PERCEPTION OF HEALTH:

A PHENOMENOLOGICAL STUDY OF THE MEANING OF HEALTH TO INDO-CANADIANS

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ABSTRACT

PERCEPTION OF HEALTH:

THE MEANING OF HEALTH TO INDO-CANADIANS

This study was designed to investigate the meaning of health to Indo-Canadians. Given the increasingly multicultural nature of Canadian society and the nursing profession's growing recognition of the importance of cross-cultural knowledge, this area of investigation is both timely and relevant.

The explanatory model of Arthur Kleinman (1978a, b, 1980, 1984) was the framework which guided the researcher to adopt the phenomenological method to conduct this qualitative study. The phenomenological method is highly suitable for enquiry into the perception and explanation of the health phenomenon.

A pilot study conducted prior to the actual research assisted the formulation of suitable questions to elicit in-depth description of the health phenomenon from individuals of this cultural group. Semi-structured interviews were conducted with eight participants contacted through an informal network of colleagues and acquaintances. Theoretical sampling techniques determined the final sample size. Participants were first generation Indo-Canadians of the Hindu faith between the ages of 28 and 56, who had resided in Canada for 6 1/2 to 21 years at the time of the study. Most participants were in their mid-40's and had lived in Canada for about 12 years.

Data collected from a total of 15 interviews with the 8

participants were analyzed according to the technique of constant comparative analysis. Common themes and catagories arising from the data formed a final analytic framework which organized the presentation of research data, and represented the essential meaning of health for the Indo-Canadians who participated in this study.

Although the researcher's original intent was to investigate the influence which culture exerts on perception of health, socio-economic circumstance and educational background were important factors in the construction of participant's health accounts. Definition of health emerged as a construct which is structured by culture, and intimately related to social milieu.

Participants described health as a multidimensional, holistic phenomenon where the body and mind are inseparable. Health was conceptualized primarily as "doing normal activities". The mind was described as the most important factor influencing health.

The findings of this study have important implications for the nursing profession. In terms of nursing practice, the findings support increasing use of cross-cultural theory to guide nursing practice. For culturally relevant nursing care to become a reality, it is crucial that nurses recognize health as a construct defined differently within different socio-cultural contexts. This research supports current moves to incorporate cross-cultural theory into undergraduate and graduate nursing curricula. Finally, in terms of nursing research, the findings of this study advocate on-going investigation of the explanatory

models of health and sickness held by the Indo-Canadian community and other cultural groups making up the Canadian mosaic.

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CHAPTER 1: INTRODUCTION

Background to the Problem

Canada today is an ethnically diverse "cultural mosaic" with cultural groups maintaining their distinct identities and remaining as distinct units within the social framework (Palmer, 1975, p. 2). Asian immigrants constitute a significant portion of the country's growing population. Each year more Asians arrive in Canada from various countries. Since 1970, Asian immigrants have made up 32% of the total immigrant population (Canada Year Book, 1985; Current Demographic Analysis, 1983).

Individuals from the Indian continent contribute markedly to this Asian immigrant flow. Between the years 1976 and 1981, the number of persons in Canada who reported Indo-Pakistani languages as their mother tongue doubled. In 1981, 16.1% of the Canadian population reported having been born outside of Canada and 7.6% of the population reported cultural heritage stemming from more than one ethnic group (Canada Year Book, 1985; Current Demographic Analysis, 1983).

In 1986, approximately 4 million Canadians reported having been born outside of Canada. Of this group, 3.3% reported having come from India, and 14% reported having come from Asia in general. For the same year, 2.9 million persons, or 11% of the total Canadian population, reported having a mother tongue other than English or French; 634,000 persons in this group indicated a mother tongue of Asian or Middle Eastern origin (Canada Year Book, 1988; Profile of Ethnic Groups, Statistics Canada, 1988).

It is predicted that there will be an increase in the immigration rate to 150,000 annually by the year 1994 (Canada Year Book, 1985). Immigration thus appears to be a factor which will exert significant influence in shaping Canadian society in the future. The reality of ongoing and increasing immigration in the years ahead affects Canada's health services as well as the population composition (Splane, 1984). In order to effectively meet the needs of the population, the Canadian health care system is challenged to adopt a multicultural perspective.

The structure and philosophy of Canada's health care system directly affects the practice of health care professionals and the provision of health care to clients. Recent government documents, such as the La Londe Report (1974) and Epp's Framework for Health Promotion (1986), have proposed equity of health for all as their goal. These two documents, however, propose a health care scheme structured largely from the perspective of white middle class society. They also appear to not adequately appreciate the fact that health is determined by the cultural and social context in which it is embedded (Coburn, D'Arcy, Torrance & New, 1987). Appreciation of the unique perspectives on health held by the various cultural groups making up Canadian society is vital for successful realization of the federal government's vision of health for all. Mechanisms and strategies for health promotion (Epp, 1986) can be fruitful only when cross-cultural viewpoints are acknowledged.

In a multicultural society such as Canada, which has formally

advocated a policy of cultural pluralism, recognition of the impact which ethnocultural factors have on the definition and experience of health and illness is essential. At present, health care professionals remain largely ignorant of, or indifferent to, cross-cultural differences among clients (Dobson, 1983; Leininger, 1984). The Canadian health care system itself often fails to meet the needs of individuals whose ethnocultural background differs from that of the mainstream population (Anderson, 1985b).

Transcultural studies explore the different perspectives on health and health care held by individuals of varying socio-cultural backgrounds. Cross-cultural nursing literature emphasizes the need for increased knowledge in the area of culturally determined perspectives on health and illness.

Transcultural Studies

As Canadian society becomes increasingly multicultural in nature, it becomes imperative for the nursing profession to adopt a transcultural perspective. Transcultural health care is both a growing reality and a future necessity, which clearly signifies cross-cultural study as an important focus for nursing research (Splane, 1984).

A sound understanding of the "concept of culture" is essential for provision of culturally relevant nursing care (Dobson, 1983). Nurses who provide care to clients from various cultural and ethnic groups need to be cognizant of factors which facilitate or impede therapeutic interaction between the nurse and the client. Traditionally educated within a unicultural,

biomedical perspective, nurses often find that their own perception of health and illness, and underlying beliefs, values and lifestyles, differ markedly from those of the client. This unicultural orientation on the part of the nurse, together with associated attitudes of ethnocentrism and cultural imposition, act as barriers to provision of therapeutic nursing care and negate the validity of the client's unique ethnocultural perspective and experience (Leininger, 1984).

According to Leininger, individuals in society are demanding culturally relevant health care and services which acknowledge their unique social and cultural milieu. She states:

> They are beginning to speak of 'cultural rights' and expect to be looked at within their own cultural patterns. The nursing profession must act quickly if it is to prevent a gap from developing between consumers' expectations and nurses' ability to deliver the services they demand. (1984, p. 42)

It thus clearly behooves the nursing profession to gain a better understanding of the client's unique ethnocultural perspective in order to provide effective nursing care to individuals from various cultural and ethnic backgrounds. Knowledge of individual subjective experience and perception of health is an essential component of transcultural nursing practice.

Knowledge of the meaning which individuals assign to the state of health promotes the appreciation of the client as a unique human being. This human-to-human relationship, based upon recognition of individual uniqueness and worth, is fundamental to

the philosophy of nursing (Travelbee, 1971).

Health is a socio-cultural construct rather than a given state, and is thus inseparable from the ethnosociocultural context in which it is grounded (Anderson, 1985b). The nurse requires transcultural knowledge to guide nursing practice so that culturally relevant nursing care can be provided to clients.

The Significance of Studies on Indo-Canadians

British Columbia has the second largest Indo-Canadian population in Canada, second only to Ontario. In 1981, 43,065, or 37% of the country's total Indo-Canadian population resided in British Columbia (Johnson, 1984). 1986 figures showed a small decrease in numbers, with 39,780 individuals in British Columbia reporting India as their country of origin (Summary Tabulations, Statistics Canada, 1986).

Despite this reported numerical decline, individuals from India remain one of the major immigrant groups in the province, ranking after immigrants from Europe, the Netherlands and China. Over the first six months of 1988, 1,890 individuals from India came to British Columbia; numbers of immigrants recorded for all other cultural groups, except those from Hong Kong, were significantly less over the same period (Employment and Immigration Canada, 1988; Appendum to the Daily, Statistics Canada, 1988). The Indo-Canadian community in British Columbia is predominately Sikh, with fewer Hindus and Pakistanis. This predominance of Sikhs in the province's Indo-Canadian community is a pattern not reflected within the Canadian population as a whole

(Johnson, 1984; Population by Ethnic Origin, Statistics Canada, 1986).

