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Reconstituting ‘The Social’

Mark Furlong

Is the vocabulary of health colonising how ‘the social’ is understood?

In the Australian university context, social work education has traditionally been based in social science faculties or, less frequently, arts faculties. Over the last decade or so, an increasing number of these programs have been relocated to faculties of health and/or medicine. For example, the social work programs of Victoria’s Deakin, La Trobe, Melbourne and Monash universities are now embedded within very large, health-centred aggregations.

Such a relocation can be expected to have consequences. For example, within this auspice it is apparently natural to frame the compulsory field practicum—each student must complete a ‘clinical placement’: a description that contradicts the expectation that the parameters of social work extend far beyond the health sector. This is not an abstract concern, as key moments in social work practice—such as community development and the agitation for more responsive public policy, or active client advocacy and collective social action—cannot be totalised within the configuration that structures current health care provision.

That is, in the received model of health care the expert professional—the clinician—uses the objective knowledge and technical competencies of their specialist discipline to act upon an inanimate site—the immobile, ignorant patient (the ‘case’). This design is based on a private, rather than a public, model of modernist professional practice, and its claim to practitioner legitimacy (that it is scientific, evidence-based, and so on) is at least at some tension with, if not antagonistic to, the basis of a politicised conception of social service action.

Yet, the above overly simplifies the current situation, as practices in the health field are not always synonymous with this received design. Indeed, a case for a progressive re-constitution of the narrow boundaries in which health care has been envisaged is gaining momentum. Perhaps best illustrated in Richard Wilkinson and Kate Pickett’s flag-flying The Spirit Level: Why More Equal Societies Almost Always Do Better (2009), a social model of health and well-being that is establishing a profile, not just with left-leaning academics but also with governments. This work puts forward a diverging paradigm to the received, expert-centred template for health care.

Using an analysis of comparative international data as a conceptual axis, Wilkinson and Pickett’s findings undermine the expectation that greater health expenditure leads to better overall health outcomes. For example they point to the fact that health outcomes in Cuba and United States (life expectancy, infant mortality) are about the same, yet the United States spends in the order of ten times what Cuba spends. Even more interestingly, these authors do not confine their focus to the traditional indicators of health status, concerned with morbidity and death. Rather, they investigate an astonishingly broad suite of what they refer to as ‘health and social problems’—homicides, imprisonment rates, literacy levels, mental health problems, obesity, teenage pregnancy and so forth—and argue that their prevalence correlates very closely to the steepness of the ‘social gradient’ in any given society.

In their analysis, the greater the gradient (the top four being the United States, Portugal, the United Kingdom and Australia), the greater the rate of problems. The lesser the gradient (Japan, the Scandinavian countries), the less these problems are present. Not only does the rate of health and social problems not correlate with a nation’s health expenditure, Wilkinson and Pickett argue, within the bracket of the twenty most affluent countries it has little or nothing to do with differences in the average income between these nations.

This work is provocative at several levels, not least of which is that it aligns with deepening concerns about health expenditure across the Western world. This alignment can be seen in the attention government is giving to, and to an extent the funding now being directed into programs concerned with, health promotion, social inclusion and the management of chronic disease. It seems ‘the social’, that wondrously bountiful community we’d all like to believe is there for all of us, is being viewed with a gimlet eye.

In the following, I want to examine these developments and to examine the possible relationships that might exist between three propositions: that ‘the social is at risk of being removed from social work’; that the institutions of, and a discourse centred upon, ‘health’ is taking dominion over how the social is envisaged and practised; and that traditional conceptual and practice formations that have rationalised the
organisation of health care have become unstable. I will argue that ‘the social’, especially at the interpersonal level, is being re-constituted in an instrumental manner, while at the same time being de-natured, possibly demolished, in terms of its older, more reciprocal understandings.

The Positive Valence of Health

Unlike services offered in welfare, disability or income security settings, health services tend to evoke positive community meanings. Health services, like the terms ‘health’ and ‘well-being’ themselves, accrue approbation, as long as they are deemed to be functioning at least moderately well. This is in stark contrast to services with negative associations, such as those that are said to foster dependence, or those that create alarm: think of child protection services which, by the devil’s only definition, can never get it right.

