely to engage in risk behaviours than others and what policies and practices might be enacted to decrease the likelihood of poor outcomes for the group. In the next paragraphs, I examine how social sciences, in this example social learning theory, also serves to inform the discursive analytic adolescent health formation by offering a way to justify a particular act of health promotion, health education.

There are three core ideas to Bandura's (1997) social learning theory; people learn from observation (observational learning or modelling), internal mental states are part of this process (self efficacy), and, a recognition that just because something has been learned does not mean it will result in a change of behaviour. In the following paragraphs, I examine these ideas more closely so that I might understand their appeal to nurses' when thinking and acting in adolescent health promotion.

In his famous Bobo doll experiment Bandura demonstrated that children learn and imitate behaviours they see in other people. As a result of the experiment, Bandura identified three models of observational learning; a live model in which an individual acts out a behaviour; an instructional model which involves descriptions and explanations of a behaviour; and a symbolic model (e.g. actors displaying behaviours in films). From these tenets, nurses may justify for role modeling and teaching certain behaviours that they

wish another to take up for example an young person making a choice to not engage in a behaviour deemed risky.

Bandura further asserts there are several conditions necessary for observational learning. These include paying attention, an ability to retain information, performing and practice of the learned behaviour, and the motivation to perform the behaviour. Moreover, according to Bandura, self-efficacy or “the belief in one’s capabilities to organize and execute the courses of action required to manage prospective situations” (1995, p. 2) are also integral to learning new behaviour. In other words, self-efficacy is a person’s belief in his or her ability to succeed in a particular situation. Bandura goes on to describe these beliefs as determinants of how people think, behave, and feel. For example, he suggests that people with a strong self-efficacy view challenging problems as tasks to be mastered, are committed to their activities and recover quickly from setbacks. In contrast, he suggests that people with a weak sense of self-efficacy avoid challenging tasks, quickly lose confidence in their abilities, and believe challenging tasks are beyond their capabilities. At this point in my exploration of this theory, I can locate Bandura’s thinking as positivist relying upon empirical evidence.

Bandura’s (1997) theory proposes that one develops perceptions of self-efficacy as a result of developmental influences from family, school, community, and peers. His theory provides several ideas about how self-efficacy develops. These are important for they help to make sense of some of the ways in which nursing might act in adolescent health promotion. Foremost, Bandura asserts that performing a task successfully and witnessing other people similar to oneself successfully completing a task contributes to self-efficacy. As a result people believe they have the skills and capability to succeed.

From this assertion, nurses who align with social learning theory might believe that educating a young person in specific ways might encourage that person to behave in particular ways or increase self-confidence. Moreover, Bandura's theory suggests that if people identify the moods, emotional states, physical reactions and stress levels that impact their perceived self-efficacy, they are then able to recognize the ways their individual moods, emotional states, physical reaction and stress levels are of influence on their self efficacy, and thus they are able to minimize their impact. For example, being able to decrease stress and elevate mood when facing a difficult task an individual may improve their sense of self-efficacy and successfully complete the task.

Finally, I think it important to note that Bandura (1994) proposes a standard methodology for measuring efficacy beliefs as one in which individuals are presented with items portraying different levels of task demands and the strength of the individual's belief in their ability to execute the required activity is then measured as self efficacy. Thus, Bandura's theory reflects a scientific method of inquiry, one where empirical and measureable evidence explain phenomena, and the researcher is an objective observer.

What discourses are involved in the continuance of the discursive formation 'adolescent health promotion'?

Embedded in the discursive formation 'adolescent health promotion' are theories about the nature of adolescents which might be grouped together as adolescence discourse. In addition, a discourse of health promotion within which we might tease out multiple discourses such as disease prevention, health education, and economics.

How are other statements about young people's health considered in relationship to the discursive formation adolescent health promotion?

It would seem that it would be very difficult for nursing to make statements about young people outside of already established adolescent categorization. For example, even if one were to state that a young person did not fit the categorization of a 'normal 16 year old' the fact that the statement refers to the categorization recognizes the persuasive power of that particular discourse to signify by age. Moreover, as seen in my discussion of sexual health risk, what may very well be a natural development, emerging sexuality, has been taken up into a risk discourse. If a young person does not address sexuality, they are not meeting developmental milestones; if they do, they are putting their health at risk.

Are there novel moves that young people can make in their encounters with nurses' that result in current statements within the discursive formation, adolescent health promotion, to be altered?

No, at this time I do not think so. Practices of adolescent health promotion hold both professional, scientific currency along side social currency. For example, both personal experiences (as an adolescent, a public health nurse, and a nurse educator supervising nursing students in public health have demonstrated that nursing's 'sex ed' talk has become part of generations of Canadians' school experience and typically it is about puberty and birth control (e.g. reduced to risks and disease) rather than sexuality and relationships. Moreover, in the literature review for this analysis I can confirm that risks to sexual health predominant nursing texts about adolescent health promotion.

Strategies

To gain some insight into how nursing frames theoretical statements (thinking) about young people and their health, and then how those statements guide nursing actions (practice) toward young people with a view to promoting health, I will discuss the two theoretical frameworks found within contemporary nursing texts about young people and their health developed by nurses. In the first example, I revisit the notion of self-efficacy (Bandura, 1997) and critically examine how Nola Pender (1987) modifies the concept in her nursing Health Promotion Model. In the second example, I critically examine the Youth Resiliency Framework (Rew & Horner, 2003).

What theories about young people and health are located within the discursive formation adolescent health promotion? How do those theories guide nurses' practice?

Earlier in this chapter I called attention to a patterned thinking evident in nursing texts; that adolescents have difficulty managing their health as compared to their adult counterparts and this necessitated nursing intervention of screening and further acts of health promotion. I also looked at social learning theory as legitimating health promotion acts. In the following paragraphs, I will critically examine how such discourse influences some nursing thinking and practices.

The belief that one has the capabilities to manage the situation at hand captures the idea of self efficacy (Bandura, 1997) and Nola Pender (1987) utilizes this thinking about self efficacy to defend self care, one of the constructs within her nursing theory for health promotion. According to Pender, health promotion may be viewed as “the actualization of inherent and acquired human potential through goal directed behaviour, competent self care and satisfying relationships with others while adjustments are made

as needed to maintain structural integrity and harmony with relevant environments” (Pender, 1987, p 22). She suggests the concept self efficacy serves as an explanation for why some people do not make healthy choices in their day to day life; they believe they can not make those choices. Operating from this theoretical stance, the nurse as an objective observer must act to determine whether a person demonstrates self efficacy and, as a result of the determination, the nurse should intervene to increase self efficacy. For example, Pender, Bar-Or, Wilk and Mitchell (2002) asked a sample of girls aged 8-17 years to ride a stationary bicycle for 20 minutes. Before they rode the bicycle, they were asked to answer a questionnaire about how difficult they thought it would be to complete the task. In the data analysis, the researchers noted that when comparing physical maturity, perceived exertion, and self-efficacy it was the girls self efficacy that explained the most variance in their perception of physical exertion (how difficult it would be to ride the bicycle). Pender et al. concluded, as a result of the data, that self-efficacy is an important predictor in adolescent health behaviour (in this case riding a bicycle).

Similar results were found in a sample of African American and European American adolescents aged 9-17 years during a prescribed treadmill experiment; data suggested self-efficacy was a predictor of perceived exertion in adolescents; female adolescents believed they would find the treadmill task required more physical exertion when compared to their male counterpart (Robbins, Pender, Ronis, Kazaris & Pis, 2004). Frenn and Malin (2003) used Pender’s framework in a study designed to track dietary changes in middle school adolescents following health education. Access to foods containing high fat content was the significant predictor of percentage of fat in adolescent dietary choices. However, self-efficacy mediated the access factor leading Frenn and

Malin to propose that adolescents who believed they could eat healthy did so. Thus, empirical data collected by these nurse researchers appears to offer one perspective on how nursing could practice adolescent health promotion.

Rew and Horner (2003) offer nursing another theoretical framework for adolescent health promotion, the Youth Resiliency Framework. In the nursing texts I reviewed, adolescents who cope well in high risk situations, such as choosing not to engage in risk behaviours or choose to seek out and utilize resources to assist them to change risk behaviours are deemed resilient (Ahern & Kiehl, 2006; Rew & Horner; Sanci, Glover & Coffey, 2003; Scudder, Sullivan, & Copeland-Linder, 2008; Tusaie & Dyer, 2004). Interestingly, while it would seem that adolescents are always already predetermined to be at risk, they may be thought of as resilient if they make particular choices. A closer examination of how nursing thinking about resilience in turn appears to shape nursing practices follows.

The Youth Resiliency Framework (Rew & Horner, 2003) guides the nursing practices so that the nurse “perform[s] resiliency assessments and intervene[s] to enhance well-being of adolescents” (p 384). In this statement the notion of well being appears to be linked to healthy lifestyle choices and one is left wondering if Rew and Horner equate well being to healthy lifestyle choices. The original understanding of wellbeing was to capture how well a person’s life was going for them (Stanford Philosophy Dictionary). I will return to the equating of well being and health in later chapters, but for now I want to acknowledge how health and well being appear interchangeable in this particular example.

While Rew and Horner (2003) focus on the individual attributes of the adolescent, Ahern and Kiehl (2006) emphasizes the interplay between environment and personal resources of the adolescent when discussing the notion of resilience. They argue that nursing preventative health interventions consider adolescent social contexts or the circumstances within which an adolescent makes a choice to risk their health. Nursing research utilizing this conceptualization confirms that the strengthening of interpersonal and social supports of adolescents has a positive effect on measures of adolescent resiliency (Aronowitz, 2005; Mahon, Yarcheski, & Yarcheski, 2004; Mahon, Yarcheski, Yarcheski & Hanks, 2007).

Thus, in the aforementioned examples, I put forth that within nursing texts there is clear evidence that nurses theorize about ways to engage with the adolescent for the purpose of modifying their health behaviours. It would seem that nursing seeks to understand the underlying processes that might answer the question; Why do some adolescents engage in risk behaviours while others do not? For example, the notion of self-efficacy informs nursing knowledge that adolescents may not believe they are capable of making a healthy choice. Similarly, the notion of resilience informs nursing knowledge that adolescents are capable of resisting the inclination to resist health or to seek out health resources that reduce the risks to their health.

How are nurses' practices facilitated or constrained as a result of theoretical statements about adolescent health promotion?

When we turn to the texts 2000 to 2010 nursing practices described include those strategies to educate young people, families of young people and youth serving organizations about the health and risks to health of young people. For example,

adolescents received educational print materials and one on one counselling sessions with a nurse to prevent alcohol consumption (Worch et al., 2000) smoking cessation (Pherts et al, 2006), and to increase their physical activity (Robbins, Gutebeck, Kazanis & Pender, 2006). A critical analysis of the counselling sessions reveals that the nurse instructs the adolescent about the health risk and dangers to immediate and long-term health of the behaviour, and provides information about the appropriate choices and behaviours.

To a lesser extent nurses included health education of the parents of identified risky adolescents. For example, Hagarty, Schmidt, Bernaix and Clement (2004) recommend the provision of educational materials to adolescents' parents about ways to support weight loss in obese adolescents. In a program designed to assist adolescents to stop smoking, adolescents received four motivational interviewing sessions with a nurse while their parents and schools received educational materials on how to promote a smoke free environment (Hamilton, O'Connell & Cross, 2004).

Health education includes any combination of learning experiences that increase knowledge or influence attitude so that individuals improve health (WHO, 2012). As a stand alone strategy, an action of health education suggests that providing information can produce a desired change. So it may seem reasonable that nurses' provide information to young people and the end result will be a reduction in poor health outcomes; adolescents will stop engaging in what is already determined to be a risk behaviour, and, the adult population in turn will demonstrate a reduction in particular symptoms and disease (e.g. cardiac health).

What are the epistemological tenets that contribute to theories developed by nurses about young people and their health within the discursive formation, adolescent health promotion? What are the results of such tenets?

Epistemology refers to any theory of knowledge that addresses questions such as: Who can be a ‘knower’? What can be known? What constitutes and validates knowledge? The way that those questions are answered also provides insight into the way the relationship between the knower and the known. Similar to Foucault’s notion of systems of reasoning, epistemological tenets are truth statements, and in our examples in previous paragraphs we may infer epistemological tenets via truth statements within nurses texts about adolescent health promotion.

Revisiting both Pender’s (1997) Health Promotion Model and the Youth Resiliency Framework (Rew & Horner, 2003) the relationship between the nurse researcher and the young person appears as one of knower to known subject. The nurse researcher has already known the young person as an adolescent first, and utilizes knowledge apparatuses about typical adolescence to guide theoretical statements and interpret data. Prior knowledge about young people and health frames nursing thinking as the adolescent is already always known as ‘at risk’ and, as a result, the nurse must act to prevent or reduce risk and thus promote health. Moreover, nursing acts to decrease risk, promote resilience or health; educate. The nurse approaches the young person as a knower with knowledge apparatuses that inform and guide practices. I am left wondering how this came to be, and what are the possible effects of what seems to be fairly uniform thinking.

Problematization

Following the writing of Foucault I began this first chapter of my archaeology dig guided by the question: What truth statements appear to shape contemporary nursing professional thinking and actions concerning young people and health. I have dug into contemporary nursing texts 2000 to 2010 guided by the elements of a discursive formation Figure 1 (Gutting, 1989) and presented my analysis of how the discursive formation adolescent health promotion defines conceptual possibilities for young people, nurse and health. I have argued that the discursive formation adolescent health promotion constitutes contemporary nursing texts, *connaissance*, from particular epistemological and methodological positions.

In Chapters 4 and 5, I continue my archaeology work by problematizing or interrupt the stability of truths that constitute the discursive formation adolescent health promotion. I will do this by tracing the history of health promotion (Chapter 4) and nurses' alignment with health promotion (Chapter 5) at a particular time in history (*savoir*) and in nursing *connaissance*. Again, the writing of Foucault will guide my thinking. He outlines three classifications of problematizations; discursive, governmental, and ethical (Foucault, 1984e). Those classifications will help me shape subsequent chapters of this dissertation that present my archaeological work.

Discursive practices that problematize *epistemes of thought* (Foucault) direct my attention to nursing production of knowledge about young people and young peoples' health. In this chapter nursing understanding of adolescent health promotion appears as the episteme or system of thinking or strategies that inform nursing that which may or may not be accepted within a field of scientificity, or the discipline. I did this by locating

those statements that nursing characterize as scientific truth when referring to the idea of adolescent health promotion via a process of critically examining scholarly publications about nursing theorizing and practices directed toward young people and health promotion (*connaissance*). From this work I am now ready to move into a deeper analysis of the discursive formation adolescent health promotion and how it came to be within the discipline of nursing. To do this I will trace the emergence of the governing practice of health promotion (Chapter 4) and how nursing then reflected those ideas in scholarly texts (Chapter 5).

Foucault's (1984d) second classification of problematization concerns those governmental practices that problematize certain objects of knowledge. In this dissertation the governing practices that shape the object adolescent and their health are of interest and contribute to the discursive formation adolescent health promotion. In Chapter 5, I ask the questions, how did thinking about the young person shift over time to that of how we know it today (adolescent), and, how did becoming an adolescent become problematized as a risk to public health and social order?

