Giornale Italiano di Educazione alla Salute, Sport e Didattica Inclusiva / Italian Journal of Health Education, Sports and Inclusive Didactics - Anno 6 n. 1 - ISSN 2532-3296 ISBN 978-88-6022-436-1 - gennaio - marzo 2022 - CC BY-NC-ND 3.0 IT- https://doi.org/10.32043/gsd.v6i1.485

HEALTH AND WELL-BEING PEDAGOGY

PEDAGOGIA DELLA SALUTE E DEL BENESSERE

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Abstract

The purpose of this article is to analyze the relationship between health, pedagogy and well-being. The World Health Organization (WHO) defines "health" as a "state of complete physical, mental and social well-being and not simply the absence of disease." Except for individual determinants, it is understandable that health is related to the condition of the population. In the first paragraph we refer to the concept of health in its different forms, then we move on to the analysis of the concept of well-being. The third paragraph focuses on the role of motor activity as an indispensable element for achieving a state of well-being.

Lo scopo del presente articolo è quello di analizzare il rapporto tra salute, pedagogia e benessere. L'Organizzazione Mondiale della Sanità (OMS) definisce la "salute" come uno "stato di completo benessere fisico, mentale e sociale e non semplicemente assenza di malattia". Fatta eccezione per i singoli determinanti, è comprensibile che la salute sia correlata alle condizioni della popolazione. Nel primo paragrafo si fa riferimento al concetto di salute nelle sue diverse declinazioni, poi si passa all'analisi del concetto di benessere. Il terzo paragrafo si sofferma sul ruolo dell'attività motoria quale elemento indispensabile per il raggiungimento di uno stato di benessere.

Keywords

Well-being, health, pedagogy

Benessere, salute, pedagogia

Introduction

The concept of well-being, thanks to the introduction of new concepts of a pedagogical nature, has now been enriched with new elements that have determined the birth of the pedagogy of well-being.
Hence the meaning and development of this new trend based on the conviction that through the implementation of particular educational relationships, it is possible to help individuals to generate positive and proactive behaviors and attitudes towards life and their existential well-being. At the base of this perspective is grafted a concept of health strongly imbued with social meaning for which any program of reception, assistance, care, therapy and educational treatments, aimed at maintaining health and pursuing the psycho-physical well-being of the

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individual, should provide for a particular attention to the socio-relational dimension. In other words, it is necessary to think of the person in a solo sense, since the state of well-being is determined by an articulated interweaving of factors that require a global management of the subject. For this reason it is useful to arrive at an ecosystem concept of health, in the wake of the ecological theory of human development, based on the idea that the health of the individual is the result of the balance between multiple subjective dimensions in interactive relationship with the surrounding environment.

1. Health and science

The World Health Organization (WHO) defines ‘‘health’’ as a ‘‘state of complete physical, mental and social wellbeing and not merely absence of disease.’’ Except for individual determinants, it is understandable that health is fickle in connection with continuous mutation of population conditions (Antonovsky 1987; WHO 1986). The WHO, in the Ottawa Charter (WHO 1986), codified for the first time the concept of ‘‘health promotion,’’ as ‘‘a global process of enabling people to increase control over and to improve their health, based on the planning and implementation of all possible’’ (WHO 1986). It is scientifically proven that healthy lifestyle, based on a balanced diet and constant practice of physical activity, promotes maintenance (primary prevention) and/or improvement (secondary and tertiary prevention) of health (Belfiore et al. 2018). Public health/collective health is generically defined as the field of knowledge and institutionally organized practices aimed at promoting the health of populations. One problem is that public health defines itself as responsible for health promotion, while its practices are organized around disease concepts. Another is that his practices tend not to consider the distance between the concept of illness (a mental construct) and getting sick (a lived experience), thus replacing one with the other. Edgar Morin, in O Problema Epistemológico da Complexidade (The Epistemological Problem of Complexity), points out that a concept cannot adequately replace something much more complex. He relates complexity to the "difficulty of thinking, because thought is a struggle with and against logic, with and against the concept"; that is, the "difficulty of the word that attempts to grasp the inconceivable and silence". The word, although it is an elaborate form of expression and communication, is insufficient to grasp reality in its entirety. Human thought has developed in two directions: towards depth, reduction and narrowing, and towards breadth, inclusiveness and the extension of borders. Modern scientific thought tends to reduce, taking up the challenge of achieving maximum precision and objectivity by translating events into abstract, calculable and demonstrable patterns. Scientific thought was presented with the challenge of fighting for breadth, of valuing an understanding of the interaction between the parts, towards unity and totality. Health and getting sick are ways in which life manifests itself. They are unique and subjective experiences; words cannot recognize them and mean them entirely. Yet the sick use words to express their illness. Doctors also use words to give meaning to their patients' complaints. In the relationship between the concrete event of getting sick, the words of the patient and those of the health professional, a tension arises that leads back to our main question: the tension between the subjectivity of the disease and the objectivity of the concepts