That health services have a positive perception is due to a mix of factors. Not least of these is the wonder ordinary citizens experience at the opera of science and regression that is evoked: on the one hand, we are mystified by and are in awe of the precint—life and death—in which the high priests of this sector officiate. On the other, we are mystified by and are in awe of the high-tech that is so shamelessly shown off.

The latter is aided by a strategic identification of health services with health science. Particularly using the badge ‘evidence-based practice’ as a phalanx, a claim for certainty, masculinity and status has been advanced by and accepted by the public on behalf of the well credentialled. And as the weight of this colonisation settles into an apparently timeless dominion, something of the pattern language associated with the powerful has leached into ordinary speech and adjacent fields of human service and community practice: randomised, double blind trials have become the gold standard for all research (despite their inapplicability in many areas); the language of clinical intervention—the image of interactionless, determinate practice where a neutral expert fires magic bullets into inanimate sites—has become the norm.

This trend is observable in everyday ways. For example, it is now commonplace for a broad range of practitioners to be in the business of ‘delivering’ what are termed therapeutic and clinical services across a range of community-based and residential settings. This is in contrast to a decade ago when the description of a service as therapeutic or clinical was almost always associated with specialist, apparently more exotic service providers, and tended to be dismissed as precious and irrelevant by those who ‘did the real work’.

So, a tight alignment between the language of medicine and the prospects for effectiveness has taken root beyond its historical location in dedicated health settings. This alignment is now well leveraged into the policies and priorities of health and community settings. But there is an even broader crossover taking place: the positive valence of the language of health, particularly in its broader guise of ‘health and well-being’, is being dispersed into the still larger sphere of public policy and administration.

Generally. In South Australia, government policies are being ‘audited’ to ensure they meet the ‘health and well-being’ test. And, whether it is literal or apocryphal, it has been said that current federal Health Minister Nicola Roxon has operationalised the same criteria as key performance indicators for her departmental staff and for those with which her department does business.

The current Commonwealth Green Paper suggests the federal government is considering taking greater, if not overall, responsibility for the funding of primary health. To state governments this indicates that health is where the money is. In response, for example, the Victorian government has proactively split its Department of Human Services into two (the departments of Health and Human Services), with the funding advantages this split was designed for to gather to the fore. Further, health is colonising other government sectors under the flag that ‘health is, and ought to be, a whole-of-government approach’. Of course, there are socio-technical, discursive and ‘politically economic’ dimensions to this colonisation, especially the latter as whatever is said to support health and well-being is thought to have positive budgetary implications. But from where did this interest in health and well-being spring?

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The Social Determinants of Health

When we talk of ‘health’ there is a complex, interconnecting set of contexts invoked. Mindful that health is where the money is, as it is where the action is from a policy perspective, it is important to be clear that there is a diverse set of fronts on which the health motif is being iterated. Firstly, there is the domain of health in colloquial speech (‘Are you well?’) and everyday experience. Personally, ‘health’/’well-being’ exists as an attribute, as illness exists as a travail (‘I’ve gone down with a bug’/‘He is suffering from an illness’).

Institutionally, there are distinct categories of health service. At one pole there is ‘health promotion’, a preventive enterprise that seeks to modify behaviours, for example, public education about the dangers of smoking and, at the
other, those familiar ‘primary health’ providers, particularly general practitioners (although another meaning concerns basic, as opposed to professional, health services). There is also the suite of high-tech ‘tertiary/specialist health’ services and, more recently, also a developing set of programs for ‘chronic illness and its management’. Finally, there is aged care, a troublesome service network ambiguously located within, and yet also extending beyond, the health sector. It is anticipated by government and policy makers that it is in these latter three sub-fields that financial liability will lie. As this century unfolds it is expected that health expenditures will continue to increase, far and away beyond CPI increases, a trajectory considered financially unsustainable.

Given this context, it is not surprising that the emerging data on the ‘social determinants of health’ have attracted a ready audience amongst politicians and senior administrators. (Left-leaning and communitarian researchers have had a longer term interest.) This data has many provocative facets, not least the finding that social variables, such as a person being a member of an at-risk group (for example, one subject to racism), or the quality of a person’s interpersonal connections, powerfully mediate the incidence and severity of a range of health and mental health problems.