In view of the significant number of individuals of Indian origin currently arriving in Canada, and the culturally distinct nature of the Indo-Canadian community, studies focusing on Indo-Canadians are clearly relevant in themselves. Moreover, given the Canadian health care system's mandate to meet the needs of the country's population, investigation of the distinct cultural perspective of health held by Indo-Canadians is timely and pertinent.

Literature and Research on Indo-Canadians: A Scarcity

Over the years, various accounts have been published of the immigration of individuals from India into Canada and their experience of building a new life in Canadian society. Many of these works were published in the early 1900's (British Columbia Public Service Bulletin, 1928; Broad, 1913). Authors over recent years have focused primarily on immigration issues, statistics, historical accounts and socio-psychological factors associated with the Indo-Canadian community (Buchignani, 1977, 1980; Filteau, 1980; Naidoo, 1980, 1981, 1984; Wood, 1980, 1984). Other authors, such as Goa, Coward and Neufeldt (1984) have focused on this group's religious traditions. Very little theory has addressed the health care concerns of Indo-Canadians. Of the literature available in this category, studies presenting actual research findings are scarce.

Nursing has begun to seriously examine health care within the

transcultural context. Anderson's work on the health of Indo-Canadian and Greek women immigrants (1985a, 1987) and the recent study conducted by Majumdar and Carpio (1988) are exemplary nursing research studies in this area. Most investigations carried out by researchers in other health professions deal with case studies of illnesses found in the Indo-Canadian community, such as malaria (Ough, 1976), filarial chyluria (Smith, 1971) and trachoma (Detels, Alexander & Dhir, 1966).

Lack of Literature on the Hindu Community

The large majority of literature pertaining to Indo-Canadians concentrates on the Sikh community. Struser (1985) researched the experience of childbirth amongst Sikh women from the Punjab. Detels et al. (1966), in their previously noted study on trachoma, looked exclusively at Punjabi Sikhs in British Columbia. Recent studies on the iron status (Bindra & Gibson, 1986) and vitamin D status (Gibson, Bindra, Nizan & Draper, 1986) of immigrants from India also focused on samples drawn from the Sikh community. Sociological and historical literature on the Indo-Canadians gives evidence of a similar bias towards study of the Sikh community over the Hindu community (Broad, 1913; Buchignani, 1977; Naidoo, 1980).

Conceptualization of the Problem

The conceptual framework for this study is the explanatory model of Arthur Kleinman (1978a,b, 1980, 1984). The conceptual framework represents the researcher's mind set, or the perspective

from which the total research process is viewed. The research question is considered to be generated from the conceptual framework itself, and supported by the framework during the research process. As an organizing framework, Kleinman's model guides the actual conduct of field work and the development of the researcher's theoretical perspective as data are collected and analyzed.

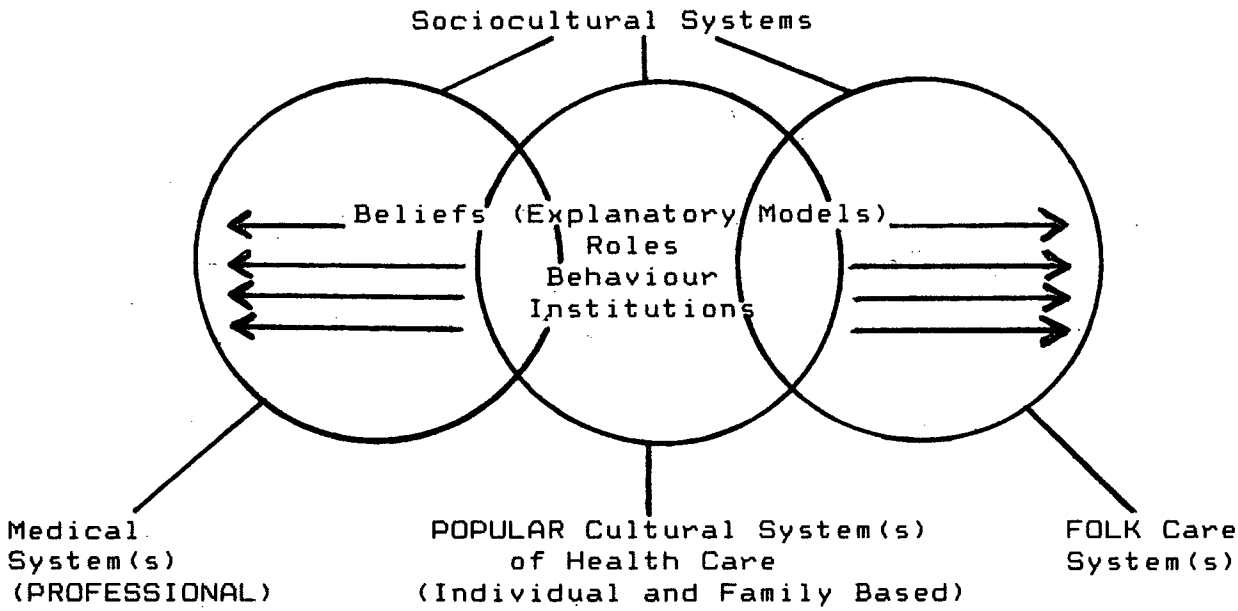

Figure 1: The Explanatory Model. Kleinman's conceptualization of the health care system (Kleinman, 1978a, p. 422).

Kleinman's explanatory model is based upon cross-cultural findings, and views health and health care as cultural systems.

The model conceptualizes three interacting structural domains, or spheres, of health care: popular, folk and professional. These "health and health care-related aspects are culturally constituted ... distinctive and overlapping". They represent the essential components which structure the individual's explanatory model for viewing health and illness (Kleinman & Chrisman, 1983, p. 570-571).

Kleinman's cultural system model addresses the discrepancy between lay and professional perspectives, or views, on the illness experience. Sickness is experienced and reacted to within the three structural spheres. Each of these domains of health care represents "a sociocultural system with its own beliefs, values and norms and its own explanatory model of health and illness". The popular domain encompasses family, social network and community. The folk domain includes non-professional healers, and the professional domain represents health professionals who base clinical practice upon complex professional health cultures (Anderson, 1985b, p. 237).

Although disease and illness are themselves explanatory models, Kleinman and colleagues clearly distinguish between the two concepts. Illness is defined as the "human experience of sickness" or the "personal, interpersonal and cultural reactions to disease and discomfort". Disease, in contrast, is considered as the "malfunctioning of biologic and psychophysiologic processes in the individual". The illness experience is influenced by culture, being "culturally shaped in the sense that how we

perceive, experience and cope with disease is based on our explanations of sickness, explanations specific to the social positions we occupy and the systems of meaning we employ" (Kleinman, Eisenberg & Good, 1978, p. 251-252).

Kleinman speaks of the cultural construction of clinical reality, wherein client-health care professional interactions represent transactions between explanatory models. The patient's explanatory model is culturally shaped and illustrates the beliefs which the individual holds about his "illness, the personal and social meaning he attaches to his disorder, his explanations ... and his therapeutic goals" (Kleinman et al., 1978).

Kleinman (1984) describes the "meaning contexts" of illness and care. In this study the researcher may appropriately refer to the meaning context of health. Kleinman and Chrisman (1983), referring to the experience of illness as a cultural or symbolic reality, propose that "emotion, cognition, motivation, behavior and social interaction are made meaningful in particular cultural contexts" (p. 569). Such cultural perspectives construct the individual's personal culturally-specific explanatory model for viewing the world.

Although Kleinman's explanatory model has been used primarily for viewing the experience of illness, the framework is also well suited to consideration of individual experience of health (A. Kleinman, personal communication, February 18, 1989). As in the illness experience, the way individuals perceive health and assign meaning to health is structured by the ethnic and cultural factors

inherent in each of the three domains. The researcher proposes that the experience of health, like the experience of illness, is culturally determined and based upon individual explanations of well-being.

Use of Kleinman's Framework within the Discipline of Nursing

Kleinman's explanatory model has been employed in recent nursing research (Anderson, 1981a, 1985b; Anderson & Chung, 1982) as a framework for viewing the socio-cultural context of health and illness. Anderson's work illustrates the potential of Kleinman's theory for guiding and supporting research within the nursing profession, and assisting enquiry into phenomena of concern to nursing practice.