that assign meaning and propose interventions to face that experience. The medical-scientific discourse does not contemplate the broader meaning of health and getting sick. Health is not an object that can be constrained within the field of objective knowledge. It does not translate into a scientific concept. The same applies to the suffering that characterizes the disease. Even Descartes, considered the first to formulate the mechanistic concept of the body, recognized that some parts of the living human body are accessible exclusively to the owner. This aspect was considered and analyzed in depth by Canguilhem in *Le Normal* et *le Pathologique*. In a more recent study, this author affirms the concept of health as vulgar - which has to do with each of our lives - and a philosophical question, distinguishing it from a scientific concept (Dorsch et al. 2016). Nietzsche, for whose philosophy vital things provide a basic point of view, states the following in relation to medicine and philosophy, revealing the breadth of all that is evoked by the term health: "I am still waiting for a philosophical doctor, in the exceptional sense of the word - a doctor who deals with the general health of people, time, race, humanity - which even once will have the spirit to bring my suspicion to the limit and venture the proposition: all philosophizing to date has not had to do with the "truth" but with something else; call it health, future, growth, power, life... " (Nietzsche,).This approximation of medicine, literature and philosophy proves that, as Edgar Morin pointedout, objectivity cannot exclude the human spirit, the individual subject, culture and society. Medicine was also considered an art. However, during its historical development it tended hegemonically to identify with a belief in the omnipotence of science-based technology. The gap between the singular experience of health and disease and the opportunities for knowledge of that experience has not been adequately recognized. This has led to a major problem in historically shaping the use of scientific concepts to instrumentalize health practices. Scientific truth predominates almost exclusively in representations of both reality and (especially) health practices. Unlike literature, scientific thinking distrusts the senses. In the development of a scientific concept, immediate contact with reality appears as a confused and provisional datum that requires a rational effort of discrimination and classification. Pedagogy and literature have always been complementary to medicine, albeit marginally. When the primacy of scientific objectivity is questioned today, it cannot be proposed to implode these frontiers in order to build a unifying discourse.

2. The concept of well-being

The WHO definition links health explicitly with wellbeing, and conceptualises health as a human right requiring physical and social resources to achieve and maintain. ‘Wellbeing’ refers to a positive rather than neutral state, framing health as a positive aspiration. This definition was adapted by the 1986 Ottawa charter, which describes health as ‘a resource for everyday life, not the object of living’. From this perspective health is a means to living well, which highlights the link between health and participation in society. A major criticism of this view of health is that it is unrealistic, because it ‘leaves most of us unhealthy most of the time; few, if any people will have complete physical, mental and social wellbeing all the time, which can make this approach unhelpful and counterproductive (Sparling, 2000). It fails to take into

account not just temporary spells of ill health, but also the growing number of people living with chronic illnesses and disabilities. Furthermore, it might be argued that focusing on 'complete' health as a goal contributes to the over medicalisation of society by pathologising suboptimal health states. Ascione et al. (2018) proposed a new definition of health as 'the ability to adapt and to self-manage', which includes the ability of people to adapt to their situation as key to health. It also acknowledges the subjective element of health; what health and wellbeing mean will differ from one person to the next, depending on the context and their needs. This is considered by many to be a limitation of broader definitions of health, on the grounds that wellbeing is neither objective nor measurable; this is discussed in more detail below (Mental health and wellbeing). A further limitation of this approach is that it is very individualistic and takes little account of the wider determinants of health. Responsibility for health is seen as individual rather than collective, with little scope to promote it as a human right.