Social epidemiologists are reporting that the prevalence of a broad range of serious health problems—diabetes, strokes, heart attacks, even cancer—conforms to this idea. Further, as epidemiologists report, if a person happens to become ill, a positive interpersonal network will ameliorate the severity of the condition. This finding has been replicated in many studies and its fullest, most socially ambitious expression is set out in Wilkinson and Pickett’s The Spirit Level. (Additional texts developing this broad argument include Ryff and Singer’s Emotion, Social Relationships and Health and Cacioppo and Patrick’s Loneliness: Human Nature and the Need for Social Connection. The latter reports that ‘loneliness [is] on the list of risk factors for ill-health and early death right alongside smoking, obesity and lack of exercise’.)

This recent research testifying to the importance of social factors in physical health complements material available since the mid 1980s on mental health. A number of high-profile reports have supported the case for decades that a social model of health is highly salient to understanding prevalence and recovery issues. (Warner’s Recovery from Schizophrenia: Psychiatry and Political Economy and Brown and Harris’ The Social Origins of Depression particularly come to mind.) Recent research around anxiety and depression, for example, has only deepened this interest. Of course there continue to be vociferous, high-profile advocates for a strictly bio-chemical, illness-based conception of mental health. These professional and public bodies have a strong grip on public attention and agitate for a radically clinical approach, for example, Beyond Blue’s approach to depression.

For those who believe that there are important social determinants to health it has become clear that illness and recovery, vulnerability and resilience cannot be well understood, nor attempts to respond appropriately conceptualised, without acknowledging the importance of the immediate, as well as larger, social context. Such acknowledgement will necessarily, at least to a degree, de-centre the traditional, clinical approach to health care: the received image of the expert acting upon the supine patient is being or will need to be significantly re-modelled. Making this more difficult is the fact there is no stable conceptual vocabulary for articulating the social context at the macro or micro level, or for theorising the connection between these levels. For example, there is no common language across the disciplines for denoting ‘the socially relational’: terms like network, families,

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supportive relationships, social attachment, bridging capital, even the ‘locally social’; can be found to denote the dimension of person-to-person interaction.

Mindful that these conceptual uncertainties will persist, from a government policy perspective, if there is empirical evidence that social determinants have an impact on health, then they are a potential site for intervention. That is, if the set of factors implicated can be identified, it might be positively manipulated to reduce the incidence, and perhaps the severity, of ill-health, which will in turn have a positive budgetary outcome. This interest in the importance of the ‘social determinants of health’ is logically animated by concern for the cost of ‘carrying’ those with chronic conditions, allied with cost concerns deriving from an ageing population. It is also possible that the reliance on expensive, high-tech medicine might be lowered, a development that also potentially de-centres the hegemony of the interests vested in the traditional clinical model of care. With costs, at this point, at the centre of policy concerns, the ‘social determinants of health’ are likely to be realised within an instrumental agenda (as will the idea of ‘preventative health’).

Re-formulating ‘the Social’ in Health Promotion

In the social model of health it is conventional to understand a person’s ‘family and friends’ as a resource — an asset there to buttress the prospects for the individual. As we have seen, supportive relationships have been reported to ward off physical and psychosocial threats to health and well-being, and, if one does happen to contract a bug or disease or suffer a mental health problem, supportive relationships will help you recover quickly or not succumb as deeply. Just as Tom Hodgkinson recently argued that Facebook understands a person’s friends and personal networks as assets — connections that can be opportunistically taken advantage of when the ‘user’ wishes — in health promotion discourse personal relationships are also an asset: a kind of prophylactic medicine.

This thinking is evident in health promotion’s public declarations: advertisements pasted in men’s lavatories exhort the reader to check whether a friend might be depressed and if so set about supporting them; posters in rural settings tell you ‘Times are tough. If you haven’t heard from your mates for a while, give them a call. Keep talking’. In the ‘Together we do better’ campaign, advertisements in newspapers describe a group of young men sitting around yarning as ‘master therapists’.