In her discussion on the relevance of considering health and illness as socio-cultural constructs, Anderson makes the following statement regarding the clinical direction provided by a nursing framework based upon Kleinman's theory:

> The question that arises is the extent to which biomedical models of clinical practice that overlook the sociocultural context in which health and illness experiences are grounded are responsive to the needs of clients in the Canadian health care system .... A framework for nursing care which focuses on the multiple determinants which shape the client's experience of 'health' and 'illness' is critical if adequate care is to be provided to the many ethnocultural groups that make up the Canadian mosaic. (1985b, p. 234-235)

The distinct research problem addressed in this study evolved

from the foregoing consideration of health as a multidimensional, culturally and socially grounded phenomenon, and the recognition that health care professionals need to become aware of the validity and uniqueness of the individual health experience and the social context of that experience.

Problem Statement

The perception of health held by Indo-Canadians is not adequately understood by the majority of health care professionals. There may be a discrepancy between the health perspective entertained by health care professionals and that of the client. When such a discrepancy exists it is unlikely that culturally relevant care will ensue. Therapeutic nursing care cannot be provided unless the client's unique cultural perspective of health is appreciated and used to guide nursing practice. Previous studies do not appear to have exclusively focused on what health means to Hindu Indo-Canadians.

Significance of the Study

Scientific Significance

Research is necessary for the professionalization of nursing (Fawcett, 1980). This study on the meaning of health to Indo-Canadians contributes to the development of transcultural nursing theory and furthers the cultivation of a unique body of nursing knowledge.

Kleinman (1984) cites cross-cultural research as highly significant in the on-going work to build a theory on the

universal and culture-specific aspects of health care. Coburn et al. (1987) recognize the need for research on the health perspectives of lay Canadians, especially amongst ethnic populations.

Leininger has recently commented on the significance of transcultural theory as a major component of nursing's unique body of knowledge. The author emphasizes the position that transcultural theory is "one of the most important and relevant theories of nursing" (1985a, p. 209). Echoing Leininger's sentiments, deChesnay (1983) states that cross-cultural research strengthens the discipline's theory base.

This study effectively builds upon earlier nursing research focused in the area of culture, ethnicity and health care, and contributes to consolidation of qualitative cross-cultural study as a major focus of nursing research.

The timeliness of this study is supported by Anderson's suggestion that future research might effectively examine the "client's subjective experiences of health and illness". She specifically poses the research question "what is the meaning of health" as a topic relevant for nursing research (1985b, p. 238-240). Other nurse researchers have cited investigation of the health experience as an important focus for nursing enquiry (Munhall & Oiler, 1986; Smith, 1986).

Practical Significance

Theory generated from cross-cultural research guides health care professionals in the provision of quality patient care. By

guiding practice, cross-cultural study benefits both the nursing profession and the client. Knowledge about culturally specific beliefs regarding health and illness, and associated expectations about care, contributes to the provision of culturally relevant nursing care (deChesnay, 1983).

Leininger (1985a) firmly proposes that transcultural theory is relevant to nursing practice, stating that nursing must be based on transcultural care knowledge and skill. Splane, in her 1983 keynote address at the Canadian Conference of Schools of Nursing, emphasized the need for transcultural health care. Splane states that there is an imperative requirement for "health personnel who understand different cultural values, beliefs and practices" (1983, p. 6).

By becoming more aware of the culturally-grounded experience of health, nurses will be able to provide better and more satisfying nursing care to clients. Such a consolidation of cross-cultural nursing theory and practice is imperative if the nursing profession is to effectively meet the challenges of the future as society becomes increasingly multicultural in nature.

Purpose of the Study

The purpose of this phenomenological study was to investigate the meaning of health to Indo-Canadians.

Research Question

In this research the following question was addressed: "What

is the meaning of health to Indo-Canadians"?

Theoretical and Methodological Perspectives of the Study

Introduction to the Methodology

Kleinman's (1978a,b, 1980, 1984) explanatory model provides a suitable framework for enquiry into individual perception of the phenomenon of health. This study focused on the lay experience of health within the popular domain, or sphere, of the model. Kleinman's framework directed the researcher to design a phenomenological study which investigated individual perception of health, in order to elicit in-depth description of the explanatory models underlying this experience.

The phenomenological research design supported by the chosen framework is the appropriate qualitative method for description of the individual health experience from the actor's personal perspective (Knaack, 1984). Qualitative approaches are gaining increased acceptance among nursing researchers as effective for studying phenomena of concern to nursing practice. Among qualitative methods, the phenomenological approach in particular is well suited to clinical nursing research where the aim is to understand individual perception and experience. A growing number of nursing researchers utilize the phenomenological approach and support its relevance (Anderson, 1985a, 1987; Anderson & Chung, 1982; Anderson & Lynam, 1987; Davis, 1978; Lynch-Sauer, 1985; Munhall, 1982, 1986a,b; Oiler, 1982; Parse, Coyne & Smith, 1985; Ray, 1985; Reimen, 1986; Smith, 1986).

Phenomenology is a philosophical perspective, or way of viewing the world and conceptualizing reality, as well as an approach to enquiry into phenomena (Oiler, 1982). As an inductive, descriptive research method focusing on the whole individual (Omery, 1983), phenomenology seeks to "uncover ground structures" of phenomena (Lynch-Sauer, 1985). It values both the "inner experience and outer behavior of a subject as viewed by both the researcher and the participants", aiming "to formulate a model for the study of human behavior at the level of everyday social organization ... (focusing) on the subjective experience of persons in everyday life" (Anderson & Chung, 1982, p. 42).

In the phenomenological method, the subject's responses constitute the data of the study (Parse, Coyne & Smith, 1985). The researcher and participant jointly explore the meaning of phenomena, constructing a description of the fundamental nature of the experience. Concentrating on the subject's experience, "rather than concentrating solely on the subjects or on objects", phenomenology attempts to "see human experience in the complexity of its content" (Munhall & Oiler, 1986, p. 57).

As Straus (1966) explains, phenomenology focuses on the lived moment, and recognizes the validity of each person's unique experience of world situations. Thus, from the phenomenological perspective, objective study of human experience is viewed as stripping reality of its primary, fundamental aspects. Research is conducted from the emic perspective of the subject (Morse, 1987), aiming to see knowledge directly through immediate human

experience (Davis, 1978).

Knaack (1984), referring to the work of Giorgi (1975) and Keen (1975), outlines the basic assumptions of phenomenology as follows:

1) faithfulness to the phenomenon as it exists;

2) the importance of experience within the world as we live it;

3) utilization of a descriptive approach;

4) description of the situation from the perspective of the subject;

5) consideration of the "lived situation" as the basic research unit;

6) "a biographical emphasis because all human phenomena are temporal, historical and personal";

7) aim to be "presuppositionless description"; and

8) emphasis on a "search for meaning" (p. 109).

These basic assumptions, or essential building blocks underlying the phenomenological method, support exhaustive description of the phenomenon of health as it is lived by individuals within the context of their unique ethnosociocultural environment.

Grounded in the recognition that context gives meaning to personal experience, phenomenological description effectively communicates insight into the human experience of health. In contrast to the traditional scientific method of positivistic enquiry, which focuses on and gives ultimate reality to the objective world, phenomenology focuses on the subjective world of the individual. Shaped by the individual's distinctive cultural,

social and historical background, this subjective world is unique for each person.

Definition of Terms

Theoretical Definition

1) Culture: refers to "the learned, shared, and transmitted values, beliefs, norms and lifeway practices of a particular group that guides thinking, decisions and actions in a patterned way" (Leininger, 1985, p. 209).

2) Ethnic: refers to "a social group within a cultural and social system that claims or is accorded special status on the basis of complex, often variable traits including religious, linguistic, ancestral, or physical characteristics" (Spector, 1976, p. 76).

3) Ethnicity: refers to "the condition of belonging to a particular ethnic group; ethnic pride" (Spector, 1979, p. 76).

Operational Definition

1) Indo-Canadian: for this study the term refers to an individual residing in Canada, who was born in India and follows the Hindu religion.

2) Health: refers to what was defined by individuals in this study.

Assumptions

The assumptions, or basic concepts and principles which were taken for true in this study, are as follows:

1) That the members of the selected sample were able to provide a subjective report of their individual perception of health;

2) That the verbal report obtained from the study participants was

true to their perceptions of health;

3) That the perception and experience of health/meaning of health varies cross-culturally;

4) That health is a state which can be described by verbal report.

Limitations

The following limitations for the study were identified:

1) Sample: The sample had to be English speaking in order for the researcher to be able to conduct all of the interviews herself. Individuals who could not communicate in English were therefore excluded from the study; consequently, the meaning which health holds for this group was not investigated.

2) Data: The presence of family members at certain points during some of the interviews may have influenced the participant's verbal report. The majority of interviews, however, were undisturbed.