A third classification of problematization concerns those ethical practices that problematize the formation of the self within certain knowledges. For Foucault (1984d), the self is determined by what is prohibited, banned or prevented...what is renounced, rejected or denied ...and what self control is necessary to live 'a good life'. In Chapter 4, I ask questions to gain greater insight into how a governing practice, that of health promotion, was taken up into the disciplinary discourse of nursing and modified as an ethical practice for nurses when thinking and acting in the context of young peoples' health.

CHAPTER 4

In this chapter, I continue the archaeological work I began in Chapter 3 by locating and critically examining the origin of the discursive formation known as health promotion in Canada. Specifically, I will address the first question I posed in Chapter 1; what interests and forces effected the creation of health promotion in Canada within the 1970-1990 period. I put forth four key milestones in Canadian health promotion (Labonte, 1994); the publication of *A New Perspective on the Health of Canadians* (Lalonde, 1974) hereafter referred to as the Lalonde Report, the Shifting Medical Paradigm Conference held in 1980, the Beyond Health Care Conference in 1984, and the publication of the *Ottawa Charter for Health Promotion* (1984) and *Achieving Health for All: A Framework for Health Promotion* (Epp, 1986). In addition, I locate and discuss the influence of two key milestones in the United States of America, the wellness movement led by Dr John Travis, and the post World War II emergent discipline of social psychology as contributing to the ways in which health promotion developed in Canada.

The aforementioned texts provide a place for me to access thinking about health promotion in savoir, outside of the discipline of nursing texts. The act of writing for publication by government may be assumed to be an accounting mechanism to the general public for representatives are required to make their thinking and policies/practices explicit in ways that, in turn, assure the public their decisions are credible and not personal views. Moreover, professional conferences require a process of peer review that encourages presenters to meet accepted standards of scholarly integrity, for example avoid unwarranted claims, unacceptable interpretations and personal views. Thus, it

seems reasonable to propose the proposed reflect thinking and practices of health promotion.

My next step was to locate truth statements in those texts, about people and health, with a view to problematize the thinking about health promotion contained in those texts (Foucault, 1984e). Then, following the four basic elements of a Foucauldian discursive formation (e.g. the *objects* it's statements are about, the kind of *authority* the discursive formation holds, the *concepts* that formulate them, and the *theoretical viewpoints* that they develop [Gutting, 1989]), I asked the questions I developed in the third column of Table 4, so that I might critically interrogate the discursive formation, health promotion, as it appeared between the years 1970-1990.

Table 4

Elements of a Discursive formation (Gutting, 1989)	Foucault's Rules for deployment of a discursive formation (Gutting, 1989).	Questions to guide analysis of the discursive formation 'health promotion'
Object	Rules governing statements about the formation an object	
	1. Does the statement characterize the subject in a certain way so that the subject is separated off from a social context into the domain of the discursive formation?	1. What statements are made about people and their health? What are the effects of those statements on how people manage their health?
	2. Who has the authority to decide what subjects belong to what discursive formation?	2. By what authority are statements made about people and their health, and as a result, regulate peoples' activities?
	3. What are the grids of specification whereby discursive formations classify and relate	3. How do statements about people and their health relate to other statements that serve to make the

	differing subjects so that they are readily and always recognized?	person and their health recognizable and distinguishable from other peoples and their health? How do these statements legitimize practices with people?
Authority	Rules for determining the function of the context from which the statement originates.	
	1. Do the people making the statement have the right to use the language?	1. What is the language utilized by when making statements about people and their health? Who makes the statements and from what authority?
	2. What institutional site contributed to the development of the language in use?	2. What institutional site contributed to the development of the language in use?
	3. What is the relative position of the person making the statement to the object of the discourse?	3. What is the relative position of the person making the statement to the object of the discourse?
Concepts	Rules that govern the formation of concepts.	
	1. What methodological approaches determine the ways in which statements of a discursive formation relate to each other?	1. What methodological approaches have contributed to understandings of 'health promotion'?
	2. How does a statement become accepted, or rejected? What other discourses may be involved in determining whether a statement is valid or legitimate?	2. What discourses are involved in the continuance of the discursive formation 'health promotion'? How are other statements about people's health considered in relationship to the discursive formation health promotion?
	3. In what ways may a discursive formation be altered to produce new statements?	3. Are there novel moves that people can make that result in current statements within the discursive formation, health promotion, to be

 altered?

Strategy	<p>Rules that govern the formation of theories within a discursive formation.</p> <p>1. How do theoretical statements guide practice within the discursive formation?</p> <p>2. What is the range of practices permitted as a result of the theoretical statements of the discursive formation?</p> <p>3. What authorities affect the theoretical options allowed within the discursive formation and to what result?</p>	<p>1. What theories about people and health are located within the discursive formation health promotion? How do those theories guide health promotion practices?</p> <p>2. How are peoples' health practices facilitated or constrained as a result of theoretical statements about health promotion?</p> <p>3. What are the epistemological tenets that contribute to theories developed about people and their health within the discursive formation, health promotion? What are the results of such tenets?</p>
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As a result of this work, I am able to present one view, *savoir*, about people and their health. It is my intent to present my argument that health promotion discourse legitimized a particular view of people and health, and authorized particular practices of health education.

What interests and forces effected the creation of health promotion in the years 1970-1990?

In Canada, various levels of government hold formal jurisdiction over health. The larger responsibility for health is constitutionally defined as residing within the provinces and territories at the same time the federal government plays a significant role in funding health care delivery as a result of its greater revenue generating capacity. Consequently,

since the advent of universal hospital and medical insurance in the 1950's and 1960's, all levels of government have been concerned with the cost of health care services, particularly the rate of increase in costs (Mhatre & Deber, 1992). This jurisdictional and fiscal context helps to situate the development of health promotion in Canada in the 1970's and 1980's. The idea of health promotion offered a legitimate space to focus on the production of health policy that dealt with health rather than the provision of that which was deemed costly sickness care and technology. It is not surprising then that the first formal document articulating, and in some way authorizing, a process of health promotion was a Canadian federal government discussion paper.

Introduction of health promotion: The Lalonde Report

In 1974, the Canadian Department of Health and Welfare published a discussion paper entitled *A New Perspective on the Health of Canadians* (Lalonde, 1974). Referred to as 'the Lalonde Report,' the paper responded to a noted trend in national epidemiology reports suggesting that the health of Canadians was not improving despite massive expansion of government spending on health services in the previous two decades. In addition, epidemiology reports demonstrated steadily increasing morbidity and premature mortality for diseases or injuries deemed to be preventable. These included chronic diseases such as heart disease, cancer, respiratory disease, as well as sexually transmitted infections and injuries (e.g. motor vehicle accidents). Lalonde's report authorized a health promotion strategy to inform, influence, and assist individuals and organizations to be more responsible in matters affecting physical and mental health which in turn, would reduce health care expenditure on the sick.

In his report, Lalonde (1974) noted that the "traditional or generally-accepted view of the health field is that the art or science of medicine has been the fount from

which all improvements in health have flowed” (p xx). In this statement, he appears to challenge a popular opinion that equated good health with the number and quality of medical services available. Alternatively, Lalonde’s Report proposed a broader concept, the health field, composed of four broad interdependent elements: human biology, environment, lifestyle, and health care organization. It outlined factors that would determine health within each element. In brief, a biomedical element that considered all aspects of physical and mental health developed within the human body as influenced by genetic make up. The environment element, in turn, contained all matters related to health external to the human body and over which the individual has little or no control including the physical or social environment. A definition of lifestyle was proposed as those personal decisions over which the individual has control such as healthy diet and regular exercise that in turn assist in the prevention of cardiovascular disease or cardiac events that may result in costly sick care and death. Health care organization included medical practice, nursing, hospitals, nursing homes, and other publicly funded health services.

Statements within the description of the health care field seemingly characterize a particular thinking about people and their health. Lalonde’s Report argues that people have a social responsibility to maintain their health, and by doing so, contribute to a reduction in health care expenditures. Thus, what appears to be a binary juxtaposition about socially responsible/irresponsible people related to health care costs: People that maintain their health are socially responsible and those who do not maintain their health are socially irresponsible and increase the financial burden of health care. For example, the report delineates those health factors that an individual is perceived to have no control

over (e.g. genetics) and those that the individual can control to ensure the prevention of disease or ill health that required government-funded sickness care (e.g a decision to smoke). In Chapter 2 I outlined Foucault's (1976/1990) thinking about bio-power as "an explosion of numerous and diverse techniques for achieving the subjectivities of bodies and the control of populations" (p 170) or what he also refers to as 'an anatomo politics of the human body. If I turn to Foucault, I find that the Lalonde report explicates a biopower such that a technology of power over bodies is legitimized and strategies that allow for the control of populations specific to matters of birth, death, illness, and health are authorized as they are written and politically sanctioned.

One authority that appears to support these statements arose from the science of epidemiology that records and presents population health patterns. As a result of particular thinking from epidemiology and economics (cost/benefit ratios), those members of government responsible for health policy and planning appear to acquire support for a particular direction for funding healthcare delivery; a powerful position over people and health, as we will discover further in this analysis.

The tabling of the Lalonde Report represented an unprecedented political move; this was the first time a national government had made a statement about what contributed to the health of a population (O'Neill & Pederson, 1994). Although the concept of health was defined as "freedom from disease and disability" (Lalonde, 1974, p. 8), the added reference to promoting "a state of *wellbeing* sufficient to perform at adequate levels of physical, mental and social activity" (p. 8) allowed for expanded thinking about health outside the confines of medical care. As O'Neill and Pederson (1994) note, although the term health promotion had been in circulation before 1974, the

Lalonde Report was among the earliest public documents to use it. Thus, a shift in authoring of health promotion appears publicly.

It would seem that the language associated with the idea health promotion offered a perspective on health beyond the biomedical parameters of health to the health behaviours of people, for example the shift in statements about the effect of disease on the body to the effect of risk behaviours on the populations. Health promotion language also appears to reflect shifts in power about who determines a healthy body so that that biomedical discourse is taken up within a larger governing discourse concerned with decreasing risks to health and the associated costs to health care as a result of those risks. For though it seems that each element in the proposed health field appears to be weighted evenly, a closer read of the Lalonde Report reveals a central argument: The greatest improvements in health in the future were likely to come through changes in individual lifestyles and improving the quality of the environment. It would seem that the Lalonde Report argues individual's choices about a healthy lifestyle have the greater impact on the health of populations. In turn, actions that assist the individual to adopt those choices or behaviours that result in the reduction of risk of disease or environments are acknowledged as reasonable and justifiable actions. From this statement, a powerful position is advanced, one that signals a particular relationship assumed by government that it holds over peoples' health –that of legitimizing and justifying actions deemed to reduce the risk of disease, or *bio-power*.

From Lalonde's (1974) perspective, health might be assumed to be living without disease or chronic health problems. This definition legitimizes practices toward people that reduce risk behaviours of people and/or promote healthy lifestyle choices. As a

result of a governmental interest in promoting health/ reducing health care expenditures, two governmental commitments resulted from the Lalonde Report and I will highlight those in the following paragraphs.

In response to the report recommendations, the Department of National Health and Welfare in Canada committed funds that resulted in the creation of social marketing campaigns throughout the late 1970's to modify risky individual behaviour e.g. ParticipACTION and Body Break. A further federal government commitment occurred in 1978 with the establishment of the Health Promotion Directorate (HPD) thought to be the first of its kind in the world. Ron Draper brought together the planning and research capacity, content knowledge (e.g. tobacco, nutrition, child health) and delivery skills (e.g. training education, social marketing) plus the community development expertise of five regional offices (Atlantic, Quebec, Ontario, Prairies and Western) to form lifestyle program teams. The HPD was successful in obtaining from Cabinet a mandate with government funding for a comprehensive program focusing on issues, target groups, and country-wide strategies that involved: informing and equipping the public to deal with lifestyle issues; promoting a social climate supportive of healthy lifestyles; supporting self-help and citizen participation; and promoting the adoption of health promotion programs within health care, social welfare, and other established programs (Draper, 1989). The HPD delivered tobacco, alcohol, drugs, and nutrition health education and social marketing targeting those individuals determined to be at high risk for developing chronic disease. As a result, health promotion practices of developing and implementing lifestyle programs designed to educate people about health risks and healthy choices was established. Furthermore, social media campaigns located health discourse outside of

medical institutions e.g. health information entered the family living room via television infomercials. Thus, it appears that a language about health, that of ‘reducing risk’ and ‘taking care of yourself’, entered into people’s day-to-day lives.

It is also important to note that although the Lalonde report proposed to reduce health care spending within a medical paradigm, it did not challenge the paradigm itself. For example the conceptualization of health as determined by the presence or lack of disease, infection, and injury mirrors biomedical thinking and acting. Therefore, it is not surprising that health promotion continued to be bound by a focus on disease prevention with an added political implication about how preventing disease would reduce health care costs. As a result of this focus, research and intervention into people’s experiences of health or lack of good health, as well as social environments of poverty, inequity, and discrimination was minimal in the early days of health promotion. This created a space for those health professionals critical of thinking about health within a medical paradigm to voice their opinion about alternative ways to think about health care.

Shifting Medical Paradigm Conference 1980

The HPD co-sponsored this conference, subtitled “From Disease Prevention to Health Promotion” along with the University of British Columbia, the British Columbia Department of Health and the Vancouver Health Department. This conference was important for the legitimization it gave to a health movement proposing alternatives to those prescribed by traditional medicine and for its emphasis on a range of healing modalities, including creating a space for spirituality, and the individual’s role in moving from illness to wellness. It was also important for introducing a wellness paradigm, in which the individual’s perceptions and experiences of health are proposed to be more important than those strictly defined by a medical diagnosis and symptom management.

However, individual social environments (e.g. poverty, gender, race) were still overlooked. The conference theme narrowly focused on freeing the individual and health care provider from medical paradigm dominance – but freeing them as individuals, not as members of a differentiated population.

It is important to note that although Canadian politicians, researchers and policy makers were prominent in articulating the idea of health promotion to government, for health care professionals and the general population more broadly, two movements from the United States contributed to thinking about and acting within the notion of health promotion. These influences can be traced back to the wellness movement spearheaded by Dr John Travis and the post World War II emergent discipline of social psychology. A closer examination of these two theoretical influences about people and health is important for us to gain insight into the ways in which the public received ideas or acts of health promotion e.g. individual or mass communication strategies about lifestyle choices.

The wellness movement

Dr. John Travis (1975) proposed a model for lifestyle change focusing on self-responsibility best captured in the slogan, “*Wellness is a choice...a decision you make toward optimal health.*” Further analysis of Travis’s health and wellness model reveals that the idea of health encompassed the body, mind, emotions, and spirit of the person. While an expanded definition of health shifted thinking beyond an absence of disease or biomedical model of health, the ways in which Travis’s notion of health was promoted remained centered on the individual. Health became equated with a way of life such that the individual was charged to design a lifestyle to achieve their highest potential for well-being. Travis outlined how an individual might successfully design their lifestyle as

occurring through a process of continual health education and growth. In this way, we see how members in a general population are already receptive to mass media campaigns and to the health professionals who offer them expert knowledge about how to make the right choices about their health. The implication of growth toward an optimal well-being suggests that one can never be too healthy, there is always more to learn and do. It would seem that in the end result the individual constantly monitors his/her self against an ever changing ideal of a healthy person. My analysis finds support in contemporary sociological literature drawing attention to processes of normalization and healthism (Rose, 2001) and the ways in which material practices become routinely embedded in social contexts (May, 2009). I will revisit this argument in Chapter 6 where I explore how discourses about health promotion gain and maintain power.