Yet, supportive relationships cannot simply be delivered, cannot simply be called up as a unilateral demand: they cannot be, as the language of the health promotion authorities sets out, ‘accessed’. One may ‘access’ a parking space or have a right to a ticket to the football, but does this same kind of logic apply in the realm of relationships? Should we even try to make it apply?

Unlike commodities or legal rights, supportive relationships have a particular character and can only be, in a powerful sense, learned and earned rather than guaranteed or stipulated. As important as the public messages coming out of health promotion are, the idea that positive relationships are a ‘personal resource’, a kind of opaque ‘goods and service’, instrumentalisations, and even to a degree commodifies, the interpersonal. In the first instance, this can be understood as naive: to propose that supportive relationships could ever be impersonally delivered is as useful as distributing menu cards in a famine (to re-purpose one of Freud’s delightful lines). Such an understanding of relationships could also be seen as counter-productive in that it seeks to repudiate the premise that relationships are, and ought to be, in the main, reciprocal and non-linear, accountable and mysterious.

More worryingly, where it is said that positive personal relationships concern a person’s prospects for maintaining the integrity of their individual autonomy, this view of the interpersonal actively perverts understanding of the most local of social contexts towards a description of distinctly post-human relationships. Put another way, if it is never ethical to treat the other as a means (Kant’s categorical imperative), following the same logic it can never be ethical to instrumentalise the intimately personal.

This criticism cues a number of important questions. If it is not appropriate to instrumentalise relationships, how might the ‘locally social’ — the realm of the interpersonal — be understood? If it is not right to be interested in positive personal relationships because they will save the state money, what is the proper ‘business’ of the intimately relational? And, from the full cluster of social determinants of health and well-being, what is the particular contribution of the distinct sub-realms of ‘the social’, particularly the dimension that includes interactions with ‘strangers’, or the more traditional network of ‘family and friends’?

The Interpersonal Social

‘The social’, as noted earlier, is a complex, indivisible matrix. Mindful then that seeking to construct an inclusive, conceptually coherent description is something of a quixotic project, it is possible to initiate a limited engagement with ‘the social’ from a modest starting point: humans are inherently social beings and interpersonal contact is an irreducible expression of this sociability. That is, a project to articulate ‘the locally social’ can begin from the idea that this arena is first and foremost, but is not restricted to, local ensembles of interpersonal relationships. Within these ensembles are conducted:

- intimate/affectionate reciprocities
- formal and informal interpellations
- highly charged symbolic ceremonies
- everyday lived experiences of materiality.

It is within such local exchanges that the sources of personhood that forge and re-cast selfhood and well-being, or personal dis-ease, go about their everyday business. That is, it is within these exchanges that ‘what I say I am’ is checked by, complemented or juxtaposed to the descriptions of what those who are most proximal or important to me ‘tell me I am’: It is this sense of ‘the locally social’, this place where formalities and informalities jostle and interpenetrate, where calibrations around key social appraisals — judgements around respect, status, level of contribution, degree of inclusion, reputation and so on — tend to support or agitate private evaluations concerned with self-appraisal.

Within all social ensembles emergent characteristics are
generated, patterns that then tend to persist over extended periods. These characteristics can be glimpsed in the protocols that an outsider observer can, to a degree, note: the specifics of etiquette and manners; the repetitive patterns found in interpersonal sequences that take place in all established social groupings, like the non-random ordering of speakers; the allocation of respective roles and responsibilities embedded in every ongoing relationships. Over time, such empirical detail tends to determine the prospects for the relational: how interactions are experienced, understood, imagined and conducted.

For current purposes, my interest is in the spectrum of social exchanges that take place between people in dyads and small groups where these interactions may be familiar or incidental. Historically, they have tended to have an embodied character—a ‘presence’ that is immediate—while more recently they have tended to become mediated by information technologies. Inclusive then, of a changing mix of relational types, what might be said of the day-to-day encounters we have with strangers, intimates and associates, the suite of contacts and relationships that take place across the wide spectrum of our affinities?