Summary

In this introductory chapter, the background to the problem was presented. The explanatory model of Arthur Kleinman was described and identified as the conceptual framework supporting this research. The scientific and practical significance of the current study were noted. The problem statement and purpose of the study were stated and discussed, along with the research question which directed the actual research design.

The theoretical and methodological perspectives of the study were advanced, detailing the phenomenological approach and

providing theoretical and operational definition of selected terms. The underlying assumptions and recognized limitations of the study have been described in conclusion.

The researcher emphasized the need for understanding subjective experience of health and illness as the basis for provision of effective, culturally relevant health care to individuals within Canada's multicultural society. This study was designed to explore the unique perception of health held by Indo-Canadians.

The methodology used in this research will be examined in depth in chapter three. The following chapter will present an overview of selected literature germane to the problem and purpose of the current study. This literature review will discuss the origin of the word "health" and various perspectives on health and illness found within the different disciplines. Literature and research on the Indo-Canadian community, together with an account of India's traditional belief systems regarding health and illness, will also be included in the subsequent discussion.

CHAPTER 2: REVIEW OF SELECTED LITERATURE

The following literature review provides the background for viewing the current study on the meaning of health. The review is divided into three sections. In the first, an overview of existing health literature presents the conceptualization of health offered by various disciplines, and examines how each perspective contributes to description and understanding of the phenomenon of health.

Reference to the origin of the word "health" provides valuable insight into the link between health and concepts of holism, and suggests that the word for health found in each language may be derived from a fundamentally different concept of the phenomenon. The literature shows that health is being increasingly recognized as a subjective phenomenon with characteristics that vary according to socio-cultural context. Cross-cultural nursing literature and research form a major focus of this discussion because of their particular relevance to the current study, emphasizing health as a socio-cultural construct and explaining why it was important to investigate the meaning of health to Indo-Canadians.

The description of India's traditional beliefs on health and illness presented in the second section of this chapter, provides additional background for viewing the Indo-Canadian perspective on the health phenomenon. The third section reviews pertinent literature on individuals from India. Chapter one presented the

background to the problem in detail and discussed the relevance of studies focusing on the Indo-Canadian community, the literature on Indo-Canadians reviewed in this section further substantiates the need for research on the health perspectives of this cultural group.

Although nursing researchers are showing increasing interest in health as a focus of investigation, cross-cultural studies remain relatively few in number. As the subsequent review shows, information on the health of Indo-Canadians is limited, and studies specifically investigating the meaning of health to Indo-Canadians are virtually non-existent.

Literature on Health and Illness

Much has been written on disease and illness. The cultural beliefs associated with perceptions of illness have also been dealt with quite extensively in the literature. There is little literature available however, discussing the concept of health and the ways in which individuals perceive and experience the health state. Even less information exists dealing specifically with individual experience of health as a socio-cultural construct, and the meaning which individuals from various cultural backgrounds assign to health.

Enquiry into the nature of health is facilitated by consideration of illness as a contrasting concept. Viewing health within the health-illness context is therefore pertinent to this discussion, since understanding what health "is not" assists

description of what health "is".

Health and illness are traditionally viewed within the context of the medical model. Consequently, over the last decade illness and health have been viewed as opposite entities, with health described in negative terms as a state where disease is absent (Guttmacher, 1978). Recent holistic health literature in contrast, advocates health as a positive state of wholeness (Blattner, 1981; Flynn, 1980; Goldwag, 1979; Pelletier, 1979; Sarkis & Skoner, 1987).

Each discipline views the human being slightly differently. In addition, differing theoretical perspectives exist within a given discipline. Various distinct perspectives on the definition of health and illness are therefore found in the literature. For example, health is conceptualized as a goal (Duhl, 1976), a response (Murray & Zentner, 1975), a wealth or resource (Fuchs, 1976), a process (Greifinger & Grossman, 1977), a task (Illich, 1976), a diagnosis (Sebag, 1979), a moral obligation or responsibility (Sider & Clements, 1984), a state (Terris, 1975), and a social status (Twaddle, 1974, 1982). These conceptualizations of health vary in their explicitness of definition and circumscription of parameters.

The following discussion presents some of the theoretical perspectives on health found in the literature, to provide a general account of current descriptions of the phenomenon of health. Examination of the derivation of the word "health" introduces the section.

Theoretical Perspectives on Health

A brief account of the derivation of the word "health" links health with the concept of holism, and identifies culture and social environment as integral aspects of individual wholeness. In addition, this etymological account suggests that each language's word for health may represent a different fundamental conceptualization of the phenomenon.

Derivation of the Word "Health"

It is proposed that the word "health" has been derived from the concept of wholeness (Keller, 1981). Investigating the historical development of the word "health", Keller, provides support for the position that health is a positive state of being encompassing all aspects of man's personality. She describes the origination of the term "health" as follows: "'Whole' was derived from 'hole' or 'hale' in Middle English and from 'hall' in Old English (hal - hole/hale - whole - health)" (1981, p. 44).

The word for health in sanskrit (the classical language from which Hindi is derived) provides a different angle on the literal meaning of the word "health". The sanskrit word for health, "svastah", may be translated variously as "self-abiding; being in one's natural state; contented; and healthy in body and mind" (Monier-Williams, 1976, p. 1277).

These accounts of the derivation and meaning of the word "health" support holistic health perspectives on the human being. According to this holistic viewpoint, the individual is "a whole psycho-physio-socio-cultural-spiritual being" related to his/her

total environment (Dorsey & Jackson, 1976, p. 77).

Perspectives found in Sociology, Philosophy and Theology

As noted, the concept of health is constructed from various theoretical perspectives. The work of Parsons (1979) and Twaddle (1974; 1982) represent two significant, contrasting sociological viewpoints.

Parsons (1979), a forefather of medical sociology, describes health as a social norm, and sickness as a form of socially deviant behaviour. While recognizing the "cultural relativity" of health and sickness, Parsons perceives them as inseparable from notions of social role, social control and conformity.

Twaddle (1974; 1982) champions a sociology of health characterized by a socio-cultural, rather than a biopsychological, focus. In line with sociology's current emphasis on the "meaning" and "grounding" of individual experience, Twaddle advocates appreciation of the context of life events. He proposes that smaller units "need to be understood in the context of larger ones" (1982, p. 347). Health and illness are consequently conceived of as social statuses constructed according to personal context, and thus related to socio-economic circumstance, ethnicity and situational factors. According to Twaddle, the client in today's health care system experiences not only problems of communication, but also an increasing sense of alienation related to economic and class differences as well as clinical and organizational factors.

Callahan (1982), Beauchamp (1982), Boorse (1982) and Capra

(1983) offer some philosophical perspectives on the characteristics of health. Beauchamp notes three prominent and competing approaches to the vision of health. He suggests that health may be seen as "a state of complete physical, mental and social well-being" as stated in the definition of the World Health Organization (WHO); as encompassing only the physical and mental dimensions of the individual; or as a state of "physical well-being without any significant impairment (Beauchamp, 1982, p. 44).

Callahan (1982) argues against the WHO definition of health, and proposes that health is a "state of physical well-being" which need not encompass "mental" well-being (p. 53). Boorse (1982) argues that health is normality in the sense of "natural functional organization of the species", and disease is deviation from the organism's natural functioning (p.68).

Capra (1983), the physicist turned philosopher, speaks of health as a "subjective experience whose quality can be known intuitively" but never quantified. Emphasizing the need to attempt definition of health, Capra proposes that "different models of living organisms will lead to different definitions of health". Health is viewed as an integral part of limited, approximate models "that mirror a web of relationships among multiple aspects of the complex and fluid phenomenon of life". Capra summarizes his perspective as follows:

> Once the relativity and subjective nature of the concept of health is perceived, it also becomes clear that the experience of health and illness is strongly influenced by

> the cultural context in which it occurs. What is healthy and sick, normal and abnormal, sane and insane, varies from culture to culture. (1983, p. 320-321)

The vision of health proposed by Capra recognizes the subjectivity of health and acknowledges the role of culture in definition of the concept.

The theologian, Tillich (1961), poses the view that health is a multidimensional concept. Referring specifically to the meaning of health, Tillich states that one must consider all "dimensions of life which are united in man" in order to understand the nature of health. Concordant with holistic health perspectives, Tillich states that the overall health of an individual is the result of the health of each dimension of his being: mechanical, biological, psychological, spiritual and historical (p. 93-99). Tillich's historical dimension acknowledges the influence which culture exerts upon health.