Thus, we see how statements within such a model of wellness both characterizes and differentiates people into another binary; the well-informed consumer of health education and the risky individual. Individuals are already always recognizable as a person at risk of engaging in particular behaviours that may result in chronic symptoms or disease. Travis, as a physician, speaks from a powerful place as one who has knowledge about medicine and an established practice in health care. If we turn to the elements of a discursive formation (Gutting, 1989) we can trace how the concept wellness contributes to the object 'the healthy person' at the same time prescribing a practice for that person to self monitor through practices of continual health education and growth.

Several assumptions within the wellness movement contribute to the formation and positioning of the health-promoting professional (e.g. nurses). Health professions are

given the authority to determine what constitutes a healthy lifestyle and, as a result of the specifications of a healthy lifestyle, further determine who is, and who is not, making healthy lifestyle choices. This determination in turn necessitates particular theoretical statements to justify the relationship between how an individual takes up expert knowledge about their health. The discipline of social psychology emerges complete with methods for justifying a health education approach to lifestyle.

Social Psychology

Social psychology might best be thought of as a discipline that uses scientific methods to understand and explain how the thought, feelings, and behaviour of individuals are influenced by the actual, imagined or implied presence of other human beings (Allport, 1985). Stated another way, social psychology encompasses the empirical study of social phenomena with a view to locating and describing variables that affect social behaviour. Such a statement implies that people are prone to social influence even when no other people are present (e.g. following an internalized idea about healthy lifestyles). It follows that mass media campaigns to inform individuals about healthy lifestyles or health risks might serve to assist in a process of internalizing particular thinking about how to live a healthy life. Moreover, theories within a broader context of social psychology suggest that individual health behaviours might be changed through health education activities prescribed by a health professional for and with individuals.

In Chapter 3, Bandura's (1997) social learning theory was critically examined for ways that its theoretical statements shaped nurses' thinking and acting in adolescent health promotion. If we take Bandura's foundational theoretical tenet, people learn from observation, we can assume some parallel between programs that government deemed worthy of funding at the onset of health promotion strategies as those that would educate

about health or health education. Specifically, Bandura argues different ways for learning to take effect; people need the opportunity to act out behaviour, receive instruction through models which involve description and explanation of a behaviour, and/or have access to symbolic models e.g. view actors modeling behaviour in a film.

If we review the HPD activities following the Lalonde report, health promotion actions might be summed up as health education of both the public and the professions within health care delivery. The public was targeted via mass media campaigns influenced by symbolic models of social learning; the health professions received funding in order to facilitate the adoption of health promotion programs within health care, and social welfare, an extrinsic reward coupled with instructional models about how to do health promotion. What might be posited as a common theme for both health educators and social marketing was the action to target those individuals determined to be at risk for chronic disease, and those professionals who provided their care. Both groups it would seem were ‘taught’ about the risks to health, the ways lifestyle modification could decrease those risks, and how those acts would result in decreased health care costs.

However, toward the end of the 1970’s as health promotion and wellness ideology gained influence in political and public arenas, this approach was also criticized as being overly individualistic and as “blaming the victim” for their health problems borrowing the phrase from the well-known book by William Ryan (1971) (Illich, 1976; Krauze, 1977; McKeown, 1976). Ryan’s work set the tone and direction for this critique: the practice of health education holds a limited view of health because it ignored the social contexts within which individuals were asked to make lifestyle choices and changes. Others picked up this critical stance and proposed a more social view of health and health

education and a broader conceptualization of health promotion thinking and actions (Brown & Margo, 1978; Crawford, 1977; Freudenberg, 1978). Another example from the United Kingdom may be located in the Black Report (1980) a publication by the UK department of health and social security. The report demonstrated that although overall health appeared to improve with the introduction of the welfare state there remained widespread health inequities related to economic inequality (e.g. male death rates in lower socioeconomic classes were twice as high as those reported in high socioeconomic classes).

In Canada, leading this argument was Labonte and Penfold (1981) who proposed that the health of oppressed peoples (the poor, women, persons from minority cultures, workers) was determined by structural conditions (poverty, hazards, powerlessness, pollution) and not by personal lifestyles. Their critical view of government approaches to health promotion argued that personal lifestyles were not freely determined by individual choice, but existed within social and cultural structures that both conditioned and constrained behavior. They suggested that government funded strategies such as health education and social marketing ignored the structural determinants of health embedded within economic, class and gender based patterns of social relationships and therefore blamed the victim. Furthermore, particular health education approaches indirectly were thought to convey a particular moral stance, for example venereal disease education programs rooted in fundamentalist sexual values exaggerated the threat of disease while at the same time promoting monogamous, heteronormative marriage (Labonte, 1981).

Thus, it would seem that health promotion arose from a government interest (the Lalonde Report) to reduce health care expenditures and to shift some of the responsibility

for health to the individual. This resulted in initial health promotion practices, those of health education ‘*en masse*’ that over time suggested problematic thinking. As Allison (1982) summarizes well, “the problem with health education does not lie in the individual approach itself but in the fact that focusing only on individual behaviour tends to neglect the environmental and social factors that are also influencing health “ (p 12). At the end of the 1970’s both medical care and health promotion were being criticized for being paternalistic; health promotion for victim blaming. By the beginning of the 1980’s, a call for a broader perspective on the thinking of, and acting within, health promotion was called for by those representing the populations not being served by current practices.

Health Promotion 1980-1990: a Charter and a Framework

In the early 1980’s Canada’s federal department of Health and Welfare and the World Health Organization (WHO) reformulated the concept of health promotion, while at the same time legitimizing the critique of health education (see Green & Raeburn, 1988). The so-called “new health promotion” proposed health to be determined by social and environmental factors (Kickbusch, 1986; World Health Organization, 1984). The World Health Organization (1984) released *Health Promotion: A Discussion Document on the Concept and Principles* defining health promotion as “a process of enabling people to increase control over, and to improve, their health” (p 2) simultaneously introducing principles of involving the population as a whole and directing action to the determinants of health. The WHO-based view of health promotion might be best described as a strategy for improving health of populations; one that recognizes interactions between individual health related behaviours and the social, political, physical and economic environment in which those behaviours occur. Such a strategy

includes health education, social marketing, mass communication as well as community development, organizational change, and public policy.

In 1985, these ideas found their way into a Canadian federal policy review supported by the Honourable Jake Epp, the Minister of Health. The minister agreed to host the First International Conference on Health Promotion in Ottawa in collaboration with the World Health Organization (WHO) and the Canadian Public Health Association (CPHA). The conference produced the *Ottawa Charter* (World Health Organization, 1986a) and the Canadian government released its own discussion paper, *Achieving Health for All: A Framework for Health Promotion (AFHA)* (Epp, 1986).

Responding to changes in thought beyond the walls of government and beyond Canada's borders, the Epp Report of 1986 broadened health promotion from the emphasis on lifestyle to include environmental determinants. It introduced the idea of healthy public policy as an upstream intervention to reduce social inequalities suggesting a more active role for government in the promotion of healthy Canadians.

This report was disseminated throughout Canada. The HPD received significant new resources to develop programs related to drug and alcohol abuse, tobacco use, nutrition, and AIDS. However, while the Epp Report championed an intersectoral, collaborative style of program development and delivery funding for risk reduction strategies continued, no new research to identify and explain the correlation between levels of socio-economic status and many measures of health status emerged (Hayes & Glouberman, 1999). Thus, while ways of thinking about the idea of health promotion expanded as a set of values and action strategies designed to improve living and working conditions, the practice of health promotion remained tied to social marketing strategies

targeting individual lifestyle. For example, governmental funding allotted to augment school and workplace programs with a view to increase the health of attendees, and, workers, and the Canadian Heart Health Initiative launched in 1987 in collaboration with the National Health Research Development Program (NHRDP). Thus, for two decades the federal government played a significant role in the development of Canadian health promotion through targeted funding. However, funding was specifically allocated to have an impact on individual lifestyle practices and institutional or community practices with a view to ensuring people made choices that improved health and decreased their need for health care.

Toward the end of the 1980's, critical attention about the limitations of health promotion practices might be summarized along a general theme that health promotion thinking and actions did nothing to alter the physical and social environment so that for some people it was impossible to adopt suggested lifestyle changes. Several suggestions within this theme follow.

Walker (1990) who described how community based services transferred responsibilities of care from state funded institutions to organizations and ultimately to women resulting in the increase in the report of illness-related symptoms in women care givers. Labonte and Penfold (1981) summed up “ the Movement” citing leftist, feminist, gay/lesbian, health and safety, anti-poverty, and environmental groups concerns about the prevailing ideology around health promotion and called for “the process of empowering people to take greater control over, and responsibility for their health” (Labonte & Penfold, 1981, p 45). An example of this process may be best seen in Penfold's question “What is more important; providing fitness programs for a few middle-aged executives to

improve their business acumen or day-care for thousands of women whose double duty of work in and out of the house make them sick?”(Labonte, 1994). This question suggests to us that with supportive resources in their environment (e.g. daycare), women might have a better chance of preventing the development of symptoms related to stress.

By the mid 1980’s Geoffrey Rose (1985), an epidemiologist, directs our gaze to what he named the prevention paradox. The prevention paradox describes the seemingly contradictory situation where the majority of cases of a disease may be located in a population at low or moderate risk of that disease, and a minority of cases are recorded in the high risk population. Rose suggests this is because the number of people at high risk is smaller when compared to the numbers within a total population. Rose provides the following example to support his argument. In the case of Down Syndrome where maternal age is a risk factor, more cases of Down Syndrome will be born to younger, low risk mothers when compared to those deemed to be as high risk. Rose explains this situation as paradoxical for as a result of risk language it becomes common practice, perhaps logical to equate high-risk populations with making up the majority of the burden of disease when the burden of disease, in this case giving birth to children with Down Syndrome births does not only take place in high risk populations. Rose’s prevention paradox helps us to reexamine what might be a pattern of problematic thinking and actions when governments or health organizations introduce a large-scale intervention to improve health. Many interventions that aim to improve health have relatively small influences and perceptible benefits on the health of most people including those deemed to be at high risk. Therefore, for one person to benefit, many people have to change their behaviour—even though they receive no benefit, or even suffer, from the change. In the

end, the high-risk population may receive little benefit from large-scale intervention but remain viewed as contributing to the burden of disease.

If we apply Rose's ideas to health promotion we note that population health strategies including environmental protection, welfare reforms, and programs directed toward other socio-environmental risk conditions that may improve aggregate health require a shift in allocation of funds from an institutionalized system designed to care for the sick. At the same time, population health strategies are asking for many people to change their behaviour, for example everybody stops smoking, drinking, having unprotected sex. However, those changes provide only indirect gain to individuals. Within this paradox, lies the questions: How does one convince an individual to risk their potential individual needs for sick care by allocating funding to population health concerns? How does one convince a population to change health behaviours for a few members at high risk?

Along the same line of thinking, Labonte (1994) describes how the Charter and the Framework seeks to remove health promotion from the natural science paradigm of biomedicine, placing it instead within a pluralistic social science paradigm of human and social relations. However, he calls our attention to the implications of a non-reductionist approach to health. He asks us to consider the dilemma: if health becomes so broadly constructed that it encompasses most of the human experience then it loses utility as a variable in policy discourse. Policy discourse implies the ability to shape government funding for health care delivery –both institutions for sick care and health promotion programs. Thus, language assumes a powerful role so that languages of risk reduction, disease prevention, and other key phrases that have gained hold in health promotion

discourse are recognizable by those in power to frame health policy and distribute health care funding. However, Labonte argues, if health remains narrowly constructed in biomedical terms the empowering potential of the Charter and the Framework is lost, socio-environmental health determinants reduced to a matter of disease prevention, and the knowledge challenges of the social movements disappear into the *technos* of institutions.

It would seem that those who align themselves with the critical theorists, may be part of a social movement that aims toward shifting dominant thinking and actions. For the purposes of this argument, “a social movement occurs when a large enough group of people with a particular vision of the world challenges the dominant social order” (O’Neill & Pederson, 1994, p 40). Taking up the idea of health promotion as a social movement, O’Neill and Pederson (1994) propose, “what contributed to the growth of health promotion in the 1980’s was the spreading of the health education critique through a loose network of critical health educators and public health activists” (p 46). The authors recount a common theme found in critical texts as one that suggests health education should have as its goal to change society, not individuals with a view to “deal, through political means, with the dominant power structure in order for the oppressed to gain more freedom (or better health) (p. 49). However, a practice emerged where professionals were acting on the behalf of community members. A discussion of how this particular practice shaped nursing health promotion practices toward young people will be revisited in Chapter 5.

As O’Neill and Pederson demonstrate in their review, the people most involved in health promotion in the 1980’s had some specialized training, worked in organizations,

and ‘did’ health promotion for pay. From this information, we might assume that health promotion was a professional rather than a popular social movement. They point to programs claiming an empowerment practice where *professionals* provide information, resources, and programs to individuals or groups who presumably have no power or are unable to enact their power without guidance and supportive intervention. How this empowerment practice differs from the criticized health education practices where the professional provides the information about the health risk and supports the individual to make the healthy choice is not readily apparent. It would seem that in both cases, the individual or group has less power (e.g. knowledge) than the professional.

In summary it would seem that we leave the 1980’s with an emerging dichotomy in health promotion thinking, one that sets biomedical approaches to health and health care in opposition to socially constructed understandings of health and health care. Moreover, a trend of specific health promotion practices, those of health education and social marketing targeting individual lifestyle changes, appears established. Governmental funding and sanction both supported those health promotion practices and in turn helped to legitimize this view of health and authorized the associated health promotion practices. At the same time, a number of diverse professionals aided by such thinking as critical social theory began questioning the legitimacy of such a narrow view into health and health promotion. It is at this juncture that I turn, and in the next chapter critically examine how nurses came to understand health promotion thinking and the actions of health promotion, particularly the thinking and actions of nursing health promotion directed toward young people (adolescents).

CHAPTER 5

In the previous chapter (4), I argued that a discursive formation, health promotion, legitimized a particular view of people and health, and authorized particular practices of health education. I defended my argument through a process of locating texts depicting particular movements in Canadian and US history highlighting when and how governing authority(s) authored and sanctioned the discursive formation health promotion. At the same time, I located those texts that critically interrogated health promotion and questioned its legitimacy. I suggested an emergent dichotomy in health promotion thinking, one that set biomedical approaches to health and health care in opposition to socially constructed understandings of health and health care.

In this chapter (5), I extend the archaeological work from Chapter 4 now focusing on an examination of the ways the discursive formation health promotion can be shown to have influenced nursing thinking and actions toward people and their health. I will address the second question I posed in Chapter 1: What nursing thinking and actions came into being alongside of the political ideas of health promotion? I undertake this aspect of the archaeological work by accessing and critically interrogating nursing texts about health promotion ideology as it was taken up and written about in professional nursing literature in the decade 1980 to 1990.

