



VICTORIA UNIVERSITY
MELBOURNE AUSTRALIA

Health inclusive education

This is the Accepted version of the following publication

Corcoran, Tim (2012) Health inclusive education. *International Journal of Inclusive Education*, 16 (10). pp. 1033-1046. ISSN 1360-3116

The publisher's official version can be found at
<http://www.tandfonline.com/doi/pdf/10.1080/13603116.2010.538867>
Note that access to this version may require subscription.

Downloaded from VU Research Repository <https://vuir.vu.edu.au/24693/>

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Abstract

When considering the relevance of contemporary learning theories to health education and promotion work in schools it is necessary to inspect the kinds of discourses used therein for how they understand and thereby constitute people and their worlds. For instance, contemporary educational practices, teaching and learning included, are dominated by constructivist theory and its person-in-the-world purview. It follows that from these discourses potentials for inclusion (and exclusion) emanate helping to constitute the very form and nature of our schools. This paper contributes to an ongoing explication of existing and persisting discursive conditions in the cultural politics of education focussing on how these inform teaching and learning in health-education. By critically examining the purposes of contemporary educational practice and the theoretical precepts which support its activities we move closer to being able to realise the possibilities of a refocused kind of work. Such practice is dedicated to engaging meaning as it is applied by those in the living of their daily lives and accordingly decentres teaching and learning to enable health inclusive education.

Key words: health education; learning theory; ontology; thirdness.

Introduction

Health education (and educational practice more generally) is theoretically informed by prevailing learning theories of the day. In contemporary societies across the globe, such practice more often than not takes its direction from constructivist theories of learning (Bandura 2005; Davis and Sumara 2002; Donald, Lazarus and Lolwana 2006). It could be argued much has been gained from theoretical advancements to constructivism. Firstly, understanding has moved beyond behaviourism addressing criticisms that such theory ignores meaning making in human action. Secondly, such knowledge advances beyond high cognitivism with its focus on the individual as a concealed information processing system analogous to the computer. Briefly put, constructivism is a broad ranging theory of the person making meaning of the world (Kelly 1955). It does not eschew its theoretical predecessors but rather integrates parts of each framework in a cognitive-behavioural model of individual action.

Interestingly though, the practice of education is today recognised as an important social determinant of health (Galbally 2004; hereafter SDOH). Navarro (2009, 15), speaking here about health education, partially pre-empts the theme of this commentary when he acknowledges:

We have plenty of evidence that programmes aimed at changing individual behaviour have limited effectiveness. And understandably so. Instead, we need to broaden health strategies to include political, economic, social and cultural interventions that touch on the social (as distinct from the individual) determinants of health. (emphasis in original)

Whilst this is a critically important admission, herein I argue that recognition of education as one social determinant of health (along with employment, poverty, etc.) is but an initial step in a broader challenge. Acknowledgement of SDOH cannot fully enable the degree of political, economic, social and cultural change health promoters and educationalists seek because of an enduring implicit theoretical paradox supporting such work. To elaborate, in the first part of this paper I pose the following question: If teaching is seen as one of the fundamentals to health promotion in schools, has our reliance on learning theories dedicated to psychological individualism been a contributing factor to the kinds of limitations Navarro points to? I argue the affirmative. Then, in the second part of the discussion, I turn to explore what learning theories need to do to better support health-education practices so as to justifiably realise education as a sustainable and equitable social intervention (Smith and Barr 2008). This is an important distinction to make. At the heart of this discussion is not a comprehensive review of current health promotion theory. Rather, it is an engagement in life-enacted learning (Corcoran 2005), a situated, responsive and dialogic activity, one explicitly committed to the practice of health inclusive education.

Politics & Education

In referring to education here I am specifically concerned with mandatory State directed systems and institutions. In lay terms these would be recognised as elementary and high schooling in the US (varying by state), primary and secondary schooling in Australia or Key Stages 1, 2, 3 and 4 in the UK. Because many schools are controlled by political authority it is vital that we attend to relationships created between knowledge and power. As Foucault's critical observations gleaned, in the past 200 hundred years western societies have seen significant shifts in State authority developing 'a new relation between politics as a practice and as knowledge' (Foucault 2000, 407). Paralleling changes in political power, the world has witnessed the formulation and formalisation of the human sciences (e.g. psychiatry, psychology and sociology). The mutually sustaining relationship between knowledge/power sees the continued development of certain knowledges which aim to objectify humanity by producing explicit norms used in the governance of human activity (Rose 1999). In the case of health education, these socio-political norms are actively embedded in what is taught in schools. In this light, Lambeir and Ramaekers (2008) include socialisation and curriculum as two aspects in what they call the educationalisation of health. In direct reference to curriculum design, they point to how 'something is being educationalised in the sense that it is being transposed, or displaced to a formal educational setting. Something is made part of the curriculum – which means that it is transfigured as an object of learning, as something one can (and should) learn about...' (438).