In the following section, some of the explanatory models of health and illness found in the literature of medicine and nursing are reviewed. Traditional biomedical perspectives, and a number of the socio-cultural perspectives on health and illness advanced by the health care disciplines, are presented in this discussion. These perspectives represent the professional domain in Kleinman's framework.

Traditional Biomedical Perspectives

Medicine traditionally views health as a state where disease is absent (Redlick, 1976; Sebag, 1979). From the disease oriented

perspective of modern medicine, a healthy individual is identified as one with no detected abnormalities. Sebag (1979) states "when no irregularities are found, an individual is presumed to be healthy". This focus on health is described rather bluntly by Redlich (1976). He states:

> From a medical point of view, health is the absence of disease. Once a patient is no longer diseased or, to put it differently, has reached a certain minimal state of health, he is of no further concern to the physician ... As no human being is completely free from disease over a lifetime, there is no perfect enduring state of health even at a minimal level. (p. 270)

Health is viewed as a state harder to conceptualize than disease (Sebag, 1979), and thus a concept not well understood within society in general. In order to better understand health, investigators are focusing on social environment, culture and ethnicity as variables which impact upon the definition and experience of health.

Socio-Cultural Perspectives within the Health Care Disciplines

Brody (1973) and Blum (1983) present us with a systems concept of the individual. Human beings in this context are seen to possess a hierarchical structure within their personality, with each personality level, or subsystem, contributing to individual health.

Health is seen as an ongoing process, manifesting continual change and activity as the individual responds to environmental

challenges. Systems theory, describing health as a composite of the somatic, psychic and social person-level areas, is particularly relevant to the study of health as a culturally-specific construct, in that it acknowledges the importance of the surrounding natural and social environment in the experience of health (Blum, 1983).

The theory and research of Kleinman (1978a,b, 1980, 1984) represent a significant body of knowledge pertaining to health and illness as concepts constructed by socio-cultural factors. Patrick, Sittampalam, Somerville, Carter and Bergner (1985) are other authors whose research emphasizes the importance of cross-cultural comparison of health values. Zola, in his 1966 research on the interplay of culture and symptoms, found that various ethnic groups accept ubiquitous conditions differently and perceive the same disease differently due to culturally specific value systems. He linked socio-cultural background to contrasting definition and response to the same experience.

The main perspectives and principles of current cross-cultural nursing knowledge are presented next. The work of key authors and researchers is discussed.

Cross-cultural nursing views. Leininger's monumental work in the field of transcultural nursing (1967, 1970a,b, 1977, 1984, 1985a,b; 1988) has contributed significantly to awareness of the need for culturally relevant nursing care. Other nurses have also recognized the influence of culture on definition of health and stress the importance of understanding the perception of clients

from other cultures (Branch & Paxton, 1976; Carpio, 1981; Dobson, 1983, 1985; Fong, 1985; Hancock & Perkins, 1985; Mercer, 1981; Orque, Bloch & Monrroy, 1983; Shubin, 1980; Sobralske, 1985; Spector, 1979; Theiderman, 1986; White, 1977). A growing volume of nursing research supports this cross-cultural focus (Anderson, 1981a, 1985a,b, 1987; Anderson & Chung, 1982; Anderson & Lynam, 1987; Majumdar & Carpio, 1988; Struser, 1985). Examination of the work of a number of these authors expands on the discussion of cross-cultural literature presented in the earlier chapter, and provides an understanding of the current state of nursing knowledge in this area.

Leininger (1970a), advocating a blending of anthropological and nursing perspectives, emphasizes the following contributions which anthropology has made to nursing theory:

(1) a "cross-cultural and comparative perspective of man";

(2) "the culture concept";

(3) "the holistic and cultural context approach in the understanding of man";

(4) "the realization that health and illness states are strongly influenced and often primarily determined by the cultural background of an individual" (p. 21-22).

These perspectives are significant to an investigation of the meaning of health from the vantage point of the individual located in his/her unique life context.

Hancock and Perkins (1985) have noted that cultural values, beliefs and attitudes heavily influence both the state of health

itself and individual perception of the state. White (1977) emphasizes the fact that peoples of ethnic origin cannot be viewed as identical with the mainstream population, and underscores the need for cross-cultural sensitivity. Shubin (1980) advocates that nurses assess the cultural factors in health and recognize the unique perspective of the client.

Carpio (1981), focusing specifically on the needs of adolescent immigrants, emphasizes the need for cultural sensitivity within multicultural Canadian society. In her discussion of cultural diversity in health and illness, Spector (1979) proposes that nurses need to "find a way of caring for the client that matches that client's perception of the health problem and treatment of that problem" (p. 75). Spector makes that following significant statement:

> Health and illness can be interpreted and explained in terms of personal experience and expectations. There are many ways in which we can define ... health or illness and determine what these states mean ... in our daily lives. We must learn from our own culture and ethnic backgrounds how to be healthy, how to recognize illness, and how to be ill. Furthermore, the meanings attached to the notions of health and illness are related to the basic, culture-bound values by which we define a given experience and perception. (1979, p. 75)

Anderson's extensive qualitative research (1981a, 1985a, b; Anderson & Chung, 1982; Anderson & Lynam, 1987) on health as a

socio-cultural construct, and the perceptions which various cultural groups hold regarding health and illness, has been noted. Studying the cultural influences on parents' perceptions of their child's long term illness, Anderson found that health goals were defined differently within different cultural contexts. Chinese and white families were found to differ in terms of what they envisioned as a desirable health state for their chronically ill children. Chinese parents regarded contentment and happiness as the most desirable health goals, while white parents considered normalization to be the most important (Anderson & Chung, 1982).

A core facet of Anderson's work is the proposal that health and illness incorporate the individual's subjective experience. Referring to the work of Kleinman, Anderson (1985b) presents a framework for examining the socio-cultural context of health and illness which provides guidance for nursing practice and research.

Sobralske's account of the perceptions of health held by Navajo Indians illustrates how socio-cultural factors shape perspectives on health. Since similar research on the perception of health held by individuals from India is unavailable, the following overview of Sobralske's research findings is pertinent to this discussion.

Sobralske's (1985) study of Navajo Indians is an example of cross-cultural enquiry specifically focusing on individual perception of health. She notes that the language employed by a cultural group reflects that culture's unique view of world phenomena; a view which includes definition of health. Sobralske

mentions, for example, that Navajo health perceptions may be better understood when their "concept of the universe being in motion" is recognized.

Navajo individuals found it very difficult "if not impossible" to define health, because "they have never really thought about the definition of health before" and regard health as inseparable from their surroundings. The inseparability of religion and health was also found to be an essential component of Navajo culture. Navajo perception of health is compared to "a state of not being vulnerable to threatening situations", and includes "a perfect body and mind" in harmony with the surrounding environment (p. 35-37).

Sobralesky's (1985) research underscores the fact that conceptualizations of health, as well as the terms used to denote health, vary among cultures. Consequently, effective ways of asking an individual about his/her perception of health, and encouraging a description of the phenomenon, may differ from culture to culture.

Health and Illness: Traditional Beliefs held in India

Although Western (allopathic) medicine is common in India, practitioners of indigenous medicine are consulted by professionals and laymen alike from all social classes, religious backgrounds, ethnic and occupational groups. The traditional indigenous Indian medical systems are Ayurveda (based upon Sanskrit texts), Yunani or Greek medicine (based on Arabic and

Persian texts), and Siddha (a South Indian system of humoral medicine). Homeopathy is also practiced widely (Leslie, 1978).

The Ayurvedic and Yunani concepts of health and illness are "coded into domestic culture, cuisine, religious ritual and the popular culture of physicians trained in cosmopolitan medicine". In addition to consulting cosmopolitan (Western) and indigenous physicians, laymen often confer with Holy men, priests and astrologers concerning health problems (Leslie, 1978, p. 244). An overview of the essential tenets of Ayurveda provides useful information on the concepts of health and illness traditional to India.

Obeyesekere (1978) notes two fundamental features of the Ayurvedic system of medicine:

(1) "an indigenous conception of the body (and mind) and its functions";

(2) "indigenous conceptions of body physiology and functions are in turn derived from the metaphysical and philosophical conceptions of a great tradition, or, as in all traditions, of an even larger cosmological or sacred world view" (p. 256).