To access nursing texts, I used the search engine Cumulative Index of Nursing and Allied Health Literature (CINAHL) to locate nursing publications that describe nursing thinking and practicing in health promotion in the years 1980-1990. I purposefully narrowed my search to this decade for it encompasses the years of the health

promotion milestones analyzed in Chapter 4. I acknowledge that some nurses may have published outside of this search engine parameter. I also note that not all nursing thinking and actions during 1980-1990 are accessible through publication. However, my intent was not to provide an exhaustive description rather access an archive that is understood by those seeking to contribute to the body of nursing knowledge for the purpose of continuing my archaeology.

In the latter half of the chapter, from my textual analysis, I put forth that there is evidence to suggest that nursing adopted a politically legitimized health promotion ideology and began to modify it to the discipline's own ends. Moreover, I demonstrate via quotes from nursing texts how the conceptualization of health promotion sanctioned by government was argued and absorbed into routine professional nursing practices, beginning with the repetitive claim that health promotion 'belonged' with nursing. I note that this claim appeared as part of an insular dialogue, one where it seemingly appears that some nurses adoption of a politically sanctioned view of health promotion corresponded with their professional bid for autonomy in the health care system and helped them distance from bio-medical perspectives on health. I demonstrate how this very political move by nursing turned nurse theorists, researchers and practitioners away from an already established and fairly sophisticated framework for developing nursing knowledge and practices about people, their environment and health.

What nurses' thinking and actions came into being alongside of those scientific ideas of health promotion?

To answer this question, I provide the reader with a critical interrogation of nursing literature of the decade 1980-1990 in which I locate and analyze text-based truth

statements that illustrate nursing thinking and acting related to promoting health. My first step was to locate truth statements in those texts, about people and the promotion of their health, with a view to problematize thinking Foucault (1984e). Then, following the four basic elements of a Foucauldian discursive formation; the object it's statements are about, the kind of authority the discursive formation holds, the concepts that formulate them, and the theoretical viewpoints that they develop (Gutting, 1989), I asked the questions I developed in the third column of Table 5, so that I might critically interrogate the influence of the discursive formation, health promotion, as it appeared in nursing texts between the years 1980-1990.

Table 5

Elements of a Discursive formation (Gutting, 1989)	Foucault's Rules for deployment of a discursive formation (Gutting, 1989).	Questions to guide analysis of the ways in which the discursive formation 'health promotion' shaped nurses' thinking and practice 1980-1990.
Object	Rules governing statements about the formation an object	
	1. Does the statement characterize the subject in a certain way so that the subject is separated off from a social context into the domain of the discursive formation?	1. What statements are nurses making about people and health promotion? What are the effects of those statements on how people manage their health?
	2. Who has the authority to decide what subjects belong to what discursive formation?	2. By what authority are nurses making statements made about people and health promotion, and as a result, regulate peoples' activities?
	3. What are the grids of specification whereby discursive formations classify and relate differing subjects so that they are readily and always recognized?	3. How do statements about people and health promotion relate to other statements that serve to make the person and their health recognizable and distinguishable from other

		peoples and their health? How do these statements legitimize nursing practices with people?
Authority	Rules for determining the function of the context from which the statement originates.	
	1. Do the people making the statement have the right to use the language?	1. What is the language utilized by nursing when making statements about people and the promotion of their health? Who makes the statements and from what author?
	2. What institutional site contributed to the development of the language in use?	2. What institutional site contributed to the development of the language in use?
	3. What is the relative position of the person making the statement to the object of the discourse?	3. What is the position of the nurse in relationship to people when making about their health?
Concepts	Rules that govern the formation of concepts.	
	1. What methodological approaches determine the ways in which statements of a discursive formation relate to each other?	1. What methodological approaches have contributed to nursing understandings of 'health promotion'?
	2. How does a statement become accepted, or rejected? What other discourses may be involved in determining whether a statement is valid or legitimate?	2. What discourses are involved in the continuance of the discursive formation 'health promotion'? How are other statements about people's health considered in relationship to the discursive formation health promotion?
	3. In what ways may a discursive formation be altered to produce new statements?	3. Are there novel moves that people can make that result in current statements within the discursive formation, health promotion, to be altered?

Strategy	<p>Rules that govern the formation of theories within a discursive formation.</p>	
	<p>1. How do theoretical statements guide practice within the discursive formation?</p>	<p>1. What theories about people and health are located within the discursive formation health promotion? How do those theories guide nursing practices?</p>
	<p>2. What is the range of practices permitted as a result of the theoretical statements of the discursive formation?</p>	<p>2. How are nursing health practices facilitated or constrained as a result of theoretical statements about health promotion?</p>
	<p>3. What authorities affect the theoretical options allowed within the discursive formation and to what result?</p>	<p>3. What are the epistemological tenets that contribute to theories developed by nursing about people and their health within the discursive formation, health promotion? What are the results of such tenets?</p>

Subsequently, from my archaeological dig, I am able to present one view into nursing knowledge about nursing, people and health promotion (*connaissance*) at one time in history.

Nurses' statements about health promotion 1980-1990

Brubaker (1983) notes that 'health promotion' was not indexed by the *Cumulative Index to Nursing and Allied Health literature* until 1983. From this statement, we might assume that nursing texts did not immediately reflect the discursive formation health promotion as it was proposed in political discourse, as early as the Lalonde Report in 1976. At the same time, the vast amount of nursing texts published between the years 1980 to 1990 reflect an already established and sophisticated theoretical approach to

developing *nursing* knowledge about people, their environment and health. Thus, we can assume that individual nurses had at hand an established history of thinking and acting toward people, their environment, and their health. While it goes beyond the scope of this chapter to re-view all of nursing texts between the years 1980 to 1990, I have selected several texts that provide us with insight into the topics of concern to nursing and the ways in which the discipline suggested knowledge might be developed to address those concerns.

Several themes that recur in nursing texts that in turn contributes to a collective history of those ideas that are of concern to nursing in 1980 onward include; educational preparation of nurses, autonomy in the work setting, a need for development of a scientific knowledge base, the ideology of professionalism, a gap between nursing service and nursing education, the need for a universal definition of nursing and a call for the delineation of a separate and distinct domain of nursing (Hedin, 1983).

In the following paragraphs, I will introduce examples select texts provide us with insight into nursing epistemological thinking: What should constitute nursing knowledge (e.g. conceptualizations of people, their environments and their health); what are the ways in which that knowledge might be developed (e.g. methods employed by nurses to build their knowledge about people, environments and health). Moreover, it demonstrates the diverseness of nursing thinking and acting in establishing a rigorous and sophisticated approach to answer those questions.

I begin by introducing the notion of paradigm. According to Kuhn (1970) a paradigm reflects, “ the entire constellation of beliefs, values, techniques...” (p147) of a group of scientists committed to a common research program. A paradigm is composed

of theory, ontology, method, standard problems, and values about the problems which scientific method is meant to resolve (Kuhn). Each element of the paradigm maintains consistency and commensurability within itself, but Kuhn argued that a paradigm replaced another stating “...debate about paradigm choice...each group uses its own paradigm to argue in that paradigm’s defense” (p94). What emerges as problematic thinking in Kuhn’s understanding of paradigm is the suggestion that method of science belongs to one particular theory such that other interpretations are excluded; a dichotomy of thinking is created that erroneously aligns sources of data against each other (the subjective responses to the objective measures).

I turn to nursing discourse during the decade I am reviewing and note that a dichotomy has formed most likely as a result of the *connaissance* of science (paradigm thinking) of that time. I begin with Fawcett (1984) who proclaims, “the discipline of nursing will advance only through continuous and systematic development and testing of nursing knowledge” (p 84). Fawcett argues for the adoption of four key concepts person, environment, health, and nursing as a metaparadigm (Fawcett; Flaskerud & Halloran, 1980) claiming that, “the metaparadigm of any discipline is a statement or group of statements identifying its relevant phenomena” (p 84). Building upon previous works by Donaldson and Crowley (1978) and Gortner (1980), Fawcett outlines the themes of her proposed nursing metaparadigm as:

- “1. The principles and laws that govern the life-process, well-being, and optimum function of human beings, sick or well.
2. The patterning of human behavior in interaction with the environment in normal life events and critical life situations.

3. The process by which positive changes in health status are effected". (p 85)

Fawcett goes on to argue for a thinking and action around the goal of "developing specific rules for the empirical work needed to generate and test nursing theories within the context of conceptual models" (p87). With this statement, Fawcett aligns her thinking about the metaparadigm of nursing with empiricism; an approach to understanding knowledge production that suggests all hypotheses and theories must be tested through a particular perspective on a scientific method. Moreover, she appears to advocate a particular epistemological view of knowledge: Positivism.

In response to Fawcett (1984), Brodie suggests the metaparadigm reflects the evolution of nursing thinking and acting within a positivist science tradition such that nursing theories aligned with other scientific and philosophical understandings of what constitutes knowledge are excluded. The response by Brodie alerts us to the different ways the disciplinary concepts of person, health, environment and nursing might be understood; the location of the concept within one paradigm or another called upon different philosophical or theoretical assumptions. What Fawcett has proposed is a 'meta' paradigm of concepts free from philosophical assumptions, thus distancing the concepts from further discussion, for example; what does it mean to be human? How is health lived?

I can further locate evidence of the emergent dichotomy in the following brief overview of paradigmatic thinking by nursing theorists. In her 'man-living-health' theory of nursing, Parse (1981) introduces two paradigms for nursing: totality from which man (person) can be viewed as a combination of biological, psychological, social and spiritual factors and; simultaneity where man (person) is a unitary being in continuous,

mutual interaction with the environment. The totality paradigm, reflects similar thinking by Newman, Sime and Corcoran-Perry's (1990) particulate-deterministic paradigm where phenomena can be viewed as isolatable, reducible and defined for the purposes of measurement and prediction. Within this paradigm view, health can be reduced and dichotomized into healthy and unhealthy characteristics. In contrast, simultaneity reflects a unitary-transformative paradigm (Newman et al) whereby the nurse, person, and environment are seen as a whole, interacting in the production of knowledge such that the ability of the nurse to hold an objective view of truth is questioned. From this perspective, notions of health are created, changing and encapsulate thoughts, values, feelings, choices and purpose of both nurse and person. I note that that simultaneity or unitary-transformative beg a different epistemology, one where truth is constructed, relative and not fixed and, as a result, shifts thinking from positivist through to constructed and/or interpretive understandings of truth statements. While this introduction is brief, I have a sense that there are multiple ways available to nurses within nursing texts to respond to the nursing concerns identified in Hedin's (1983) review, particularly the development of a knowledge base that delineates a distinct domain of nursing, a universal understanding of nursing, and resultant professional autonomy in the workplace.

However, when I direct my gaze back to when the discursive formation health promotion emerges in nursing texts, I see an alignment with one particular paradigm (totality) and a shift in corresponding argument (less about nursing, more about health care). Let me consider Brubaker (1983) who informs that a "loss of faith in technology" (p. 1) has contributed to a shift in thinking that health care should be focused on the

prevention of disease and disability. She supports her position suggesting “this shift in thinking is not always based on philosophical concerns: sometimes it results primarily from the expedient weighing of cost benefit ratios” (p1). From this it would seem that Brubaker calls for nurses to shift their thinking and acting from the philosophies that shape nursing understanding of people, their environments and health to identifying those health care practices that are at the same time effective and contribute to a reduction in health care expenditures. Her linguistic analysis of nursing texts grounds her argument that nurses interchange the words health promotion, health maintenance, and disease prevention and thus one common definition of health promotion for nursing is necessary. However, her analysis reveals that some nurses do not view health promotion as merely disease prevention, for example, “some authors believe that health promotion is directed toward self-development growth and high level wellness” (p 4/5) and “nurses frequently imply that health promotion and disease prevention are not the same thing” (p4). I get the sense that at this time in history nursing texts reflect the differing nursing paradigms such that nursing has critically engaged with the discursive formation health promotion as it appears to an already established philosophical understanding of people, their environments and their health as something more than disease prevention.

At the same time Brubaker appears to discount the breadth of thinking available on those same concepts and concludes her analysis by proposing one nursing conceptualization of health promotion as “health care directed toward growth and improvement in well-being through processes that encourage alteration of personal habits or the environment in which people live” (p12). Moreover, she suggests health promotion practice “as a center that provided holistic care by practitioners socialized to

facilitate health promoting behaviours” (p10). Brubaker’s conceptualization of health promotion, as a way of clarifying and unifying nursing thinking and aligns with a totality or particulate-deterministic paradigm such that health and well-being equates with the prevention of disease. As a result, nursing appears with the politically sanctioned discursive formation health promotion.

Interestingly, Brubaker (1983) claims that if nurses are able to clearly articulate their effective practices associated with promoting health they will in turn be able to challenge the disease orientation of the current system and establish an autonomous place for themselves. At the same time, her argument falls short in demonstrating how nursing acts designed for ‘altering of personal habits’ and ‘facilitating health promoting behaviour(s)’ distances the nurse from an understanding of health as the prevention of disease.

In another text, Moore and Williamson (1984) undertake a sophisticated review of the historical development of the concept of health promotion and claim that nursing has been promoting health since Florence Nightingale first wrote ‘Notes on Nursing’. They begin with the premise that the discipline of nursing, “responds to societal trends in an effort to meet the perceived needs of the culture in which it exists” (p 195) note several historical trends in governing acts of health promotion and locate nursing’s response: The promotion of the health of the individual through governing practices (1920-1960) where nurses acted to ensure the health of young draftees; social engineering practices (1960-) where equalizing access to health care took precedence and nurses acted in school health programs. Thus, these authors argue nursing as already always promoting

health of people as a result of governing practices, justifies a place for nurses in the 'new' concept of health promotion.

What we can take from Moore and Williams (1984) argument is that nursing has an established history of promoting peoples' health that is at the same time shaped by societal discourses about people and health (savoir), and nursing's efforts to secure a space for its disciplinary and professional aspirations for autonomy (connaissance). They suggest, "Nurses must examine the concept health promotion and begin to understand and define its interaction with nurse theory and practice" (p195). With this statement, there appears to be room for nurses' to critically examine the politically and economically driven view of health promotion as it appeared in political documents (e.g. the Lalonde Report) and call attention to congruence with an already established epistemological dialogue about the discipline of nursing. Moreover, the potential pitfalls of such an adoption for disciplinary and professional growth might be thoughtfully considered.

However, as I critically examined other texts published within the decade for truth statements about nursing and health promotion, I uncover an insular dialogue where nursing claims health promotion its own. There is little evidence to suggest that nurses' shared their understanding of having always promoted health outside the discipline.

For example, Johnson and Parsons (1984) state with certainty that, "health promotion has always belonged to nursing" (p 193). Referring to Nightingale's suggestion that the profession of nursing should concern itself with 'sick nursing' and 'well nursing' they further argue "America's first public health nurses knew community clinics and homes were the natural settings for the practice of nursing...to teach wellness

and disease” (p193). Implicit in this statement is the idea that health promotion emphasizes wellness while preventing disease and may extend beyond the individual person into homes and communities. The statements also reveal an assumption about nursing thinking and actions directed toward people and health; the practice of nursing has always been concerned with lifestyles and modifying peoples’ health practices through teaching or health education.