To suggest that a main purpose of education and schooling is to enculturate young people in the norms and practices of communities has been acknowledged since Antiquity. Nevertheless, concerns over political interventions by governments (and those involved in knowledge production) in education around health-related topics are present (Craig 2007; Furedi 2009). These criticisms speak to the idea that something (to continue Lambeir and Ramaekers' terminology) is being driven furtively into schools and it is something that could be counterproductive to the very people it is intended to help. Ecclestone (2004) believes that a pervasively emergent approach to learning, based on a 'diminished' understanding of people, is shifting views in education. She foresees that:

...preoccupation with vulnerability and psychological damage makes three side effects more likely. One is that more students and educators come to believe that people deemed to be marginalised or disaffected from education are unable to cope without support. The second is to shift attention from inequality outside and inside the education system to a focus on people's feelings about it. The third is to lower aspirations for achievement if this involves struggle, risk or challenge. (118)

Such criticism I find difficult to accept for three reasons. First, it seemingly fails to comprehend the generative possibilities of contemporary education, in particular the potential

benefits that come from health promotion work in school communities. This work, as many health and education professionals know, can deploy across a range of applications from school health promotion and prevention activities involving all community members (i.e. school staff, students and their families) to individual intervention. As Ecclestone would have it, a 'preoccupation' with inclusive education short-changes the potential capacity of marginalised or disaffected populations. This is an interesting point and one which reminds practitioners to never predetermine the capacities of those with whom we consult. Nonetheless, focussing solely on one point along this continuum (i.e. individual intervention) is unnecessarily myopic. Secondly therefore, discourse of this sort fails to acknowledge the variety of ways in which education, particularly around aspects of supportive and collaborative health-education intervention, can contribute to SDOH. How else could we separate our attending to lived inequalities (i.e. inequalities present either/both inside and/or outside school that promote marginalisation) from our experiences of such? This simplistic account glosses over valuable contributions linking daily life to SDOH. Thirdly, and ultimately, the line that I pursue in this paper contends that views like Ecclestone's cannot be accepted because they are based on the same prevailing discourse of psychological individualism that I am concerned impedes the work of committed health educationalists.

Psychology & Learning

Constructivist theories have been heralded for how they position the person as an active participant in learning processes and for acknowledging the social situatedness of learning (Lave 1996). Certainly this sounds encouraging if one is interested in seeing developments leading to learning being premised in relationally-oriented psychosocial action (Grenier 2010). However, close scrutiny of constructivist first principles highlight the fact that psychological individualism remains its *raison d'être*. For example, contemporary learning theories (and associated institutional discourses) commonly refer to student or learner-centred approaches (see e.g. Biggs 1996 or Cornelius-White 2007). Here, the person-in-the-world purview of constructivism is enacted when, as 'students gain a deeper conceptual understanding, they learn facts and procedures in a much more useful and profound way that transfers to real-world settings' (Sawyer 2003, 4). There are two fundamental concerns to be raised regarding the way in which knowledge has been conceived under the terms of psychological individualism. First, as knowledge is objectified it loses moral and ethical specificity – its personableness if you like - becoming indiscriminate and static and second, when knowledge is seen as such it is considered functionally transmittable and able to be located within the individual. Let us consider these points further.

The 'deeper conceptual understanding' referred to above speaks to the constructivist view of cognitive structures or mental representations people are said to possess and use when thinking (Neisser 1967). Presumably, as one becomes more knowledgeable, one's mental abilities expand in capacity (or depth). For example, health educators can teach students about the established benefits of certain food groups to assist in informing the choices made at the tuck-shop (Shepherd et al. 2006). This ability is subsequently said to be transferred from thought to action when performing a particular task e.g. like choosing a meat pie or a salad sandwich. Thus, in the space between what is considered to be public fact and private