In accordance with the Ayurvedic tradition, Indian culture sees the individual having a fundamental relationship with nature. The universe is seen to be made up of the five elements: earth, water, fire, air and space. These five elements are the basic units of all life, and comprise the 3 humors (wind, bile "fire" and phlegm "water") and the 7 physical components of the body (food juice, blood, flesh, fat, bone, marrow, and semen). Health

is seen as a state where the three humors are in optimal balance, with harmonious functioning of physiological systems. Illness is believed to arise when there is imbalance of the 3 humors, and consequent disequilibrium in the individual. Foods also contain the 5 elements and are classified as hot or cold, with certain foods taken at different times of the year and for different physical conditions so that health is maintained (Helman, 1984; Kakar, 1982; Obeyesekere, 1978; Vora, 1986).

Indian therapeutic approaches are largely based upon restoration of physical and mental balance or equilibrium. Kakar (1982) explains this Ayurvedic perspective:

> The restoration of the balance of bodily elements and thus of health rests on the consumption of environmental matter in the right form, proportion, combination and at the right time ... seasons, plants, natural substances and constituents of the body are all integrated in a complex yet aesthetically elegant theory of physical health as an equilibrium of somatic and environmental elements. (p. 231)

Literature on Individuals from India

American literature is essentially devoid of discussion of the culture of individuals from India. As a reflection of the ethnic populations found in the United States, American cross-cultural health care literature focuses primarily on the Black, Latino/Hispanic, Japanese, Chinese, Vietnamese and American Indian communities. The majority of textbooks on cross-cultural

health care, such as those by Spector (1979), Harwood (1981), Orque, Bloch and Monrroy (1983) and Branch and Paxton (1976), do not include information about individuals from India.

Canadian and British publications constitute the main sources of information on the perspectives of individuals from India. Dobson's (1983, 1985) work with various ethnic groups in Britain looks at the problems immigrants from India encounter within the Western health care system. Dobson, however, discusses the Sikh community almost exclusively. Previously noted Canadian literature reflects a similar focus on individuals of the Sikh faith (Buchignani, 1977, 1980; Detels et al., 1966; Gibson et al., 1987; Struser, 1985). As described in the subsequent section, accounts and research on Indo-Canadians' health concerns and perspectives on health are limited in number.

Indo-Canadians

In the discussion of the background to the problem, a portion of the available literature on Indo-Canadians was cited. Most literature was seen to concentrate on historical and socio-cultural characteristics of the Indo-Canadian community rather than health issues.

Literature discussing Indo-Canadians in the province of British Columbia has focused for the most part on the life and history of the Sikh community (Ames & Inglis, 1973; Bains, 1974). The study by Drakulic and Tanaka (1981) focuses on the Sikh population but also refers to Ismailiism and Hinduism.

Most published research on Indo-Canadians is disease

oriented. That of Ough (1976), Smith (1971), Detels et al. (1966), Gibson et al. (1987) and Bindra & Gibson (1986) has already been noted as representative of this research. Investigations examining Indo-Canadian health concerns are scarce, and studies addressing subjective experience of health related issues, such as childbirth (Struser, 1985), are rare.

Anderson's (1985a) research on the health concerns and help-seeking experiences of Indo-Canadian and Greek women immigrants is an example of investigation focusing on Indo-Canadians from a feminist perspective. To date no Indo-Canadian research dealing specifically with men has been found.

The recent quantitative study by Majumdar and Carpio (1988) investigating the concept of health among selected Canadian ethnic populations, is noteworthy as apparently the only research which specifically aims for subjective description of the Indo-Canadian view on health. This survey recognizes the importance of culture in definition of health, and offers description of the concept of health according to four components: physical, social, mental and lifestyle. The study, however, does not focus exclusively on the perspectives of Indo-Canadians and presents an somewhat narrow account of the health phenomenon. The study also fails to specify the characteristics of the Indo-Canadian sample population in terms of Hindu, Sikh or other ethnicity.

Literature on the health concerns of Indo-Canadians is largely not grounded in research. Thompson's (1987) article on

health promotion strategies for Indo-Canadian women in Ottawa is a good example of recent journal literature focusing on the health needs of this group, but lacking the support of data from actual nursing research.

Summary

To provide a background for viewing the current study, various perspectives on the concept of health have been presented through an overview of selected literature. An account of the derivation of the word "health" offered support for holistic perspectives on health, and introduced discussion of some contrasting views on health presented in the sociological, philosophical and theological literature. Traditional biomedical perspectives on health and illness, as well as some of the socio-cultural perspectives found within the health care disciplines, were summarized in terms of their contribution to conceptualization of health. This discussion shows that health remains an abstract concept with parameters that vary cross-culturally and according to social context.

A major portion of this review was concerned with cross-cultural nursing literature because of its significance to the current investigation. The nursing theory of Leininger was emphasized as fundamental to cross-cultural nursing enquiry. The work of Anderson (1985b) was noted as current qualitative nursing research focusing on health and illness within the socio-cultural context, which specifically supports the focus of the current

study.

The key concepts from Sobralske's (1985) study on the Navajo perception of health were discussed as particularly useful background to the present research, given the lack of similar studies specific to the Indo-Canadian culture. Majumdar and Carpios' recent (1988) research on the health perspectives of various Canadian ethnic groups was noted as apparently the only investigation framed to specifically address Indo-Canadian views on health. Majumdar and Carpios' study, however, provides a quantitative description of health restricted to the four components: lifestyle, social, mental and physical, and fails to specify details of the characteristics of the Indo-Canadian sample population.

Examination of the primary concepts of India's belief system surrounding health and illness provided further valuable background information for this study. Current health literature on the Indo-Canadian community was found to contain virtually no information on this cultural group's unique perspectives on health. The need for research in this area is clearly evident.

The discussion in this chapter revealed health as a multidimensional concept influenced by socio-cultural factors. The supporting framework directed the researcher to adopt the phenomenological approach in order to gain insight into the individual subjective experience of health. Chapter one provided an introduction to the theoretical and methodological perspectives which grounded this research. The following chapter will present

details of the methodology used in the study.

CHAPTER 3: METHODOLOGY

This chapter describes the methodology used in this qualitative research. The selection of study participants and procedures for data collection and analysis, as directed by the phenomenological method, are presented. The conduct and outcome of the pilot study carried out prior to commencement of actual research are detailed in the preliminary discussion on participant selection. Issues of reliability and validity in phenomenological research are considered in conclusion.

Selection of Participants

Theoretical sampling

This phenomenological research employed theoretical, nonprobability sampling methods, in contrast to the probability sampling methods used in deductive, quantitative research. In theoretical sampling the researcher ultimately selects the study participants according to the needs and direction of the research.

Theoretical, or selective, sampling is based upon the premise that "all actors in a setting are not equally informed about the knowledge sought by the researcher". Some individuals in a group or culture are viewed as more knowledgeable and receptive to being interviewed than others (Morse, 1986, p. 183).

Morse (1986) provides the following relevant description of the assumptions underlying non-probability sampling:

Because the researcher is interested in meaning,

> understanding a concept, and making sense of the setting, and the object is to obtain data that are comprehensive, relevant, and detailed, the voluminous verbatim notes, in bulk alone, limits the sample size. Thus, because of the small sample size and the time and effort required to collect data, it is essential that the researcher maximize opportunities to obtain the most insightful data possible. (p. 183)

Theoretical sampling is used to enter into the context of the phenomenon under study, obtain rich data samples and advance theory (Duffy, 1985; Stern, 1980). This research method does not aim to test theory. The method involves a continual decision-making process which continues until data categories are saturated and no new themes emerge. Adequacy of the sample is accomplished when "the researcher experiences redundancy in descriptions", in that "repetition of statements regarding the phenomenon under study" occurs (Parse et al., 1985, p. 17). Morse describes this completeness of sampling as the point at which theory "does not have any gaps, makes sense, and has been confirmed" (1986, p. 184).

The researcher using non-probability sampling techniques does not aim to generalize study findings to the population at large in the traditional quantitative sense. In qualitative research, phenomena are examined in "their natural settings", and researchers argue that "generalizability is itself something of an illusion" as no situation can ever be entirely context free.

Qualitative research findings are applicable in that the "general can be found in the particular" (Sandelowski, 1986, p. 31).

Sandelowski states that applicability of qualitative research should be viewed in terms of the criterion of fittingness. Referring to the work of Guba and Lincoln (1981), Sandelowski describes this "fit" as follows:

> A study meets the criterion for fittingness when its findings can 'fit' into contexts outside the study situation and when its audience views its findings as meaningful and applicable in terms of their own experiences. In addition, the findings of the study ... 'fit' the data from which they are derived. The findings are well-grounded in the life experiences studied and reflect their typical and atypical elements. (p. 32)

Criteria for Selection

Participants were selected on the basis of their experience with the phenomenon under study and their ability to communicate this experience (Anderson, 1985a; Knaack, 1984).