Mindful exchanges embedded in a common history and recurrent patterns of interaction are the more obviously significant; in a material sense, each meeting, even if fleeting, impersonal or barely noticed, can be considered a variation on the category ‘relationship’. In established connections with others, in these spontaneous, evanescent relationships important transactions can occur, implicit performances concerned with identity and reality construction. With (at least) a million years training in being sensitive to the nuances of group dynamics we can be affected by a moment in a crowd, a gesture when you are standing in a queue, an instant when you unexpectedly catch the eye of or are meaningfully ignored by the driver in the lane next to you when your cars are gridlocked together at an ‘intimate’ distance.

This theatre may be reciprocal in its enactment of status and concern—it may be ‘civil’—or it may be asymmetrical, iniquitously distributing socio-personal costs and rewards. It may maintain the participant’s identity and self-esteem, or it might endanger, even disturb, these categories. In their cumulative effects, or their potential to have a particular, albeit occasional psychodramatic power, under certain conditions chance encounters have traction, heft, which is now understood to have important effects. The effects of these impersonal, yet personal, transactions might be harder to register, harder to fathom and make sense of, than those that those that occur, for example, between a priest and a parishioner or a grandmother and a grandchild. Yet, as Wilkinson and Pickett so powerfully argue, being ‘dissed’ by those who don’t know you in the street, an act of dehumanising disregard that is cued by the perception you are unsightly or a loser, can trigger shame and ostracism. Such experiences can lead to a lower self-appraisal, higher cortical levels, diminished immune function—a whole progression spiralling downwards that, over time, involves serious negative health consequences.

Micro-transactions and, even more so, their importance are difficult to track. And, exactly because the locally social is opaque, it is timely to ask: what is going on with how we are getting on? What is happening in shops and in cars, at sporting and artistic venues, on public transport and in homes, schools and workplaces? In the small domains of interpersonal practice, in the ongoing transitions that those that occur, for example, between a priest and a parishioner or a grandmother and a grandchild. Yet, as Wilkinson and Pickett so powerfully argue, being ‘dissed’ by those who don’t know you in the street, an act of dehumanising disregard that is cued by the perception you are unsightly or a loser, can trigger shame and ostracism. Such experiences can lead to a lower self-appraisal, higher cortical levels, diminished immune function—a whole progression spiralling downwards that, over time, involves serious negative health consequences.

Despite the instructions given to us in the modernist, neo-liberal narrative, humans are not discrete agents that exist inside their skins. The new health promotion narrative goes some way towards acknowledging, and potentially valorising, this social being-ness.

We have been acculturated to think in terms of the binary of ‘self’ and ‘society’. Living within this binary tends to have the evanescent realm of the relational pass by unnoticed. Geoff Sharp (in ‘To market, to market’, Arena Magazine no. 100) has one view of what is happening to the locally social: that the process of market thinking has undermined, if not colonised, the informal mores that have long been associated with ‘direct presence’: those codes of conduct traditionally found in families, friendships and communities. Another view is Anthony Giddens’ opposite idea: that ‘pure’, equitable relationships have never been more possible.

How is sociality being experienced, understood and performed now? Is it in good shape, flexible yet resilient, as some would have us think?
Perhaps it is entirely fungible, a vestige or trace that can take any number of forms without losing its essential qualities. Or is it currently being stressed and pressured, being bent, thinned and made fractious in new and dangerous ways, as Zygmunt Bauman and Ulrich Beck argue? Is it being de-natured, or just going on getting on with its timeless purposes? These are large questions that an open lens offered by a radical interest in the social determinants of health and well-being could capture.

In an examination of each example of local, small-scaled sociality it is necessary to pursue the ideal of what Clifford Geertz called ‘thick description’. That is, what is of interest are the phenomenological and behavioural details of what is being transacted: what exactly can be said of the manners that are characteristic of the encounter; what is their empirical configuration, dynamic and trajectory? Even more immanent, what are the respective roles and responsibilities that have been allocated between the participants, the (more often than not) implicit ‘dance parts’ that structure actions and meanings enacted in these encounters?