3. Pedagogy and Motor Activity

Everything concerning the educational problems related to Motor Activity falls within the field of study of Sports Pedagogy. According to Isidori (2009), it is from the need to "... renew and update the discourse on the pedagogical implications related to motor and sport activities in contemporary society, and to provide greater scientific credibility to Pedagogy applied to the field of Sport..." that Sports Pedagogy has undergone an important development in recent years, both in terms of focus on the subject and in its practical application into the educational contexts. Among the most meaningful contents and fields of study of the subject, the one related to the values of motor practice is of particular importance (Demetrio, 2001). Indeed, although common opinion believes that sports practice involves a series of essentially positive values, such as cooperation, healthy living, solidarity, socialization and self-control, and despite the fact that, in most cases, practicing sport can be a solution to limit some critical issues typical of young people (such as using drugs and falling into situations of psychological, physical and emotional distress), it is true that there are several aspects for which sports practice can turn into something totally non-educational.

According to Isidori and Fraile (2008) there are three types of values connected to Sport:

- Pure values: these are those positive values that have the potential to ensure respect for the dignity of the person, and can contribute to his or her personal development. From the point of view of motor education, they must be considered as a reference point during all stages of the educational process. These are, for example, health and well-being, peacefulness, socialization, social integration, friendship, loyalty, motor creativity, self-improvement, self-control, and active participation. Unlike other human practices, in which prolonged effort plays a significant part, it is the particular value of lucidity - whether physical or intellectual - that must characterize motor practice. Its maintenance and implementation should be promoted by educators as much as possible.
- Counter-values or disvalues: they directly result from the bipolar nature of sports values. Each of the positive values identified above corresponds to an absolutely opposite concept.

This type of imbalance and dystonia is usually generated when sports practice is not framed in the right context, i.e. when the aspect of the educational intentionality for the improvement of the person is overlooked. All the aspects that we do not hope to see in sports practice are represented in the disvalues: violence, manipulation, narcissism, hedonism, consumerism, sexism, and racism.

- Mixed values: these are those neutral values that, depending on the way they are presented and developed by sports educators and trainers, can take the form of values or disvalues. For example, mixed values are victory, reward, competition, performance, health and well-being, and identification with top athletes. When victory - which is a neutral value in itself - is presented as the only goal to be achieved at all costs, it can become a disvalue, because to achieve that goal the young person could, for example, take forbidden substances. Sports performance itself can become a disvalue if the young person, in order to pursue it at all costs, does not care about his or her health, for example by undergoing training sessions unsuitable for his or her age and body.

Conclusion

The concept of well-being is transformed from "condition" to "possibility" overturning the attitude of the subjects towards their own existence. The individual learns to plan his own well-being and, consequently, to master all the circumstances of his life related to both states of well-being and malaise, to manage changes, to know how to ask for help, to acquire coping strategies (emotional, cognitive, behavioral) to evaluate events, given responses and their effects in self-care. It seems necessary, therefore, to think of an idea of well-being in which the different psycho-pedagogical, social-health, welfare-rehabilitative skills are integrated with each other (Garista et al. 2015). The pedagogy of well-being "teaches to teach how to feel good", is an educational path that aims to trigger in the person the process of learning to learn to feel good. In this process, "feeling good" essentially becomes a "feeling good" to live more and more and with greater awareness the subjective dimension of the quality of life, understood not only as the absence of illness but, above all, as a place of well-being.

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