The criteria for selection of study participants were as follows: Indo-Canadians between the age of 25-60 years who were born in India and had resided in Canada for at least 5 years at the time of the study; all participants were to be able to read and converse in English so that the researcher could conduct all interviews independently without the aid of a translator.

Rationale for Criteria

Hindu rather than Sikh individuals were selected for this

study because: (1) they represent a group towards which less research has been focused; (2) it was assumed that this group's command of the English language would be superior to that of Sikh individuals coming from the rural Punjab, since Hindu immigrants generally come from urban settings; (3) the researcher is familiar with the traditions and lifeways of the Hindu community.

Adults were selected as study participants because longer years of life experience imply greater familiarity with the phenomenon of health, and increased ability to provide detailed verbal description of that phenomenon to the researcher. A wide age range (between 25-60 years) was set for participants in order to assure access to an adequate sample. First generation Indo-Canadians who had resided in Canada for a minimum of five years at the time of the study were specified to insure participants' grounding in India's culture, as well as opportunity for experience of life in Canadian society. A maximum time of residence in Canada was not specified for the sample.

Both men and women were included in the study in order that the researcher discover if any sex-difference is involved in the perception of health, and avoid the error of assuming that both sexes respond similarly. The fact that the participants were English speaking Hindus quite likely determined a certain social status, and no formal socio-economic criteria were specified for the sample.

Selection Procedure

In this study participants were recruited through an informal

network of colleagues and acquaintances advised of the investigation focus by the researcher. Initial contact with potential participants was made through a person from this informal network.

The network person presented suitable potential study participants with a formal letter of information describing the purpose and conduct of the study, and a consent to contact form (see Appendix A). Potential informants interested in study participation signed the consent to contact form. They then communicated their consent for contact by either directly phoning the researcher, or returning the consent to contact form to the researcher through the network person. In the case of those participants who contacted the researcher by phone to convey their consent for contact, the researcher obtained the signed consent to contact form at the initial meeting with the participant.

Only one deviation from the described procedure for indication of consent for contact occurred. One potential informant mailed the signed consent to contact form to the researcher; this individual, however, was not included in the study as an adequate sample size had already been obtained.

After receiving consent for contact, the researcher communicated with the potential informants by phone, and described the study in detail and answered any questions at that time. An initial interview was arranged with individuals who agreed to participate in the study. Upon actual meeting, the researcher reassessed the potential participant's suitability for inclusion

in the study, and the formal consent form for participation in the study (see Appendix B) was signed.

A total of 16 individuals were contacted by the informal network for study participation. Of these 16, 3 people contacted were not interested in taking part in the study, and 2 people failed to indicate their consent for contact to the researcher although they had initially expressed interest in study participation to the network person. The researcher thus obtained a list of 11 knowledgeable and receptive participants. From this list of 11, 3 persons were not included in the study as a sample size of eight was determined sufficient.

The final sample consisted of six women and two men. Following description of the pilot study, the characteristics of the sample population will be presented in detail.

The Pilot Study

Prior to actual conduct of the research, informal meetings were arranged with two Indo-Canadian women contacted through the informal network according to the criteria and contact procedure described for the study sample.

At this time the researcher tested the initial trigger questions (see Appendix C). The two individuals participating in the pilot study were asked the initial trigger questions and requested to provide feedback on the appropriateness of these questions for eliciting a description of the phenomenon of health from Indo-Canadians. The information obtained from the pilot test assisted in the formulation of appropriate trigger questions to be

used in the research interviews (see Appendix D).

Both of the pilot interviews were tape-recorded, and one was transcribed by the researcher. The considerations for protection of human rights outlined for the actual research were observed during the pilot study. Pilot interviews were commenced subsequent to receipt of formal approval for conduct of the research study. The pilot testing procedure was completed during the first two weeks of the research period.

Pilot Study: Results

The initial trigger questions were revised according to the feedback obtained during the pilot test. The two pilot participants described the initial trigger questions as "good", and offered two suggestions regarding alteration of the test questions:

(1) that study participants be asked about the relationship between food and health;

(2) that the researcher should ask about the phenomenon of health using the question "What do you think about health"? The pilot participants suggested that this single question would elicit a description of health in terms of health maintenance, feelings about health and activities carried out when healthy.

Characteristics of the Sample

The final study sample consisted of eight Indo-Canadians, of whom six were female and two were male. Participants' ages ranged from 28 to 56 years, with the majority of study participants being in their middle 40s.

The sample was quite homogeneous in terms of socio-economic status and lifestyle. All participants were of comfortable means. Of the 8 study participants, 6 lived in free-standing homes, and 2 in attached dwellings. Three women in the study were homemakers, of whom one occasionally worked outside the home. The remaining study participants were currently employed in professional occupations; two individuals in this group were self-employed. Seven of the eight participants lived in the Greater Vancouver area, and one lived in a nearby municipality.

Seven of the participants were married and one was a single parent. All participants had children, with 6 participants having children living at home. At the time of the study, the participants' time of residence in Canada ranged from 6 1/2 to 21 years; most participants had lived in Canada for about 12 years. One female participant had lived in the United Kingdom for three years prior to coming to Canada; the remaining participants had come to Canada directly from India. Participants were born in various areas of northern India, including the Punjab.

Several participants commented to the researcher that they had not given much thought to the meaning of health prior to the researcher's interviews. The two male participants indicated familiarity with traditional Indian medicines, and spontaneously described this subject matter during the course of the interviews.

One participant, describing the sense of pride she had in her cultural background, mentioned the fact that she "couldn't be Canadian without her Indian heritage". For this participant,

being Canadian meant being Indo-Canadian.

Data Collection

The phenomenological method aims to construct human experience as it is lived. Elicitation of a description of the phenomenon under study is a process of exploration shared by the researcher and participant. Data are not considered to be biased by the researcher's full involvement in the collection of data nor the "subjectivity" of the participants. "Meaning" is rather constructed as an "inter-subjective" phenomenon during the encounter between the researcher and participant.

In order to appreciate human experience from the perspective of the individual, the phenomenological approach requires the researcher to use "bracketing" during data collection. During this process, the researcher lays aside "the natural attitude to the world" resulting from personal biography, so that the "layers of meaning" which give rise to interpreted experience are removed (Oiler, 1986, p. 72-73). In other words, the researcher recognizes that the mind is not a "tabla rasa", and that the world appears according to the way the individual constructs and interprets it. Bracketing is the process of deliberately suspending, or setting aside, these preconceived notions about the meaning of the phenomenon under study so that "bias in reflection on experience" is controlled and the experience is brought into "clearer focus" (Knaack, 1984; Oiler, 1982, p. 179).

Data Collection: The Procedure

Data were collected through 15 in-depth, semi-structured interviews. Interviews varied from 45 to 90 minutes in duration, with most interviews continuing for a one hour period. In several instances, the researcher's actual contact time with the study participants extended past that of the formal interviews. All interviews were conducted in the participants' own homes.

In the majority of cases, interviews were completed without any disturbance from external sources. In those few instances where a family member or household pet entered the room during the course of the interview, the discussion between the researcher and the participant was not apparently affected.

Interviews were tape-recorded on an audio-recorder and transcribed verbatim. Ten interviews were transcribed by the researcher herself. Listening to and transcribing the interviews proved very helpful aspects of the data collection and analysis process. This experience afforded the researcher additional insight into the participants' sentiments and emphasis placed on certain portions of the interviews, and so encouraged the researcher's entrance into the participants' descriptions of the phenomenon. In the case of the 5 interviews transcribed by a typist, the researcher listened to the interviews in detail during the process of correcting and proofing the script.

All participants stated that they felt comfortable with interviews being tape-recorded. During the second set of interviews participants were notably more relaxed than during the

initial interview, and appeared to totally ignore the presence of the audio-recorder. The researcher established good rapport with all participants during the initial meeting. The vast majority of participants indicated that they had enjoyed describing their perceptions on health to the researcher.

Details of the Interviews and Construction of Accounts

Two interviews were conducted with 7 of the 8 study participants; one participant declined a second interview. The first set of interviews involved the researcher asking one or all of the formulated trigger questions (see Appendix D) to initiate description of the phenomenon. Once the researcher had asked an initial trigger question the direction of the interview was determined by the participant, with the researcher's subsequent questions concerning the health experience being framed according to the participant's responses and free description of the phenomenon.

Each interview built upon earlier interviews so that a complete account of the phenomenon under study was obtained. In accordance with phenomenological methodology, the second set of interviews permitted the researcher to validate and clarify data collected during the initial interviews. During the second interview, the participant was also able to expand further on the description of health and describe deeper levels of perception into the phenomenon. Upon conclusion of the second interview all participants stated that they had exhausted the theme of discussion. This was also the opinion of the researcher. The two

sets of interviews resulted in rich data providing a concrete description of the phenomenon of health.