cognition, objective or scripted knowledge can seemingly be transmitted, stored and deployed if and when it is required. To some this may seem like an overly mentalistic account of constructivism but such admission does not negate the fact that this is how, particularly in educational contexts, the theory is operationalised. In contrast, Davis and Sumara (2003) vigorously claim that constructivism has been misunderstood and they provide a notable (if not fateful) example to demonstrate their point. When undertaking collaborative research with elementary and middle school teachers they realised that their own understanding of constructivism, focussed on process-oriented aspects of learning (i.e. acts of ongoing construal rather than building cognitive scaffolds), was often missed by teachers whose focus instead was on the transference of knowledge via teaching. As such, the teachers co-opted constructivist discourse in support of representational accounts of cognition. These kinds of accounts, similar to the description provided by Sawyer above, assume that knowledge of an external world beyond the embodied individual can be without too much effort represented in the individual's thought and/or memory. The teachers were it would seem employing a 'banking' model of education (Freire 1970) whereby the task properly engaged sees the teacher depositing externalised knowledge into student's internalised cognitive space. The commonly used term 'memory bank' services this kind of discourse. Davis and Sumara (2003, 137) lamentably concluded: 'The decisions of many to ignore broader structures and collective dynamics as they focus on isolated topics and individual learners seem to have contributed to a deeper entrenchment of the assumptions that disciplinary knowledges are amoral and schooling is a benign (if not beneficial) project'.

In the Introduction I made the point that this discussion was not necessarily a review of contemporary health education and promotion theory. That said, it may be relevant here to briefly acknowledge developments in the area to consider whether the kinds of psychological discourse they employ offer authentic alternatives to models fixed to ideological individualism. For instance, recent work in the field points to the theorisation of social context in understanding health behaviour (Burke et al 2009). Also, the literature acknowledges the use of ecological perspectives in health promotion programming (Potvin et al 2008). But yet, as I have been arguing in relation to learning theory, the prevailing model of personhood in health promotion work continues to rely on person-in-the-world constructivism: 'The trajectory of theory, then, can be viewed as moving from a paradigm that places emphasis on the individual as the primary agent of change to a paradigm that conceptualises the individual as enmeshed in a complex system of influences that ultimately shape behaviour' (Di Clemente et al 2002, 7). The disciplinary knowledges Davis and Sumara refer to above are infused with power more often than not producing normative outcomes. Put simply, the knowledges people live by (e.g. employing psychological individualism as the dominant discourse regarding human being), maintain a certain sociopolitical status quo and cannot be accepted as either amoral or benign. Such recognition lies at the heart of inclusive education and will be discussed in detail below. As a final point here, Welle, Russell and Kittleson (2010) outline five philosophies said to underpin health education and these include cognitive-based, decision-making, behaviour change, freeing/functioning and social change approaches. If there were any question regarding the prominence of constructivist theory in health education one only need recognise the dominance of cognitive-based (i.e. information dissemination) and decision-making (i.e. teaching thinking skills) approaches manifest in current school-based health education practice.

Taking these considerations into account I return to the declaration made at the beginning of this article. Whilst Navarro's statement reasonably calls for communities to attend to SDOH it does so without addressing discourses of learning informed by psychological individualism. If we are to scrutinise underachievements in health education practice this is one crucial area where our attention should be focussed. These are, as I have outlined, learning practices more often than not intended to start and finish with reductionist and disjoined views of human being. Acknowledging this goes to further explicate the theoretical paradox which began this paper. What I have been suggesting is that much of what accounts as health education is informed by curriculum, pedagogy and assessment aimed at individual behaviour change, attempts to effect such change via building cognitive capacity and does so within normative frameworks wherein issues of power and morality are more often than not left undisturbed.

Scrutinising health education

Health education's normative agenda continues to attract scrutiny. Ecclestone (2004, 122) warns of the dangerous rise of 'therapeutic education', which includes aspects of health education (e.g. Social Emotional Aspects of Learning [SEAL] in the UK), as being 'a retreat from positive individualism to interest in people's emotional and psychological weaknesses'. As suggested above, this view of education remains circumscribed for several reasons, one of which being that it fails to engage the scope and range of activities involved when health and education practice collaborate in schools. Such debate is also inextricably informed by how we see or understand knowledge. The discussion in this instance is founded on an age-old distinction made today mainly by psychologists which engages human being as principally couched in terms of cognition and/or affect. It may come as surprising that Ecclestone and Hayes (2009, 153) are comfortable with suggesting that it is 'obvious that emotions are involved in teaching but primarily with the intention and not with the content of what is transmitted'. However, what this unsurprisingly means - as this position stands behind current dominant discourse in learning theory - is that knowledge should remain inherently objective (i.e. content-driven and cognitively apprehensible) thus able to be known apart from any emotional (read affective) perplexity. It is a short step from extricating emotionality from teaching to also seeing education, as Davis and Sumara warned above, as morally neutral activity (see also Campbell 2008).