The rest of this chapter has been divided into four sections, following the four basic elements of a Foucauldian discursive formation; *objects, authority, concepts, and theoretical viewpoints* (Gutting, 1989). Further critical interrogation will assist us in identifying how the adoption of the discursive formation health promotion by some nurses as their own, in turn shaped nursing thinking about people, environments, health, and nursing.

Objects

Truth statements made within nursing texts about people and their health and wellness suggest a general assumption that health is at the same time an individual, personal responsibility, and a nursing responsibility. Statements within nursing texts argue that health and wellness of people reflect their lifestyle choice and as a result maintaining health and wellness is a personal responsibility. For example, Fritz (1984) suggests that it is time for people to “fac[e] the reality that we are responsible for our own well being and can not blame the environment directly for our poor health” (p 263) arguing that personal lifestyles are responsible for at least 51% of health and chronic health problems or “diseases of civilization” (p264). Grasser and Goggin Craft (1984) argue that people have “the potential for self-responsibility in assuming wellness behaviours...the most significant factor determining health status” (p216). These

statements suggest that people have responsibility in maintaining health and wellness, and as a truth statement, it is difficult to argue that people should not have some responsibility in maintaining health and wellness. What is interesting is how nursing thinking and practices toward people in light of such a statement reflects further truths about the relationship between people, their health and wellness and nurses.

Fritz, (1984) asserts, “nurses are in a position to make positive changes [arrest the development of chronic disease and rising health care costs] through helping people attain and maintain wellness” (p264). Examples of how nursing might help people include statements by Grasser and Goggin Craft (1984) who suggest “the health task before us is to make it more attractive for people to follow healthful practices and less rewarding to choose unhealthful behaviour” (p208) and Johnson and Parsons (1984) who argue that “the scope of health promotion concerns [nurses’] understanding of desirable and undesirable behaviours” (p193). A general process is outlined in nursing texts I reviewed, whereby people are at first prompted and then guided by the nurse to make choices for a healthier existence (Crowell, 1984; Petze, 1984; Tegtmeir & Elsea, 1984; Williams & Hastings Davis, 1984) or in some cases, legislation may suggested to ensure people make the right choices to ensure health and well being (Post, 1986). It is evident in texts that I have read, that nursing believes that people require particular nursing acts so that they might change their health behaviours and lifestyles.

While the greater number of texts reviewed focused on individual health and wellness of adult populations, examples of nursing thinking about health promotion with young people and the family were also located. Specifically, Petze (1984) proposed that nurses be aware of and assess for the family’s competency in promoting wellness of

members including “communication skills, previous learning and associated coping behaviours, insight into one’s own actions and motivations, and ability to connect with others emotionally, willingness to be honest and open in dealings with others, problem solving capabilities and follow through on plans” (p231). From this line of thinking, nursing interventions were said to include ‘discussing and enumerating the behaviours, statements, and actions that are evidence of functional and dysfunctional coping...education and information exchange” (p235). Thus, we see in family nursing as a continuation of nursing practices of assessing for wellness behaviours and intervening through a process of education.

Toward the end of the decade, a call from Gillis (1988) for nursing to focus their gaze on the adolescent body suggests the existence of a relatively clear moral and political stance available to individual nurses in relation to young peoples’ health. As Gillis states, there is “...an urgent need for adolescent health programs at an early age to help eliminate those behaviour patterns that are contributing to chronic disease in an already ‘endangered species’” (p 10). Gillis places her argument within a context of eliminating patterns of chronic disease similar to Fritz (1984). In another example, Farrell, Kettle and Lummis (1984) question how nursing practices might meet the health education needs of students’ 17-24 years of age. They outline a strategy of meeting individual students with a view to encouraging them to discuss and identify their specific health needs. The nurse is then given the task to help students to meet those needs at the same time teaching students how to take responsibility for their present and future health by suggesting what health needs the student must consider.

As a result of a perspective that suggests people have a responsibility to adopt lifestyles that promote health and wellness, it would seem that nursing assumes a professional role in regulating healthy lifestyle choices. Smith Shultz (1984) best sums up in this phrase “for years nurses have been assessing selected aspects of patient’s lifestyles (e.g. prenatal care)...use of a nursing theory that emphasizes the whole person naturally incorporates examining the patients’ lifestyles” (p 271). Thus, we see a particular view of peoples’ health that suggests that there are always already people requiring nursing and, these are the very same people requiring health promotion. The result of this view leads to particular categorizations of people.

The person then may be specified as one who has sufficient knowledge to make healthy lifestyle choices and one who does not; the person is always already distinguished as responsible for their self care or irresponsible and requiring assistance through education by nursing about how to better care for themselves. Some examples of this thinking include Bridges Flynn and Alfred Given’s (1984) proposal for a common nursing practice, “lifestyle assessment and its effect on health combined with other traditional nursing care activities (p241). Similarly, Fitz (1984) suggests that ‘educational programs used with [nurses’] relationship skill’ will result in ‘the recipient’s adoption of wellness behaviours that promote health’ (p 216). In nursing texts, an argument is put forth that nursing discourse inform nursing practices of health and wellness promotion they do not refer to any particular nursing knowledge source or theory. Let us see where the authority from which they speak arises.

Authority

In the texts I reviewed, the authority from which nursing truth statements about people and their health and wellness may be traced to nursing alignment with what

Foucault proposes are systems of reasoning. They, in turn, may be accessed through a critical interrogation of language in use that reflects the authority from which nursing justifies nursing thinking and actions toward people and health promotion.

Between the years 1980 and 1990 nurses' claim health and wellness promotion as the practice of reducing peoples' risk to their health, and a nursing practice. For example, Smith Schultz (1984) contends that, "nurses are in an ideal position to provide patients primary prevention direction...to stimulate motivation for behavioural changes in patients [and as a result] establish lifestyle changes [that] will reduce health risks" (p271). She argues, "with the health knowledge and wealth of interventions presently available" (p 271) nurses should routinely incorporate lifestyle assessment tools to enhance both nurses' and peoples' awareness and involvement in their health. Smith Schultz provides us with an example of a tool she designed for an individual's lifestyle assessment tool based upon a list of risk factors accessed from a provincial Health Risk Index.

In other example, Cobb-McMahon and Williams (1984) clearly articulate a role for community health nurses beginning with the premise, "before the community health nurse can identify a need for change she must first conceptualize the ideal model of wellness and compare the ideal with a health risk appraisal to identify various shortcomings and focus patients for change" (p 28). The authors then go on to delineate the roles for a community health nurse: A catalyst for change, a solution giver, a process helper, and a resource giver. Each of these roles suggests the nurse acts to promote a particular view of wellness, one that 'patients' should strive to attain.

A discourse of normalcy is clearly evident in nursing thinking and acting in this time period. In the nursing texts I reviewed, nurses' recount ways to examine a person's

lifestyle in terms of the strength and weakness of health behaviours compared to a grid of normal behaviors and then act to educate people about how to modify their lifestyle (Bridges Flynn & Alfred Giffin, 1984; Black & McDowell, 1984; Kort, 1984; Logan, 1984; O'Hagan, 1984; Scott, 1984; Smith Schultz, 1984). At the same time, they offer little evidence that their nursing efforts in promoting health will have any effect on peoples' lifestyles.

For example, Brehaut (1988) acknowledges a generalized belief that it is difficult to evaluate the effectiveness of any health promotion program in relation to health status of a given population. Alternatively, she offers the idea that nursing health promotion programs be assessed for impact on health awareness, and knowledge of health behaviours. Williams and Hastings Davis (1984) recommend that nurses continue to persist in changing behaviours of their clients offering the idea a continued persistence by the nurse will eventually effect a change in behaviour. What is concerning about these statements is how nursing is shaped into a role of health educator, a governing practice, arguing nurses will modify lifestyles and contribute to a reduction in health care delivery costs. At the same time, nursing is absolved of demonstrating that individual nursing practices indeed do as they claim they will.

Nurses refer to system of reasoning, nursing, as legitimizing their thinking and actions toward people and their health and wellness. Yet Pender (1984) in a review of health promotion research discovers only two studies; both applying Orem's theory and the notion of self care in their exploration of nurses, people and health promotion to reflect that nurses might be thinking within their own theoretical tradition to demonstrate effectiveness of their acts. Nursing language aligns with health promotion discourse as it

emerged in political documents, for example reference to decreasing health care costs, reducing health risks and decreasing incidence in chronic illness (see Chapter 4).

Moreover, the emphasis on health behaviours and health education approaches reflect thinking from the discipline of social psychology, particularly social learning theory (again discussed in Chapter 4).

Several concepts were repeated in the language nursing used when thinking or acting in health promotion. These will be critically examined in the next section of this chapter and later linked to the theories that support them.

Concepts

Reynolds (1988) in a review of measures of health used in reports of nursing research reveals that despite articulation of a holistic concept of health in dominant nursing theoretical views, nursing research focuses on indicators derived from a clinical model of health as the absence of disease. There is evidence to suggest similar thinking and acting in nursing writing about how nurses conceptualize and act health promotion. While there seemed to be consensus that, “nurses need to approach health promotion critically, retaining only those concepts and strategies most likely to ensure growth for patients and the profession” (Johnson & Parson, p 194) the ways in which nursing texts described nursing practices of health promotion betrayed the ways they conceptualized health. For example, Cloutier Laffrey (1985) suggests health promotion thinking as “the relationship between self-actualization and health conception” yet at the same time recommends health promotion acting as “identifying those variables that predict health behaviour choice” (p 285) with a view to ensure individual movement from risky to healthy lifestyles.

There is evidence that within the discipline, some nurses recognized how nursing thinking and acting in health promotion were incongruent. Woods (1989) asks nurses to consider how self-care has been conceptualized as compliance to treatment and symptom management and makes a case for nursing to develop a broader understanding of the concept. At the same time, Pender (1984) proposes an operational definition of health in health promotion thinking and acting that includes, “the holistic dimensions of health” (p 99) but then goes on to describe those dimensions as, “self-care competency, self-actualization, quality of life, productive longevity and lifestyle pattern” (p 99). While the dimensions of health suggested might appear value free, she argues for “valid and reliable tools for measuring health and health related concepts, and, improved methods for measuring the effectiveness of nursing interventions” (Pender, 1984, p 99) suggesting that the nursing practices influence movement within such dimensions as self-care competency and lifestyle pattern. It is evident that the concepts that particular nurses utilize in their thinking about health promotion contribute to a positivist and mechanistic view of health as a continuum of states from illness to wellness. As a result of this thinking, nursing health promotion acts are narrowed to the process of health education.

Torres (1985) suggests a nursing conceptualization of health education as “any activity that promotes health related learning that in turn produces changes in an individuals capabilities or dispositions, understanding or ways of thinking, beliefs or attitudes such that the individual changes attitude and/or acquires skills that generate changes in behaviour and lifestyle” (Torres, 1985, p 8). This particular conceptualization of health education permits nurses to practice in ways that promote individual self care behaviours necessary for a healthy lifestyle. Similarly, Hartweg (1990) proposes

conceptualizing health promotion self care within Orem's general theory of nursing. Her argument, health promotion self care as a continuous action that is self initiated and deliberately performed to increase an individual's experiences of contentment, pleasure, and happiness (wellbeing).

In the next section, we shall critically examine the ways in which nursing theoretically support concepts embedded in statements they make about their thinking and acting.

Theoretical viewpoints

One might assume, as a result of nursing's proclaimed interest in developing a distinct discipline, they would turn to an already developing, reasonably sophisticated and well thought theoretical structure. Yet, it would seem that in their efforts to achieve professional autonomy, nurses actually abandoned some nursing theory to assist them and turned instead to the language of health promotion. For example, Pender (1984) offers some insight into this turn as she describes, "an investigative trend in nursing [that] parallels increased public concern about decreasing the cost of medical care and increasing the quality of life through health promotion and illness prevention" (p83/83). She illustrates the difference between health promotion (activities directed toward developing resources for clients that maintain or enhance well-being and self-actualization) and illness prevention (activities aimed at protecting clients from specific or actual health threats and their harmful consequences). Pender (1987) articulates a model for nursing that would help differentiate those practices involved with disease prevention or risk screening from those acts that might reflect a nursing approach to health promotion.

At first glance, this model describes a more rigorous approach to understanding nurse acts in promoting health. However, the theoretical tenets that support the conceptualization are derived from an already established 'social cognitive theory'. This psychological theory claims that one way to change peoples' behaviour is to alter how they think. Pender introduces new conceptualizations: health behaviours which, once identified, direct nurses to act to decrease the probability of becoming ill; and, health protection which encompasses those nursing acts directed toward the early detection of illness. At this juncture, the similarities to what nursing texts reveal nurses are already thinking and acting as a result of adopting a politically sanctioned health promotion ideology are apparent: health behaviours or disease prevention? Health protection or screening for risk? The concepts are languaged differently but the proposed nursing thinking and acting appears to be the same. In contrast, health promotion and wellness are suggested by Pender to be those acts aimed at sustaining or increasing the level of well being and self actualization of a given individual or group.

Pender's (1984) attempt to mould together two very diverse views of health; the medical view of health as absence of disease and normal functioning or stability with psychological notions of well being and self actualization reflects a desire to join together those concepts that are objective and can be measured; symptoms of disease and risk behaviours with subjective thoughts about well-being. Scientific approaches to knowledge development lend to the technical understanding of health promotion as risk appraisal and risk reduction; health as an absence of disease where empirical measures assist in determining healthy or sick bodies. Alternatively, the notion of well-being implies a subjective perception of a happy life. However, the ability to place parameters

around subjective happiness becomes difficult except when one equates health with well-being. In each approach, the person may be categorized. A person may be viewed as assuming responsibility for maintaining a healthy body through acts to reduce their risks to their health and modify their lifestyle without nursing acts. Alternatively, an opposite view of the person as one who requires nursing acts to understand the importance of reducing risks to their health and receive expert education about what a healthy lifestyle entails. Another view of the person seems to be the happy person, somewhat related to an understanding of well-being or the unhappy person. In this case it seems if the person is happy yet unhealthy, the nurse acts to modify thinking so that the person assumes responsibility for health. Alternatively, if the person is unhappy there is room for the nurse to suggest how adopting healthy lifestyle practices will contribute to experiences of well-being and happiness.

While Pender (1984) attempts to develop a somewhat rigorous conceptual model to guide nursing thinking and acts within health promotion her reliance on theories already established within the discipline of psychology reflect a trend in theorizing health promotion similar to politically legitimized thinking about health and wellness. Her proposed model fits with a nursing totality paradigm where the person, environment and nursing act can be reduced to measureable components. Thus in the 1980's a pattern of thinking and acting emerges in nursing texts about health promotion that mirrors the politically sanctioned health promotion ideology including those acts authorized as health promoting. Moreover, nursing texts suggest that nursing aligns health promotion with an already established paradigm of totality, where person, health, environment and nursing

acts can be reduced and empirically measured, and, as a result of this particular turn toward health promotion, a specific view of health and nursing emerges.