Further, are these allocations equitable, contested or assumed, and do the espoused ethics and accountabilities that are declared by the participants align with what actually takes place? As Gilbert Ryle observed of the difficulty distinguishing a purposive wink from involuntary tic, there is an intense interpretative complexity involved in making social judgements. When it comes to examining the locally social, this condition means an aspiration to ‘thick description’ is a requirement, even if this aim can only be approximated. Participation in the above dyads and small groups, as well as in the chance happenings of locally civil sociality (whether the mode of address is proximal or mediated) can never be simply a ‘functional’; let alone an instrumental, matter. Rather, a spectrum of interactions, the many and varied examples of participation that take place, are the condition within which humanness is realised and health and well-being supported or eroded, honoured or poisoned.

While it is acknowledged that the meanings transacted in such local exchanges are likely to, but will not necessarily, derive their particular attributions from the specifications than have been authorised in relevant, larger socio-structural formations—ideology, religion, law and so on—this is not to say the local is totally submerged by the socio-structural. That is, as the locally social is being considered, a decision can be made to privilege immediate personal relationships mindful of the significance of top-down moments of influence.

Such a division is, at best, of course, a kind of ‘regulatory fiction’ (to re-purpose a phrase from psychoanalysis): representatives of ‘relevant, larger socio-structural formations’, such as locally based clerics, pass across the local/socio-structural divide. Although it is to reify a rupture between the ‘larger’ and ‘smaller’ realms, it is a welcome development that the locally social is being given a profile within the emerging interest in ‘social determinants of health’. This interest in dyads and ensembles, spontaneous and formal groupings, has the potential to be a countervailing moment to an abiding concern for individual subjectivity, identity and selfhood and the allied interest in individual consciousness, autonomy, self-determination, rights and so forth that so early characterises the discourse of a culture where individualisation has taken root.

### ‘The Social’ and the Value of Relationships

In Bernard Wolf’s dystopian classic *Limbo* (1952), the narrator says: ‘The human skin is an artificial boundary: the world wonders into it, and the self wanders out of it. Traffic is two way and constant’. Despite the instructions given to us in the modernist, neo-liberal narrative, humans are not discrete agents that exist inside their skins. The new health promotion narrative goes some way towards acknowledging, and potentially valorising, this social being-ness. On the other hand, like Facebook, and the cultural logic of the market more generally, in the hands of policy makers focused on cost and social management, ‘social determinants of health’ tend towards an instrumental understanding of relationships.

In the first instance, the contrast of a ‘social determinants of health’ model to the traditional clinical response to illness is a progressive moment. This is seen in the movement in health policy and practice towards health promotion and the importance of social inclusion. All this, of course, is music to the ears of social workers: ‘That’s all good gear. That’s what we’ve been on about for ages!’ In this context, acceding to or complying with social work’s relocation within a health faculty presents as a positive, even if ambiguous, prospect.

Compared to the institutional status and positive discursive valence of health, it is clear that the ‘welfare’ badge is a goner. Yet, in the specific educational site where social work finds itself, is it possible that being embedded within a health/medical setting will, over time, significantly shape the way social work is allowed to perform, which, in turn, will tend to shape how it understands itself? Faculties of health science have institutional interests, strategic directions, expectations of professional privilege and so on, that are not consonant with an emancipatory or contesting vision.

Schools of social work, like everyone from the university to the federal Cabinet, currently wants to ride on the health express, to go where the action is—and that is in the health sector and/or to use the health metaphor. Yet, this is to ride the tiger’s back or, if you prefer, to shake hands with a gorilla, as there is likely to be an unstable relationship between advantages and disadvantages, between the progressive and the regressive, in the kinds of alliance politics that will be involved. Everyone wants to get on the high table of policy, to revel in the positive status that health currently enjoys. Yet, you can’t engage in parallel play if you are in bed with a gorilla.

At broader level, it is certain ‘the social’ is currently being bent, even re-constituted, by forces endemic to late capitalism and that it is within this context that the ‘social determinants of health’ model will take shape. Here the struggle will be to resist the invitation to re-cut understandings of ‘the social’ to align it with a purpose that is both task-focused and naïve. Rather than commodifying personal relationships as a useful a resource in the job of realising a healthy, autonomous citizenship, a contesting version locates interdependence and fairness, personal accountability and social inclusion, as orientations to be valued in their own right.