Another resonant point stemming from Ecclestone and Hayes' position is that knowledge exists as static and value-free content to be 'transmitted'. Once again from the banking premise (Freire 1970), knowledge existing in thought is suggested to move or be transmitted from one person (e.g. teacher) to the next (e.g. student). To contest this view would seem to some, nonsensical. If human thought does not exist within a person, where then does it exist? Of course, questions like these prove difficult to answer in the limited space available here. Nevertheless, for the purposes of the present discussion a rejoining question could ask: Is it important to physically locate thought (cf. Susswein and Racine 2009)? Consider the possible potentials if dominant views were to be reconsidered in this way. For starters,

knowledge need not be deterministically aligned with either cognition or affect and in doing so would no longer automatically service discourses of contained individualism. By reconsidering ideas concerning the locatable existence of knowledge we could move to understanding knowledge as praxis, in the form originally suggested by the ancient Greeks whereby knowledge is applied amenably in practical activity (Aristotle 1992; Tountas 2009).

A response to the challenge Navarro sets cannot simply be to refocus attention from individual to structural interventions. Whilst there is obvious benefit to including within curriculum what is known as SDOH (i.e. knowledge concerning how issues like education, poverty or economics affect life potentials), broader scope for change calls for development in learning theories and teaching practices. First, these would need to incorporate conceptualisations of both individual and collective action and yet also be able to move beyond the dichotomy. This does not mean that we need remove the person from learning or social action. With so many cultures in our world tied to ideological individualism it would be difficult to envisage how such an option could be possible. No, instead, in focussing on practical activity ('how to go on' in Wittgenstein's [2001] terms) and the knowledges that inform its accomplishment, examination turns to understand responsivity within praxis. Here we can talk of a psychology premised on an ontology of activities rather than one defined by inferred possessed substances (e.g. cognition; cf. Harré 1995 or Shotter 1993). A brief example should help to illustrate the point.

Whilst practicing as a psychologist, at first in prison and then in schools, I was perplexed by how governments understood it that retributive punishment can and should be used as a primary means for changing behaviour. One example of this was (and remains) the practice of school exclusion. I was uncertain exactly what was to be gained from excluding a student who was already experiencing difficulties (academic and/or relational) at school (and often too at home or in their community). When engaging the student, an ontology of substances would subsequently be invoked as professional practices and the psychological discourses surrounding students created a deficit-based understanding of the person (Corcoran 2003). In effect, the student possessed an 'anger management' problem or his (more often than not) motivation to learn would be called into question. Conversely, and to this day, I wonder how educational practice informed by an ontology of activities would play out? A preliminary consideration I felt would be that practices of exclusion (and inclusion for that matter) would need to be explicitly considered for how they enact potentials for prospective action. Not only should educators be attentive to the temporality of life-long learning, they should also heed the relevance of process orientations to education or what I have previously called life-enacted learning (Corcoran 2005). Such concern moves the current discussion to directly address the notion of health inclusive education.

Health inclusive education

Thus far I have employed a subtle distinction when referring to health-education. I do so to draw attention to the relationship of what has been (the hyphenless) and what could be (the

hyphenated) envisaged between health and education. Past efforts in the field of health education have seen individuals come to this work primarily from their own separate disciplines i.e. as health professionals or educationalists. In schools, more often than not it is a case of the latter as educators deliver health-related content via the curriculum. There are instances of the former, as was the case over the 8 years I worked as a school-based psychologist. In this work I was continually frustrated with the exclusivity of disciplinary bias. For the life of me I could not understand why health-education was not second nature to the work of health promoting schools. In this section I will extend my discussion concerning how we come to understand and apply health-education. This is a kind of prospective work explicitly aimed at enabling equitable and sustainable ontological forms of discourse and one which creates a special mode of transdisciplinary enterprise.