In Chapter 4 my archaeological work concluded that in the US and Canada, health promotion ideology in 1970-1990 proposed that the individual's health status was determined primarily by personal behaviour, stated another way the major determinant of health is lifestyle. As a result of such thinking, individual differences in health status were attributed to individual choice; individuals were held to be responsible for their own health, and, as a result, obliged to undertake self-care. It would seem a governing expectation that a responsible person, or citizen, recognizes responsible choice is to adopt a healthy lifestyle.

In this chapter I present and discuss similar values clearly reflected in the normative and prescriptive assumptions about health promotion recounted in nursing texts. Nursing truth statements suggest that the individual's health status is determined primarily by personal behaviour and circumstances over which the individual is believed to have control. Nursing practices are directed toward individual cognitive thought processes that are believed to influence behaviour. Consequently, nursing health promotion centers on health education practices and other techniques to effect the behavioural changes that they freely choose to make. In these instances, nursing knowledge is borrowed from the disciplines of education and psychology.

Thus, health promoting acts described in by nurses in the 1980's nursing literature suggests that within nursing there existed a view of health as something that could be determined by the individual's capacity to avoid diseases or health 'problems'. Nursing health promotion practices associated with this particular view of health included a focus

on self-care, health education, and illness prevention. In general, nurses intervened upon individual behaviours and not the political or social context in which they were located. The reality of nursing's engagement with health promotion appears to be one in which a role for nurses construct a role for themselves as health screener and educator that will in turn help meet the economic demands of modern health care delivery. At the same time, there is little evidence to suggest that those nurses' questioned how a risk reduction approach to people's health might mirror a medical model of practice, one that nurses historically had disassociated from as they developed their own theories of practice. Indeed, I found only one article that turned a critical gaze to nurses' practices in health promotion technologies (e.g. screening).

Allan and Hall (1988) explore the problems that the medical model has created for health care recipients and nursing. Citing Hughes and Kennedy (1983) they argue that the "medical model represents an ontological view of disease so that disease becomes a self-contained thing that attacks the person" (p 26). Such a belief directs the technologies of the medical model to focus on diagnosing a disease, discovering a single cause, and determining a cure. Allan and Hall point out how the influence of the germ theory paradigm operates here, whereby a biochemical orientation to medical treatment responded causation and treatment has shaped medical thinking and actions. Thus, for medical practitioners, "a mechanistic view of the body as a machine" (p 24) has ensued.

In contrast, these authors draw attention to a theme in nursing theorizing whereby the discipline continues to struggle to develop and distance nurses from medicine with an ontological view of the person as mind-body-society. Allan and Hall delineate differences in practices evident in the two ontologies whereby "physicians diagnose and

treat disease ...diseases are abnormalities in the function or structure of body organs or systems” (p 26). In contrast, they suggest, “illnesses are the subjective experiences of individuals with altered physiological, social, or psychological states of being” (p26). Their argument goes on to critique a practice of trying to fit a subjective illness experience into abstract diagnostic categories of biological conditions that are independent of the environment, society, and culture. This article stands alone against the many health promotion texts in this decade that, appear for the most part, to attempt to understand the person’s health risk behaviour apart from the contextualizing factors.

In Chapter 6, I will commence my genealogical analysis with a view to furthering my critical interrogation of the discursive formation adolescent health promotion following the oeuvre of Foucault. Through this deeper analysis, I will offer my perspective about how that particular formation holds power today in nursing thinking and acts within the context of young people and health. Building on the work of Nancy Lesko’s (2005) genealogy of adolescence discourse, I will demonstrate how that particular discourse was developed and holds power through a process of thinking and practicing risk reduction.

Chapter 6

In this chapter I provide the genealogical analysis necessary to continue to address the third question I posed in Chapter 1: Why might some nursing practices directed toward young people be resistant to critique and change? According to Foucault (1976/1990), genealogy provides a place for me to consider power relations and their technologies that regulate individuals. Foucault proposes that through genealogical analysis I am able to critique the origin of thinking of particular truths by showing they are fabrications. I do this by tracing the shifts in systems of reasoning about truths so that I might uncover how truth is created, legitimized and serves to subjugate the body through technologies of power. I refer to Chapter 2, Table 2 where I have outlined the questions that serve to frame my approach to genealogical analysis.

To help us situate my genealogy work, I refer back to Chapters 3, 4, and 5 where I located and critically interrogated nursing present day thinking and acts toward young people and their health as unquestioned uptake of the discursive formation *adolescent health promotion*. I problematized how the discursive formation initially developed, circulated, and was popularized. By situating nursing knowledge about adolescent health promotion in specific histories and political contexts my intent was to create a space to investigate the political implications of unquestioning acceptance of the categorization of a 'risky adolescent' on nursing acts that promote predetermined healthy lifestyle choices. I queried the implication of the assumption, promoting a healthy lifestyle could be equated with the philosophical notion of well-being.

As a result of this archaeological work, I am now able to locate and name two confident nursing practices within the context of young people and their health: “reducing risk” and “promoting well-becoming”. I have purposely chosen the word confident to capture the certainty, secure and convinced manner that nurses approach their health promotion thinking and actions within the context of young peoples’ health. Those confident practices declare the nature of nursing practice relationships with young people, and invite nurses to find instances of their truth in new encounters. In theoretical terms, confident practices guide nursing thinking and acting determining the limits of possible thinking and actions by nurses toward young people. Confident practices serve to inform nursing what is important and enduring in adolescent health promotion and may be located within two broader theoretical discourses about young people and their health within human science: the biological view and social constructionist view.

Reducing risk

From my textual analysis several assumptions appear to frame a nursing practice of risk reduction in the context of young people’s health and, as a result, serve to ground adolescent health promotion practices in biological theories. For example, the concept *adolescence* implies that all people naturally transition from child to adulthood and that such transitions are evident in visible changes in their physiology. These stages are defined using particular markers: For example, mobility and the movement from crawling to standing to walking to running; absence and presence of body hair, change in the pitch of voice, and changes in hormonal balance that makes reproduction possible. Because of the implications of some of these changes (e.g. the formation of a biologically productive human during what we claim is the adolescent period), the maturity to be fully

conscious of these implications is framed as being open to question (by the nurse and society). As a result, adolescence has become a pre-eminent period that is treated as 'risky' by adults and in particular ways by health professionals. Nurses who subscribe to this particular view suggest that by virtue of their incomplete development, adolescents are at risk of decisions made regarding their health at a time when their consciousness of the implications of those decisions is lacking in maturity. In Chapter 3, I have argued that nurses assume a powerful position in health promotion practices, most noticeably in 'sexual health' promotion practices. The language of risk presupposes particular cultural understandings of young peoples' health as worrying, disorderly, and naturally occurring including those processes that endow nurses with authority in adolescent health promotion. For example, nursing practices are sanctioned through their licensure that in turn guarantees they have met a requisite authority about adolescent growth and development. This act legitimizes their ability to speak for adolescents in social institutions. For example in public schools nurses have assumed an expert role that shapes what and when sexual health education materials are necessary to ensure the safety of young peoples' sexual health. The nurse has the power to decide or at least contribute to the decision about when the young person is ready to learn about healthy sexual relationships including decisions about what the content of such learning. Moreover, the nurse is also available to the adolescent 'at risk' to provide the necessary interventions to reduce the effects of risk behaviours on adolescent sexual health. This nursing authority appears to arise from a biological interpretation of young people and their health.

The biological view

The biological view or natural view of adolescent health promotion serves as the ground upon which much of nursing theory and practice as well as health-related policymaking is based. This approach to understanding adolescent health promotion assumes that young people between the ages of 12 to 18 have naturally occurring, biologically generated characteristics, and that, because of their immaturity, they may, without realizing it, engage in risky behaviours, and have unarticulated health needs (Sussman & Rogal, 2004). Such thinking about adolescent development may be traced back to 1904, when Stanley Hall proposed a biological based ideal of human development where the optimum condition was health; adolescence a period of ‘storm and stress’ that required expert intervention to ensure the development of a healthy body. Although the notion of storm and stress has been discredited in contemporary psychology (Lerner, 2004; Lerner & Busch-Rossnagel, 1981), a lingering assumption within an unexamined naturalist view of adolescence suggests the biological changes of puberty continue to create psychological, emotional, and interpersonal problems in adolescence. For example, Graber, Brooks-Gunn, and Galen (1998) suggest that navigating the emotional and physical challenges of developing a sexual identity is one of the important transitions that take place during the period of adolescence. Thus if I turn to the literature about adolescent sexuality I expect to find inquiry directed toward understanding those processes that facilitate or constrain young peoples ability to navigate those challenges associated with establishing a sexual identity.

However, the ways researchers approach adolescent sexuality we discover most inquiry directed toward collecting data that describes the sexual maturation of the adolescent body (Brooks-Gunn & Paikoff, 1997) as well as reporting the ways in which

sexual activity may risk the health of adolescents (e.g. infections, disease and unplanned pregnancy) (Boyce et. al., 2006). It would seem that as a result of the data at hand, health professionals are directed to focus their gaze on the risk to the adolescent body that could result from their engagement in sexual activity. As a result of the concern of effects of sexual activity on the adolescence body, they promote sexual health in ways that overlook the day-to-day contexts within which a young person's sexual maturation and the meaning that may hold occurs. For example, a practice of ensuring adolescent sexual abstinence or sexual safety overlooks adolescents' desires for romantic relationships and intimacy (Fine, 1988; Fine & McClelland, 2008). Similarly, practices of mass education within social institutions more often focus on normative, heterosexual intercourse health risks neglecting the diversity of sexual identity and expression (Barron, 2005).

It would seem that thinking about adolescence as solely a biological development implies that the adolescent experience exists outside of society and history. From the biological perspective, all adolescents encounter similar, predictable experiences that can be located in frameworks depicting stages of physiological development within the discourses of human science. For example, frameworks and theories prevalent in the 1960's about adolescent development in which specific stages of cognitive, psychosocial, and pubertal growth are pre-determined as a result of scientific inquiry. Consequently, knowledge that contributes to the establishment of the disciplines of psychology and medicine and to a lesser extent education and nursing are placed in a powerful authority to inform about the nature of adolescents and normal or typical adolescent behaviour. In turn, health promotion policy and programs sanctioned within political institutions (e.g.

government) are shaped by the knowledge contributions of the aforementioned disciplines reflect discourses of normality and evolutionary thinking.

Promoting well-becoming

The notion that young people are transitioning into adulthood suggests an evolutionary arrival to a place of (greater) responsibility. For me, this raises a question; are young people ever really trusted to make responsible decisions? For it seems that the category of responsible is always somewhat suspect. Consider the act of drinking alcohol. On one day, as a young person, you are thought to be irresponsible (18 years of age) and then the next day, at age 19 years you are treated as fully responsible...you have arrived. Similarly, responsibility to drive a car, gain employment, engage in sexually activity, or live independently. Each of these transitions are signalled through the notion of 'coming of age' or other language of emergence and arrival. Such language directs the nurse's gaze on the healthy, rational adult the young person will become, inviting him or her to overlook young people's perceptions of issues influencing their present day health and, perhaps more importantly, their sense of well-being as both immature and short-lived. For example, a young person's gain and loss of a romantic partner may be dismissed as 'puppy love'; a young person's shyness and feelings as if they do not belong may be dismissed as 'moodiness'.

Well-becoming thinking implies young people, by virtue of their biological underdevelopment, are not rational or autonomous and as such their ability to contribute to discussions about their health and well-being may be disregarded as immature, irrational or in need of guidance (dependent) until they have become, in this case rational and autonomous. A belief that young people cannot be relied upon to act rationally or

responsibly in matters pertaining to their health and well-being appears to shape nursing adolescent health promotion thinking and doing. For example, the words health promotion and health education are often interchanged in nursing texts. Indeed, as we have seen in previous chapters, most nursing acts described as health promotion would be more aptly described as educating the young person about sanctioned lifestyle choices. A shift in language from health promotion to health education suggests that nurse assumes a powerful role in educating young people about what it is to be healthy and in doing so, contribute to the construction of a particular social understanding of adolescent health. Moreover, the philosophical notion of well being as I use it here, that which gives people a sense of how their lives are going, continues to be interpreted through stages of adolescent growth and development underlining the powerful contingency of the nurse's authority to determine when young peoples' perceptions becomes rational and they are deemed capable of giving thought to and acting for their well being.

The social constructionist view

Social constructionist thinking provides a place for us to consider how specific social contexts serve to construct thinking about young peoples' health and well being in distinctive ways. Social constructionist thinking offers the idea that realities are local, specific and developed by particular groups in particular social contexts (Schwandt, 2000; Stetsenko & Arievitch, 1997). For example, adolescent health does not exist 'out there' in the world but only in and through the social institutions that give the notion meaning and the ways that individuals may take up that meaning. As a result, the ways in which young people or nurses participate in the construction and institutionalization of 'adolescent health', the way health is *known* and made into tradition by those people, is of interest to social constructionist thinkers.

Social construction implies an element of contribution by people. However, biological age determinations are evident in legal and social policy and in culture norms. They have a significant influence on how and when young people may contribute. For example, legislation that guides particular hiring practices (e.g. hiring individuals 16 years or older) become regularized practices which in turn shape societal understanding about the age at which an individual is sufficiently responsible to be hired into the workforce. Thus, a legislated and regularized practice suggests to people that maturity to work begins at 16 years of age. Contribution to the work force, in this example is legislated and acknowledged at a certain age.

Yet age markers are fluid and sometimes contradictory within social institutions. Chronological boundaries have been set anywhere from 10 to 24 years of age. For example, the term youth encompasses ages 10 to 24 years, while the term adolescent includes persons aged 10-19 (WHO, 1986b). Designating adolescents as children is common. For example, the UN Convention on the Rights of the Child of 1989 defines child as all individuals below 18 years of age. Adolescence may further be divided into three developmental stages based on physical, psychological, and social changes: early adolescence, 10/13-14/15 years; mid adolescence, 14/15-17 years; and late adolescence, between 17-21 years (WHO/UNICEF 1995). Such varied and entirely arbitrary views about the term during which people are considered adolescents demonstrate to us how power operates through social actors who make use of those definitions of adolescence that social institutions proclaim as authoritative. As a result, constructions of adolescent agency through signification are legitimized. At the same time, while age markers appear to differ, there is agreement that the idea of adolescence captures a period of gradual

transition from childhood to adulthood that normally begins with the onset of signs of puberty, and is characterized by physiological change.

It would seem then, that a social constructionist perspective draws attention to how specific contexts of adolescent development (e.g. economic or educational opportunities) serve to construct young people in distinctive ways. For example, entry to the workplace is one way for young people to move from dependence to independence. In another example, social constructionist thinking about young people and their health in particular contexts and institutional arrangements acknowledges the diversity of experiences of young people from different class, race and gender circumstances. Yet social constructionist thinking never fully interrogates the pervasive power of the idea of the natural, biological adolescent. The notion that young people are fundamentally different because of their age appears to go unchallenged. And as a result of this position, the uncritical acceptance of ‘truth(s)’ about young people remains. I have outlined some of those truths in Chapter 3 including nurse statements that young people are vulnerable, in need of protection and particular nursing practices that guide them toward a rational adulthood. Thus, it would seem that social constructionist thinking may not consider the ways in which the creation of the modern adolescence reflects particular understandings of time and citizenship.