Jensen (1997) outlined what he saw as two paradigms within health education. On one hand, there is a 'moralistic' paradigm described as pedagogically didactic and content driven, offering no opportunity for students to engage their own ideas about what health might mean within the gamut of their own lives. The alternative, a form of 'democratic' health education, was based on a holistic concept of health, geared to practical activity and welcoming active participation in learning. However, absent from Jensen's reconceptualisation was a view of the psychosocial able to promote the kind of learning anticipated and hoped for as 'democratic'. To this point, more recently Stenner and Taylor (2008, 431) contend:

A transdisciplinary psychosocial studies would deal with the space 'between' and would be inclusive enough to move between the abstractions of different sciences, noting their necessary exclusions, whilst simultaneously taking into account the situated personal knowledge and experience of non-specialists and other forms of subjugated knowledge.

In turning our focus to practical activity we require, as I have been calling for here, a form of health-education that is able to both incorporate and move beyond individualistic and disciplinarily-monologic frames of reference. As Stenner and Taylor (2008, 423) propose: 'The challenge is to invent new ways of thinking the social and the psychological together rather than separately and hence to recognise the extent to which they are distinct aspects or expressions of a unified process'. The kind of practical activity I refer to is nothing out of the ordinary...and yet it could be. It is a kind of life-enacted learning that constitutes what Wittgenstein (2001) called our 'forms of life' and herein lies the ontological aspect of health inclusive education. These are unified (though not uniform) processes which help to direct how it is that a member of society or community should act in any given situation. In relation to health-education, these are knowledges which have the potential to guide us in more explicitly equitable and sustainable forms of life. Of course, they also can potentially disjoin us from the world and our relationships as is the case with most dominant forms of psychological theory, constructivism included.

Heterotopic approaches to psychosocial action enthusiastically enable options or alternatives to understanding, providing accounts which are inclusive of possibility, engaged historically and activities which promote dialogic relationships (Corcoran 2006). Let us consider three examples of this kind of work. Almost a decade ago Crossley (2001) provided an incisive discussion of how mainstream psychology constitutes knowledges relating to behaviours understood as 'healthy' or 'risky'. The discipline does so, she argued, through interventions focussed on the delivery of information and training skills. The concern Crossley highlighted is that this kind of approach, akin to the banking model of education, facilitates a one-size-fits-all method and in doing so poorly engages questions of meaning, value and identity for those for whom health education and promotion is intended to serve. As Crossley suggests, 'people's ideas about health, illness and disease have their own rationality – a rationality which arises out of the circumstances in which they live their lives and out of interactions with others which create a sense of morality, values, or an orientation to "the good"' (2001, 170).

Similarly, in his insightful work regarding resilience, Ungar (2004, 139-140) notably observed: 'We seek in our children, both boys and girls, a fanatical desire for them to be conventional without attention to their (and our own) discourses of resistance. Efficacy in social relations that give voice to this resistance is closely linked to experience of competence, whether that competence is expressed prosocially or problematically'. As health professionals, educationalists and many parents well know, regardless of age, people do not always make the kinds of choices deemed appropriate according to the benefits of established knowledge. According to Ungar, young people, particularly those seen to engage in 'high risk' behaviours (in relation to health these might include smoking, drug and/or alcohol use, law breaking, and so on), may in fact be doing what they can given available resources to define themselves in ways they consider fit for purpose. Might Crossley's and Ungar's perspectives offer vital insight into the relative underachievement of health education?

Finally, continuing with the notion of 'risk', Zyngier (in press) appeals for educational practices that problematise meaningful student and teacher engagement when each participates in learning. Paralleling the call I made in the previous section for responsivity within praxis, this form of activity he terms 'pedagogical reciprocity'. Zyngier explains:

The struggle over the definition of risk is significant in itself for it reveals the on-going ideological and epistemological divisions among educators and policy makers, as well as the general public. Research on student risk has shown that an exploration of the questions of class, power, history and particularly students' lived experiences and social reality reveal a complexity of factors that lead marginalised youth to leave school prematurely. It is therefore crucial that questions of power, equity, and engagement with difference be addressed if we are to improve (learning) outcomes, not just for the most marginalised youth, but for all (my emphasis).

It should be stressed that health inclusive education would purposively avoid targeting and segregating certain sub-populations and individuals on the basis of perceived needs or risks adjudged against psychological or social normativities. Often, these reductionist accounts act to disable young people as public knowledge of their capacities become subsumed within diagnostic categories like Attention Deficit Hyperactivity Disorder (Graham 2008), autism (Billington 2000) or depression (Nylund & Ceske 1997). However, a dilemma then presents when discourses of disablement and psychopathology are intrinsically tied to teaching and learning resources. Whilst acknowledging difference, the pragmatic and ethical imperative (and challenge) is to work with and against the available discourse without losing sight of what is meaningful to all involved (cf. Hayes 2003).

Following Slee (2008), I see inclusive education writ large, fundamental to the cultural politics of education and the ongoing reconstitution of the nature of schooling. However policy and practice in the area are defined, these should indubitably share a common purpose – to strive for equitable social change by enabling prospective action across all forms of human being. And so, extending Stenner and Taylor's position I envisage health-education, as a means to health inclusive education, promoting:

- a) differing disciplinary standpoints or knowledges yet looking for opportunities to occupy spaces between wherein unique forms may be known;
- b) the situatedness of knowledge yet accepting applicability across contexts;
- c) respect for heterogeneity and homogeneity in the commotion of what it means to be human (e.g. age, gender, ethnicity, etc.);
- d) practical and active participation whereby one is always acknowledged as being in relationship with another; and
- e) peoples' ongoing ability to resist, affirm and/or reconstitute being.

In relation to teaching practice compelling similarly focussed developments have occurred looking to elaborate a 'third space' in teaching and learning. Third space, according to Gutiérrez (2008, 152), 'is a transformative space where the potential for an expanded form of learning and the development of new knowledge are heightened'. Borrowing ideas from cultural (Bhabha 1994) and literary (Bakhtin 1986) theory, third space is created when joint action (Shotter 1995) sponsors hybridisations of meaning. As Bhabha (Rutherford 1990, 211) observes: 'The process of cultural hybridity gives rise to something different, something new and unrecognisable, a new area of negotiation of meaning and representation'. When teacher and student meet in third space, 'a deterritorialisation of one's consciousness from the inside of one's self to the outside, or into a Thirdspace between self and the Other' (Kostogriz 2006, 186) occurs. Such 'deterritorialisation' is what I have been arguing is required for learning theory to enable an ontology of activities. It is to an explicit recognition of relational joint action which I now turn for discourse on its theorisation further envisages the potentials of health inclusive education.

Health-Education's contribution to thirdness

According to Shotter (1995), life is a constantly engaged form of responsive activity or joint action. Most importantly for considerations around psychosocial theory and its use in health-education, such activity not only involves you and I (as in the commonplace constructivist self-centred dyad), it also entails a third participant. This is an important consideration which has been given insufficient attention in learning focussed discussions to date (cf. Cheyne and Tarulli 1999 and Eun, Knotek and Heining-Boynton 2008 for exceptions). Shotter elaborates: 'although invisible, the real presences generated in our active relations with our surroundings have agency, and, like another person, can exert that kind of personal force upon us' (Shotter 2003, 5). Supporting this view, previously I have discussed the theoretical differentiation of first and second nature accounts of human being (Corcoran 2009). How these contribute to understanding joint action in health-education and its relevance for what is discussed as thirdness is set out below.

First nature accounts are those generated via dominant knowledging practice that historically have provided concretised and static forms of being. This is the kind of substance oriented view of ontology I mentioned above. Within this kind of knowledging practice we find the means by which professionals (e.g. educational psychologists and teachers often as representatives of State authority) adjudicate students' abilities in relation to their performance inside normative frameworks. Whilst there are arguably valid reasons supporting such practice these often lead to less than equitable, pathologising and disenfranchising outcomes for young people (Wyn 2009). To move toward understanding and incorporating the relevance of joint action and thirdness to health-education those involved in the field must begin to explore second nature accounts of human being. Knowledge in this sense is always provisional as it endeavours to recognise how issues of meaning and power act upon us to constrain perspectives about who we are and what we are able to do. Because knowledge is provisional does not mean its reach need be limited. The social, political and cultural adaptability of knowledge is a pragmatic concern often left implicit in relationships. Also and more importantly, such provisional knowledge can help to enable us to promote what is valued and meaningful to our sense of personal, relational and collective wellbeing. Again, this is a matter of pragmatics. What I am highlighting here is a direct and immediate challenge to practices in education, learning theory and curricular design and involves the need to acknowledge the capacity each has to contribute to thirdness or the 'real presences', as they are and are yet to be known. To achieve this, as I have argued, we require theory able to accommodate both first and second nature accounts of human being.