Moreover, the idea of social construction may fall short in helping me to understand the historical processes through which constructions such as adolescence are assembled and become socially powerful and widely distributed. The social constructionist view similar to the biological view appears bound to (human) scientific and evolutionary thinking about normal adolescent growth and development. Thus it

seems reasonable for me to suggest that if nursing thinking and acting toward young peoples' health is to change, nurses must stand outside those two views in reflection.

In the next section I consider how a third view, a philosophical view, assists us to address the fourth question outlined in Chapter 1: What elements of nurses' current practices might change if we were to think and practice with young people differently? I begin by inviting my nurse colleagues to consider the political and philosophical implications of the discursive formation adolescent health promotion.

Nursing and the adolescent body: the politics of human science

Foucault (1976/1990) suggested people live in a bio-political age in which the management of life is the matter of political power. In other words, what human sciences reflect are not universal truths about human experiences. Rather, human sciences provide reflections on what a society values and how it organizes itself to govern people's experiences in ways that align with those values. Foucault suggests that throughout history, within the domain of what is called the human science, there exists a treasury of devices, techniques, ideas and procedures that help us constitute a certain point of view which can be very useful for analyzing what is going on now and change it. At the same time, human sciences reflect a tendency for normalization and account for the division between what is considered normal and pathological (Foucault, 1984c). As a result of this thinking, bodies of knowledge that are developed within the presuppositions of human science serve to grid human behaviour from deviant to desirable. In turn, application of that knowledge serves to promote acts that simultaneously create and confirm normality. Stated another way theoretical norms emerging from human science serve to effectively manage thinking by providing a framework for understanding the

desires and behaviours of self and others. Let me explain using examples from both Foucault's writing and my own work in the project on which this dissertation reports how these ideas might relate to the constitution of the adolescent.

Bio-power

In his text *Discipline and Punish the birth of the prison* (1975/1995), Foucault suggests a political technology of the body (*technologie politique du corps*) in which might be read a common history of power relations and object relations offering some ideas to us about why particular discourses are adopted and hold power. Foucault suggests that throughout history the body has been the site where power and knowledge hold influence, evident in his claim that power inscribes itself onto the body. Foucault suggests that we can access this relationship, that of power and the body, through examining, at any given time, how a body is interpreted and is subsequently acted upon as a result of adopting a particular regime of truth. He offers the notion of bio-power, which he locates as a technology of power and defines bio-power as a way of managing individuals, groups, indeed entire populations of people: bio-power becomes power over life by situating biological life as a political event (Gastaldo, 1997). Foucault suggests bio-power becomes possible and holds power when the social body becomes an object of government. In the following paragraphs, I argue that the social body of the young person, the adolescent, is an example of bio-power and one that influences how nurses think about young people and their health.

Nancy Lesko (2001) presents a genealogy of adolescence and the ways in which both *connaissance* and *savoir* about young people were and are shaped through a discourse of adolescence in North America. Lesko begins her text by introducing Haeckel's recapitulation theory, which presupposes that each individual child's growth

recapitulates the development of humankind; the movement toward the moral, rational and autonomous being. Thus, Haeckel's theory proposes that each child enacts the evolutionary climb from primitive to civilized society. Accordingly, Lesko argues, that the construction of adolescence provided a space in time to monitor, control, and shape young people through programs and policies to ensure the modern social order and promote citizenry in the Western world. Simultaneously, new experts on adolescent development created a space for themselves (*connaissance*). They, supported by scientific reasoning, described what factors were necessary to ensure the growth and development of healthy, rational, autonomous, and moral citizens. However, concurrent discourses shaping modern and scientific understandings of adolescence included political discourses concerned with racial progress; economic discourses shaping the workers of the future, and social discourses concerned with building a nation of unity and power (Lesko). Together, these discourses contributed to the material practice of monitoring and controlling adolescent development. Lesko concludes that the idea of adolescence was constructed within a political (visioning a new world) and theoretical (recapitulation theory) context that was paternalistic, exploitive, and colonizing. Her argument creates for us a space to reflect about how adolescence as a human science discovery was produced to both support and extend particular political commitments.

Lesko (2001) also offers some insight into how the body of the adolescent became a political concern. She begins with Hall's (1904) theorizing about scientific child study and human progress (building upon Haeckel's theory) and traces how his theorizing resulted in the body of the adolescent becoming a site for scientific gaze. As a result of this gaze, Lesko argues in contemporary society it is easy to locate a range of disciplinary

thinking and acting toward the adolescent body. For example, the governing practices of keeping adolescents asexual, in schools longer (thus dependent), and ensuring that out of school time was spent in organized recreation under the watchful gaze of adults. Lesko argues that this practice tradition led to the development of several key truths about adolescents in both scientific and popular reasoning (*savoir*). The first truth suggests that young people, as adolescents, ‘come of age’ into adulthood. The second truth argues that physiological changes to their body (e.g. ‘raging hormones’) create unpredictable and uncontrolled behaviours. And the third truth maintains that adolescents are peer oriented, that is, succumb to peer pressure and being part of peer cultures that socialize them to peer norms. From these truths, it would seem that ‘the truth about adolescents’ is that they are not fully autonomous, rational or determining...all of which are valued characteristics for successful, modern adults. This particular truth positions teenagers as immature and inferior to adults at the same time placing adults as superior to adolescents. In the end, adults always already know what is important and enduring of the adolescent experience; what may be disregarded as transitory experiences.

Following Lesko’s thinking, adolescence may be viewed as that place for surveillance and scientific gaze to ensure the growth and development of citizens who will reflect the societal values in their respective worlds that are already established by powerful elites. In my archaeology analysis in Chapter 3, I presented the ways in which nursing practices survey for risk behaviours (and respond to reduce risks) that nurses perceive may impede the healthy growth and development of young people to a particular view of a responsible healthy adulthood. I have also directed attention to how, in the instances of sexual health the nurse may focus on the risk of sexual activity and disregard

the young person's emerging sexual identity and desire for intimacy. Thus, I expected to discover in my archaeological digging that the introduction of a political discourse of health promotion contributed to nursing's view of the adolescent body. However, as my archaeological analysis in Chapter 4 and 5 reveals, nursing thinking and acting toward health as risk reduction and promotion of lifestyle was already recognizable prior to health promotion discourse in Canadian political discourse in the 1970's. Here, texts by Foucault can assist us in tracing back when the body became a site for surveillance and medical scientific gaze.

It would seem political thinking about the adolescent body was already established in human science discourses prior to the introduction of health promotion in political discourses in the 1970's. In an essay entitled, "The politics of health in the eighteenth century" Foucault (1984f) introduces us to "the consideration of disease as a political and economic problem for social collectivities which they must seek to resolve as a matter of overall policy" (p274). From this statement we may extrapolate that from Foucault's genealogical analysis, the site of physical health and well-being of the individual and collective body has become a site for political concern and power. He presents his ideas based on historical accounts of a shift in the way power operated in society beginning with the Middle Ages through to the 18th century. Foucault recounts power influences in the Middle Ages as those concerned with war and peace (the power of a monopoly of arms) and the punishment of crimes through judicial power. He suggests that toward the end of the Middle Ages, the maintenance of order and the organization of enrichment to be a new place for power and by the eighteenth century "the disposition of society as a milieu of physical well-being, health, and optimum

longevity” (p277). It is here, at this juncture, Foucault argues that the “problem of sickness among the poor is identified in its economic specificity, the health and physical well-being of populations comes to figure as a political objective which the “police” of the social body must ensure along with those of economic regulation and the needs of order” (p278). He goes on to suggest “the sudden importance assumed by medicine in the eighteenth century originates at the point of intersection of a new “analytical economy” of assistance with the emergence of a general “police’ of health” (p278). But for what purpose one might ask? Perhaps a ready answer is the preservation, and maintenance of a workforce (and Foucault would agree). However, he also asks us to think about the emergence of the idea of a technology of population, one where “the biological traits of a population become relevant factors for economic management, and it becomes necessary to organize around them an apparatus which will ensure not only their subjection but the constant increase of their utility” (p279). The importance of these ideas, Foucault states, can be linked to particular thinking and practices that subsequently emerged pertaining to ‘the privilege of child and the medicalization of the family’ and ‘the privilege of hygiene and the function of medicine as an instance of social control’. In the following paragraphs, I relate Foucault’s discussion of these ideas and how they may be linked to present day nursing thinking and practices in adolescent health promotion.

Foucault (1984f) proposes that through the medicalization of the family the correct management of childhood and I would add adolescence shifts the family to “a dense, saturated, permanent, continuous physical environment which envelops, maintains, and develops the child’s body...to organize the matrix of the new adult

individual” (p 280). As a result, the health of children and adolescents becomes one of the family’s most demanding objectives. For example, Foucault draws our attention to the numerous medical texts and journals that address themselves to the care of babies and children, particularly targeting the poor. The medicalization of the family, he suggests, is the first instance of the medicalization of individuals for the family is assigned the moral and economic costs of ensuring the good health of the social body and the general duty to embrace notions of hygiene and those scientific techniques made available by medical professionals and endorsed by the state. Moreover, Foucault argues that the program of hygiene as a regime of health for populations brings with it certain authoritarian medical interventions and controls. The doctor, he suggests, becomes “the great advisor and expert...of observing, correcting, and improving the social “body” and maintaining it in a permanent state of health” (p284). While Foucault’s arguments center on medicine and the doctor, I suggest that nurses’ aligned with both the biological view and social constructionist view of adolescence are placed in a similar position of great advisor and expert who observes, corrects and improves the social body of the young person with a view to maintaining and creating a permanent state of health.

It is not my intent at this juncture to argue that nursing thinking and acting toward the health of the ‘adolescent’ body is not useful or necessary as part of a professional practice. What I am questioning are the ways in which an interest in health may be shaped through political interests of economy and social order and the possible limits of such thinking and acting. Again, several concepts Foucault discusses in his approach to genealogy assist us in our re-thinking about adolescent health promotion.

Bio-politics

The idea of bio-politics, a second concept that that began with Foucault, and was taken up by Foucauldian scholars such as Nikolas Rose (2001) offers me a space to reflect upon a governmental practice of mass scale interventions for the purpose of maximizing life or governing practices. Within practices of bio-politics the government of 'risk' which Rose refers to as "a family of ways of thinking and acting involving calculations about possible futures in the present followed by interventions in order to control that potential future" (p7) emerges. These practices have particular importance for how I understand current thinking and actions about young people and their health particularly the confident practices of nurses in 'reducing risk' and 'promoting well-becoming'. I am suggesting that confident nursing practices are part of a larger body of governing practices captured by the notion of governmentality.

Governmentality

Foucault (1979) suggests governmentality encompasses those acts that aim to shape, mould or affect the conduct of peoples, and for the purpose of this project, young peoples. Foucault (1963/1994; 1975/1996) refers to such acts as hierarchical surveillance, normalizing judgment, and the clinical examination. Using examples from the project on which this dissertation reports I address the question: How do nursing acts in adolescent health promotion mirror those acts of surveillance, normalizing judgment, and the clinical examination and as a result, affirm or construct politically sanctioned standards of normalization or unquestioned truths about young people and their experiences?

Foucault (1963/1994; 1975/1996) suggests hierarchical surveillance to encompass those acts where one, from a position of power or knowledge, watches or supervises

another who, by virtue of the surveillance relationship, is positioned as having less knowledge or power. If I refer back to Chapter 3, and re-view nursing thinking and acts toward young people and their health through the idea of hierarchical surveillance I can locate how ideas about health promotion appear to be similar to a position of hierarchical surveillance, for example statements that suggest that adolescents “[lack] the requisite cognitive abilities for adult decisions (Christopherson & Jordan Marsh, 2004, p 101); are “a particularly vulnerable population” (Ahern & Kiehl, 2006, p 12); adolescent health requires protecting and monitoring (Abrams, 2006; Davis, 2005; Jaskiewicz, 2009). It would seem that in order for nurses to position themselves as protecting and monitoring they would have a framework from which to operate and an approach from which to act.

Again, as per Foucault’s (1963/1994; 1975/1996) depiction of governmentality, the clinical examination offers nursing a place to engage with young people and their health at the same time revealing a framework of normalizing judgment. According to Foucault the clinical examination is an act where one in a position of power examines another against standards and norms often simultaneously suggesting what norms or standards the examinee should attain. The clinical examination thus becomes a place where standards or norms are used to judge to such extent that control is exercised by others’ knowledge over individuals, as well as control exercised via individuals’ knowledge of themselves (normalizing judgment) (Foucault). Some examples from my work in Chapter 3, for example Guaio, Blakemore and Wise (2004) who argue the “imperative that screening for risk behaviours be the standard of care when an adolescent presents for a physical exam or health visit” (p 56) suggests that nursing already has an understanding of what norms the young person should demonstrate regarding their health

risky or normal. Moreover, it would seem not only are adolescents the recipient of a normalizing gaze, nursing also monitors nurses by categorizing risk screening as a standard of care. It appears that nursing practices both govern and are governed.

In the previous paragraphs, I have presented how Foucault's suggested acts within governmentality provides us with a starting point to reflect upon how nursing acts directed toward young people and their health might reflect governing practices and the way that such practices position nursing within powerful relationships in relation to the young people they care for.

Moreover, I propose that a genealogy informed by Foucault (1984d) also allows us to consider the ways in which knowledge has been linked to power. According to Foucault, "power is not an institution and not a structure; neither is it a certain strength we are endowed with; it is a name that one attributes to a complex strategic situation in a particular society" (1976/1990, p 92). Foucault further clarifies his notion of power suggesting "something that is acquired, seized or shared...power is exercised from innumerable points in the interplay of nonegalitarian and mobile relations" (p 94). Thus, guided by the ideas of Foucault in the project on which this dissertation reports, we can locate power in techniques related to discipline and normalization and within relational acts between the nurse and the young person.

In summary, as a result of my archaeological work examining adolescent health promotion I have suggested two confident nurses' practices, those of reducing risk and promoting well-becoming. I believe those confident practices are at the same time acts of surveillance and clinical examination guided by normalizing judgment. In addition, from my genealogical analysis I am able to argue that if we locate 'reducing risk' and

‘promoting well-becoming’ within the idea of governmentality, I argue that in doing adolescent health promotion nurses practice from a position of pastoral power to both survey and supervise young people in matters pertaining to their health such as acts of screening for risk. The notion of pastoral power as a technique of governmentality is captured by Dean (1999) who suggests that through various therapeutic regimes others are cared for at the same time they are shaped into an appropriate, normalized way of life. The act of screening may be best thought of as a therapeutic encounter where nurses obtain information about the young people they care for about their health and well-being. At the same time young people are sharing their thoughts and actions and through this process their awareness of their own growth and development increases as a result of the messages the nurse delivers in response to their concern. Thus, as nurses promote young peoples’ self awareness for the purposes of self surveillance they reflect a powerful normalizing judgement and as a result promote a form of well becoming that seeks to shape young people into particular types of valued citizens. In the next and final chapter, I will provide a postscript for nursing and discuss the implications of my work.