Acknowledging thirdness is of critical importance for changing future learning practices because, unlike objectively driven, individualistically-centred, person-in-the-world explanations which more often than not leave issues of ontological constitution implicit, within second nature accounts, it is explicitly recognised that knowledges are constituted in processes of relational responsivity and that these are primarily validated within discussions of what values mean for being human. Shotter (1995, 78) summarises this point saying:

...the 'grounds' for our claims to knowledge ultimately are to be found in who we 'are', in our forms of life. For it is in our socialisation into certain ways of being that we learn how to do such things as making claims, raising questions, conducting arguments, sensing disagreements, recognising agreements, and so on. These ontological skills – these ways of being a certain kind of socially competent, first-person member of our society – are necessary for there to be any questions, or arguments, at all.

Here we are invited to acknowledge, as Dewey (1990) did over 100 hundred years ago, an ontological imperative to education which actively helps to create our worlds and who we see ourselves to be in those worlds. As already suggested, these are moral and ethical contexts within which we learn and experience success and failure, praise and admonition. And yet, despite recognition for their negotiated nature, adjudications regarding healthy behaviour are more often than not dominated by those with the power to speak above others. Teachers, health professionals, one's role matters not. Whilst these positions are socially charged with authority such acknowledgement does not, by proxy, equate to their decisions moral or ethical (qua natural) validation. The dominance of certain discourse in such decisioning could mean that, for any number of reasons (economic, political, relational, organisational, etc.), members of our communities (e.g. children, young people, teachers or health professionals) have been negated the opportunity to voice preferred ways of being or, that in their attempts to be heard, a person's vociferousness is adjudged 'risky' or ignorant of normative standards.

This is not a naive call for disquieted voices to be raised for to do so only perpetuates the practice that the loudest voice holds sway. Rather, this is a call to go beyond understandings of Vygotskian (1978) socialisation by proximity – learning in health-education simply cannot be accomplished by proxy! This claim may be queried by activity theorists whose uptake of Vygotskian constructivism aligns more with the position of Davis and Sumara referred to above and less to the concretisation of knowledge and disjointed explanations of social action (cf. Daniels and Cole 2002). Nevertheless, notions around pragmatism play a central part in second nature reconfigurations speaking directly to issues of equity and sustainability in contemporary communities. To extend the point implied in the previous paragraph, social authority is more often than not understood to be natural because of the pragmatics involved. If health-education is to be truly democratic it must attend to and rebuke the implicit nature of knowledge/power. In doing so, knowledge becomes the servant and not the master of the forms of life we envisage for ourselves and future generations. This kind of knowledge is sustainable because it is constantly under review by those it serves. But there is a responsibility here that cannot be avoided or denied. It is a practical moral responsibility to those with whom we share our lives. Because knowledge is shared in this way it distinctively sustains who we are, letting us know what is not permissible or beyond our present means yet still allows us to reach for our dreams, seek out our hopes and willingly pursue our desires. Admitting that health education has underachieved is not admitting failure, it is the first step to change.

Conclusions

In this commentary I have acknowledged how societal norms are purposively embedded in educational practices. As participants in democratic states, we should together argue and closely scrutinise our institutions and their related practices. It is through this kind of participatory engagement that people come to imbue within these practices a sense of themselves and the values they want institutions to adhere to and promote. Particularly in the field of education, debate can (and I argue should) invoke an unsettling of one's sensibilities – an ontological crisis of sorts (Thomson 2005). For educators and those educated, such experience shows commitment, investment and purchase in the presence of the activity and also suggests how and in what ways learning practices can be enabled for future change. Health inclusive education goes beyond the appearance of curricular containing objectified health related knowledge delivered by teachers to students. To participate in health inclusive education school staff, students, families and learning communities must actively and purposively engage not only what it means individually and collectively to be healthy but also, and probably more pragmatically important, how becoming healthy (i.e. change) within these forms of life can be sustained.

I have intentionally avoided use of a term common to discussions of this kind, that which discusses the 'hidden curriculum' (Apple 1971), for I believe we must progress dialogue past the deconstruction of societal practice to offering ways to reconstruct our daily activities. Whilst helpful to the cause, it is not enough to merely point to what is implicit without providing a means to engage an alternative. Instead, the kind of relationally oriented psychological understanding Shotter provides connects with Deweyian ideas concerning the ontological purposes of education to offer us another option. By following leads such as these we proactively position ourselves, moving toward more equitable and sustainable theories, discourses that responsively engage what being human means to the practical activity of learning in inclusive healthy communities.

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