Chapter 7

Postscript

The purpose of this philosophical inquiry was to provide a means to open space to consider the political nature of nursing knowledge development about young people and their health. Consequently, I embarked on an explication of the history of the present following a critical analysis of contemporary nursing approaches to adolescent health promotion practices. To guide the project on which this dissertation reports I applied specific concepts located within a Foucauldian approach to archaeology and genealogy.

In Chapter 1, I introduced my reader to the intent of this philosophical inquiry including the parameters of the project, and the ideas that my inquiry offers to problematize knowledges that currently constitute the discipline of nursing. Specifically, I outlined the four questions that would frame my archaeology and genealogy work. Those questions: What interests and forces effected the creation of governing practices in health promotion in Canada within the 1970-1980 period? What nursing thinking and practices in adolescent health promotion came into being alongside of those scientific ideas of health promotion? Why might some nursing thinking and practices directed toward adolescent health promotion be resistant to critique and change? And, what elements of current nursing practices might change if we were to think and practice with young people differently?

In Chapter 2, I described my methodological plan, a discourse analysis informed by the assumptions within Foucault's thinking and writing about archaeology and genealogy. My purpose for this chapter was to at the same time introduce my readers to

the thinking that informed Michel Foucault's philosophical oeuvre, and to demonstrate how I would take up particular aspects of that oeuvre to inform my philosophical work. As a neophyte Foucauldian nurse scholar, I adopted and modified a framework proposed by a recognized Foucauldian scholar (Gutting, 1989) in order to provide clarity and structure to my methodological work. I was able to demonstrate a progression in thinking from Foucault, to Gutting, to Ryan as I critically interrogated texts (see Figures 1-4).

In Chapter 3, I recounted my archaeology of nursing health promotion practices in adolescent health promotion 2000-2010 in Canada and the United States. Within this chapter I (re)view nursing thinking and acting within the context of young people and their health through a process of critically interrogating truth statements and problematizing nursing thinking and acting. I began by digging out truth statements that hold currency for nursing about nurses' role regarding the health of young people guided by a broad question: What truth statements appear to shape contemporary nursing professional thinking and actions concerning young people's health? I located and presented the discursive formation 'adolescent health promotion' followed by a problematizing of how it defines conceptual possibilities for young people, nurse and health. For example, I explored in some depth how the discursive formation adolescent health promotion constitutes contemporary nursing texts, *connaissance*, from particular epistemological and methodological positions (pages 19-24, 25-29).

In Chapter 4, I continued my archaeological excavation answering the first of my four questions outlined in Chapter 1: What interests and forces effected the creation of governing practices in health promotion in Canada within the 1970-1980 period? I called

attention to what seemed to be an emergent dichotomy in health promotion thinking by 1990, one that set biomedical approaches to health and health care in opposition to socially constructed understandings of health and health care. Moreover, I suggested the evident trend of specific health promotion practices, those of health education and social marketing targeting individual lifestyle changes established by 1990. I argued that government funding and sanction both supported those health promotion practices and in turn helped to legitimize this view of health and authorized the associated health promotion practices. At the same time, arising from the textual analysis of published literature, I excavated a questioning of the legitimacy of such a narrow view into health and health promotion evidenced within the published work of a number of diverse professionals aided by such theoretical constructs as are afforded by critical social theory.

In Chapter 5, I named and discussed the implications of nursing thinking and practices that came into being alongside of those scientific ideas of health promotion. I continued my archaeological dig by answering my second question: What nursing thinking and practices in adolescent health promotion came into being alongside of those scientific ideas of health promotion? Moreover, I demonstrated via quotes from select nurses' texts how the conceptualization of health promotion sanctioned by government was argued and absorbed into routine professional nursing practices, beginning with the repetitive claim that health promotion 'belonged' with nursing. I discerned that this claim was an insular dialogue. I called attention to the ways in which nursing's adoption of a politically sanctioned view of health promotion corresponded with the profession's bid for autonomy in the health care system and a distance from bio-medical perspectives on health. I observed how this very political move by some nurses turned them away from

an already established and fairly sophisticated framework for developing nursing knowledge about people, their environment and health. The archaeological work enabled me to argue that nursing has assumed a professional role in regulating healthy lifestyle choices.

Having completed the archaeological work, I then turned my attention to the genealogical work of critically interrogating nursing thinking and acting within this particular context of health promotion.

In Chapter 6, I outlined and presented my genealogy following the oeuvre of Michel Foucault. Two confident nursing practices, those of reducing risk and promoting well-becoming are presented here. I argued that those confident practices are at the same time acts of surveillance and clinical examination guided by normalizing judgment. I then continued my genealogy work answering the third question outlined in Chapter 1: Why might some nursing thinking and practices directed toward adolescent health promotion be resistant to critique and change?

From my genealogical analysis I am able to argue that if we locate ‘reducing risk’ and ‘promoting well-becoming’ within Foucault’s notion of governmentality, we see that in doing adolescent health promotion nurses practice from a position of pastoral power to both survey and supervise young people in matters pertaining to their health (e.g. acts of screening for risk). The notion of pastoral power as a technique of governmentality is captured by Dean (1999) who suggests that through various therapeutic regimes others are cared for at the same time they are shaped into an appropriate, normalized way of life. The act of screening may be best thought of as a therapeutic encounter where the nurse obtains information about the young people they care for about their health and well-

being. At the same time young people are sharing their thoughts and actions and through the process their awareness of their own growth and development increases as a result of the messages the nurse delivers in response to their concern. Thus, as nurses promote young peoples' self awareness for the purposes of self surveillance they reflect a powerful normalizing judgement and as a result promote a form of well becoming that seeks to shape young people into particular types of valued citizens.

It is not my intent at this juncture to argue that nursing thinking and acting toward the health of the 'adolescent' body is not useful or necessary as part of a professional practice. What my analysis permits me to do is to question the ways in which an interest in health, shaped through political interests of economy and social order, impose limits on the thinking and acting practices of nurses' in their work with young people. As a result of my genealogical project, I am able to suggest how particular reasoning(s) about adolescent health promotion helps to produce particular kinds of subjective experiences. It would seem that nurses are in the process of developing an expertise in population management particularly in the promotion, protection and management of health. This view is supported by critical nurse researchers who question nursing's uptake of bio-power in their thinking and actions in relation to health promotion and suggest that thinking and acting within a health promotion discourse (e.g. economic predictors, demographic projections, epidemiological data, market studies and scientific views into the lived experience) are more often used to exact the truth about a population and justify governmental policies (see Gastaldo & Holmes, 1999; Holmes & Gastaldo, 2002; Perron, Flueter and Holmes, 2005; Purkis, 1997).

In my own work, it would seem that since the 1980's the health promotion movement has linked health to most aspects of public and private life for example, lifestyle and sexuality (sexual health). Nurses have promoted notions of self-care and self-responsibility for health and as a result have contributed to a political discourse centered on promoting the development of the good citizen, one who lives politically sanctioned healthy lifestyles.

In Chapter 7, I now (re) turn to the final question outlined in Chapter 1: What elements of current nursing practices might change if we were to think and act differently with young people? From this question, I seek to continue to problematize the confidence from which nursing thinks and acts toward young people and their health. If my work serves to disrupt that confidence, I believe it will create a space for us to consider where ought nurses' confidence toward young people be.

Consider this scenario. A nurse enters into a classroom to deliver a sexual health education class. Before she enters the classroom what the nurse 'knows' about sexual health he has gathered from epidemiology research (e.g. the incidence of sexually transmitted infections, the incidence of teen pregnancy, and the associated health care treatments and costs). Epidemiology reports might also inform him of the probable age of sexual activity for the young people in the classroom at hand. She may have concerns about how the probability of sexual activity relates to the legal definition of age of consent for sexual activity. He may have other information at hand and 'know' the socioeconomic background of the students; she may have some 'knowledge' about how social determinants of health and the resources available to counter those determinants operate within the school and community.

The nurse will have professional knowledge of best practices in adolescent sexual health, particularly in health education strategies. These will help him plan her presentation about what information young people should know about sexual health risks, the best way to deliver that information. At the same time the nurse is aware of the choices young people ought to make to minimize or alleviate those risks. The nurse enters the classroom.

A quick glance at the students and the nurse is confronted with a group of young people who present differently in physical appearance, physiological development as well as levels of comfort and engagement with the proposed topic. Perhaps his first question to herself might be, how will I account for the diversity of individuals in this presentation? However, undaunted, the nurse also ‘knows’ the adolescent. Through popular narratives (*savoir*) and scientific discourses (*connaissance*), from clinical and anecdotal stories, the instability, emotionality, present-centeredness, and irresponsibility of the adolescent remains for the most part an unquestioned discourse. For the nurse, both professionally and as a member of society, the adolescent is readily and always recognized as a population requiring regulation. At this point the young people in the classroom cease to become a group of diverse individuals and may be viewed as one, an adolescent population. Moreover, the nurse is aware that he was not invited into the classroom by the individual students or even the school administration; she is there to engage with an adolescent population at risk, not a group of individual young people with individual concerns. He has sought out the adolescent population in a place where there are already required to be present. This particular practice has a longstanding history

within health promotion where it is a safe assumption that almost 'everyone' recalls or expects the 'sex ed' class as part of their public school experience.

As she speaks, she may attribute continued observed signs of disengagement and disinterest or discomfort as typical behaviours of adolescents. He has some normative developmental knowledge that informs her adolescents are not rational or autonomous and as a result of this thinking, their ability to contribute to discussions about their health and well-being may be questioned and/or disregarded as immature, irrational or in need of guidance. He delivers her message to the best of her ability and experience, and leaves. She is confident she has met his standards of practice. He has no way of knowing how her practice has impacted the young people with whom she engaged. The teacher enters the room and the students move on to another educational requirement, such as a class in Science.

While this example has highlighted how nurses often promote health for one of the identified 'risks' associated with adolescence, sexual intercourse, there is little evidence to suggest that the same description would not apply to any nurse delivered educational session on teen suicide, school bullying, smoking, alcohol or recreational drug use. For in each case of the aforementioned identified risk, the young person is already recognizable as an object (adolescent). As a result of the categorization as object, authoritative statements continue and confirm the categorization as object (adolescent at risk) at the same time granting power and authority to the person (nurse) to act in particular ways. In turn, the authoritative statements or acts by the nurse reflect specific concepts and strategies, technologies of power, that in turn support the continued categorization of object (adolescent). What I find problematic about this thinking and

acting toward young peoples and their health is the contradiction between thinking and acting. The nurse acts out a strategy to inform the young person of risks to their health by providing information about making healthy lifestyle choices. At the same time the nurse recognizes that the adolescent as not yet fully rational or autonomous to make choices. This view continues to justify a particularly powerful technological approach to engaging with young people as one of delivering information about how they may or will risk their health and inform them about the right choices to make. As previously mentioned it is not my intent at this juncture to argue that nursing thinking and acting toward the health of the 'adolescent' body is not useful or necessary as part of a professional practice. At the same time, I am left wondering, what might be different for nurses and young people if nursing stepped out of what appears to be a contradiction between thinking and acting in the context of young peoples' health?

Perhaps a beginning for nurses to think our way out of present day confident practices is to question the ways in which an interest in health may be shaped through political interests of economy and social order and consider the possible limits of such thinking and acting on nursing practices. How might the nurse then view the young person, their health and the professional role of a nurse engaging with young people for the purpose of understanding their health? Let us consider the aforementioned example. However, in our consideration let us consider how the nurse might claim confidence in both the nurse and the young person.

In a (re) view of our example the nurse has access to the same knowledge apparatuses as previously mentioned. However, the knowledge does not serve to inform

a binary thinking. As I noted in Chapter 6, adolescence discourse questions when the individual young person might assume responsibility for their health shaping thinking about the young person as rational vs irrational, responsible vs irresponsible, mature vs immature, healthy vs unhealthy, risky vs safe et cetera. Moreover, since the 1970's individual responsibility for health has shaped health care delivery in particular ways and resulted in similar binary thinking, for example autonomy vs heteronomy, choice vs circumstance, individual vs social et cetera (Minkler, 1999). In the end, when it comes to the young person and their health, as a result of established binaries, and the notion that young people are transitioning through an evolutionary arrival to a place of (greater) responsibility I am left to wonder: When are young people ever really trusted to make responsible decisions? For it seems that the category of responsible is always somewhat suspect. I propose that nursing consider how the nurse might at the same time remain professionally responsible yet recognize the young person as also responsible.

A place to start might be with a reviewed understanding of the word responsible. In contemporary definitions of responsibility in health care, the emphasis is placed upon our understanding of personal control and self-sufficiency; we are as individuals deemed to be responsible or not by how we reflect a general understanding of what it is to be 'in control' or 'self sufficient'. However, an etymology of the word 'responsible' allows us to break the word down into the word stem. To 'respond' implies an encounter and an answer to that encounter, to respond implies we engage or relate to some 'thing' outside of us. Thus, it would seem that to be responsible, one must "... answer to an engagement or an appeal, to be opened towards the outside, towards others and to take part in the world" (Devisch, 2012, p 143). Continuing this line of thought, responsibility implies

more than one's self control or efficiency: responsibility also implies the answering to, the engagement in a social relationship.

Armed with a more philosophical view of responsibility compared to the concrete one most often encountered in health care, the nurse recognizes the young person as already engaged and taking part in the world and more importantly capable of answering to an engagement. He is able to avoid the binary thinking implicit in her knowledge and broaden his thinking how one is responsible for their own and another's health. The nurse recognizes a co-responsibility such that the responsibility for health becomes not one of the nurse or an other but the intermingling between the other and the nurse. This does not imply a shared responsibility, for that would only open up another round of binary thinking. Instead, co-responsibility creates a space for recognizing the social relationships within which one thinks about being responsible, and the fluidity of boundaries.

The nurse may now (re)consider her knowledge about those risk behaviours attributed to adolescence. He has an opportunity to ask several important philosophical questions before planning her approach to nursing care. She asks, if risk behaviour is a matter of individual choice of the young person, how is it that many young people simultaneously choose to engage in the same behaviours? Moreover, he questions if risk behaviour is related to an inability to make rational choices, how is it that many young people manage to avoid those same risk behaviours? At the same time she disengages from the lure of the individual vs social circumstance binary and (re)thinks ideas about shifting responsibility to social contexts. For in that case, the same questions would

arise; how is it that some young people with 'richer' social circumstances engage in risk behaviours, while other young people with 'poorer' social circumstances do not?

The nurse confidently engages in relationship with young people with a view to understanding the social meanings they hold about health. She recognizes that perceived risk behaviours are not simply a matter of too much or too little information delivered in the right or wrong manner. He approaches young people first at foremost as people who already have individual and social understanding about their health that may or may not be reflective of the knowledge she has at hand. She recognizes that the young person as capable of responding, answering to and engaging in relationship to her. His practical application of her nursing knowledge begins with engaging in that relationship, and acknowledging the shifting boundaries of co-responsibility. The possibilities open to the nurse surpass the deliverance of the right information at the right time via the right venue; the nurse engages with young people to understand first and foremost who they are, how they are already responsible. The nurse might confidently examine where a nursing role fits within the shifting boundaries of co-responsibility for young people's health and what acts might arise from that fit.

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