Field Notes

The researcher maintained field notes throughout the study to complement the data obtained in the interviews. The method of keeping field notes is unique to each researcher (Spradley, 1979). In this study the researcher kept a journal containing notes describing the ambience and conduct of each interview, as well as the researcher's personal experiences of interaction with the study participants.

Protection of Human Rights

Informed Consent

Each study participant received a detailed explanation of the research purpose and procedure in the form of oral and printed information. The network person or researcher provided the participant with a letter detailing information about the study, and an accompanying consent to contact form (see Appendix A). After discussion with the researcher at the initial meeting, each participant was asked to sign a written consent form for participation in the study (see Appendix B). The participant's signature on each form acknowledged receipt of a copy of the form.

Each participant was given the opportunity to ask questions concerning the research prior to signing the consent form. Participants were informed that participation in the study was entirely voluntary, and that they might refuse participation and remove themselves from the study, or refuse to answer any

questions without negative consequences of any kind. Participants were also informed that they might request erasure of any tape, or portion of a tape, at any time during the study without negative consequences of any kind. Written permission was obtained from each participant for interviews to be tape-recorded; this was included in the formal consent form described above.

Confidentiality

Confidentiality of all collected data was assured. The audio tapes were transcribed and coded so that the names of the participants did not appear on the transcripts, and were known only to the researcher. Any names used by participants during the course of the interview were removed from the transcript by the researcher.

The researcher, her thesis committee, and a typist were the only individuals with access to recorded data. Study participants were assured that their identity would not be revealed either during the course of the study or in any unpublished or published materials.

The University of British Columbia Behavioural Science Screening Committee for Research Involving Human Subjects provided an ethical review of the study, and granted approval before actual research was commenced (see Appendix E).

Data Analysis

The process of constant comparative analysis used in phenomenological study directs the researcher to begin data

analysis as soon as data are collected (Morse, 1986). Data collection and data analysis are necessarily described as separate events for practical purposes.

In reality, however, the researcher's "analytical and observational activities run concurrently (and) there is temporal overlapping of observational and analytical work. The final stage of analysis (occurring after observation has ceased) becomes, then, a period for bringing final order into previously developed ideas" (Lofland, 1971, p. 118).

Parse and co-workers (1985) describe this process in slightly different terms. According to these investigators, data analysis involves the three-fold process of intuiting (or contemplative dwelling with the data), analyzing and describing. In the final process of description of the findings, the researcher moves from the subject's description to a structural definition of the phenomenon.

In this study data analysis was carried out according to the methodology advanced by Knaack (1984) as outlined by Colaizzi (1978) and Giorgi (1975). Following each interview, audio-tapes were transcribed verbatim. As the initial step in formal data analysis, the transcripts were read through several times to give the researcher an overall sense of the subject's description of the phenomenon of health.

In the next step of analysis, significant statements pertaining directly to the topic under investigation were extracted from the data. Meaning units (which remained faithful

to the original data) were formulated as they emerged from significant statements. Using creative insight, the researcher contemplated upon and refined each unit in order to capture the most complete meaning, retaining the informant's own words as much as possible during this process.

The above steps were repeated for each transcript. In accordance with the tenets of theoretical sampling (Morse, 1986), meaning units extracted from the first transcript were compared with those extracted from the second transcript, and so forth, until a point of saturation was reached where redundancy in descriptions of the phenomenon occurred.

Formulated meaning units extracted from the descriptions were then organized into clusters of themes regarding the experience of health. The researcher at this point referred back to the original transcripts to validate the clusters of themes. Any contradictory themes were recognized as real and valid, and the data retained.

The non-redundant clusters of themes were integrated into a comprehensive description of the experience of health. This analysis was validated with the study participants during the second interviews by asking if the analysis correctly described their experience of the phenomenon. As a result of this analytical process, the researcher constructed a phenomenological description of the essential structure of health as experienced by the study participants.

Reliability and Validity of Data

The issues of reliability and validity in qualitative research center around truthfulness, credibility, auditability and confirmability. In order to fulfill these requirements, data must faithfully reflect the human experience, and the investigator's "decision trail" must be clear so that other researchers can easily follow the line of reasoning (Sandelowski, 1986).

In phenomenological studies, the researcher collects data personally. The validity of data depends upon the ability of the researcher to "tap the subject's experiences" and use the method of "reduction or bracketing" of personal presuppositions. Obtained data is accepted to have both face and content validity under the assumption that the participants "have experience with the research topic and can communicate their experiences". Feedback and clarification of collected data are employed to assure the validity and reliability of the research; as the researcher can "never assume that s/he understands the meaning of the phenomenon" (Knaack, 1984, p. 112-113).

Sandelowski (1986) has discussed strategies for achieving rigor in qualitative research. Auditability is achieved by the description, explanation or justification of a number of steps in the research process such as how the investigator first became interested in the topic and how the topic is viewed. The research report itself is of great importance in the achievement of auditability. Creditability is managed by the researcher adopting such strategies as checking for the representativeness of data,

triangulation, and obtaining validation of data from subjects. The establishment of auditability, truth value and applicability achieves confirmability. The truth value of the research is determined by phenomena and experiences being discovered as they are perceived by the subjects (Sandelowski, 1986).

Summary

The phenomenological perspective determined the methodology employed in this study. This chapter has described the methods of participant selection, data collection and data analysis utilized in this research consequent to interpretation and implementation of the phenomenological approach. Issues of reliability and validity in qualitative research were discussed in brief.

Theoretical sampling methods directed selection of participants meeting the stated criteria for inclusion in this research. The initial pilot study provided direction for formulation of specific trigger questions to initiate participants' description of the phenomenon during semi-structured interviews.

Shared, in-depth exploration and dialogue between the researcher and participants according to the phenomenological method, resulted in construction of a description of health based upon informant accounts. The following chapter presents the results of this study.

CHAPTER 4: PERCEPTION OF HEALTH: THE MEANING OF HEALTH TO INDO-CANADIANS

This chapter presents the results of the study, using participant accounts to describe how participants experienced health. Although the subjective experience of health is unique, by virtue of the distinct social, cultural and historical factors inherent in the individual life context, study participants described the health phenomenon in a strikingly similar manner. During data collection and analysis, central themes emerged which were common to the descriptions of health provided by all participants.

A final ordering of the common central themes, and refining of previously developed ideas, led to the formulation of a definitive analytic framework for the research findings. This coherent "general design", or framework, supporting analytical description of data, represents a "set of logically interrelated ideas" discerned by the researcher after contemplating upon the data for an intensive period (Lofland, 1971, p. 124).

This final analytic framework is used to organize the data presented in this chapter, and represents the fundamental meaning of health for the Indo-Canadians who participated in this study. It provides a vision of health true to the accounts of individual study participants, and includes the essential aspects of each participant's description of the phenomenon.

When study participants described their experience of health, they located it within the overall context of doing normal

activities. Participants' descriptions of doing normal activities therefore make up the first section of this chapter, along with an introductory discussion of the importance which participants ascribed to health.

This overall context of doing normal activities frames two central themes, or levels of description of health, arising from participant accounts. The first level of description focuses primarily on the condition of the physical body and explains health in terms of complete health, partial health, and sickness; a three phase continuum referred to here as "the three phases of the health experience". The second level of description explains health in relation to the mind and other factors influencing health. These two levels of description together represent a holistic view of health, and constitute the second and third sections of this chapter respectively. A schematic and narrative description of the final analytic framework will now be presented.

Health: The Most Important Thing in Life

DOING NORMAL ACTIVITIES:

A) The Three Phases of the Health Experience
Complete Health - Partial Health - Sickness:

1) Complete Health:

- Body and mind together: Total unit healthy
- Doing happily, doing well
  - Energetic resistance
  - Independence and control

2) Partial Health:

- Can do with effort, and not well
  - Decreased energy and resistance
  - Decreased independence and control
- Temporary and bothersome

3) Sickness:

- Cannot do, cannot fulfill responsibilities
  - Low energy and resistance
  - Dependence, lack of control
- Serious, permanent, worrisome
- Return to health, or chronic illness and death

B) Factors influencing the Health State:

1) The Mind:

- Worry (mental stress)
- Positive mental attitude

2) External Factors

- Diet and exercise
- Sleep and cleanliness
- Use of medicines
- Maintaining routine
- Working outside of the home
- Home atmosphere

Figure 2: Components of the Framework.

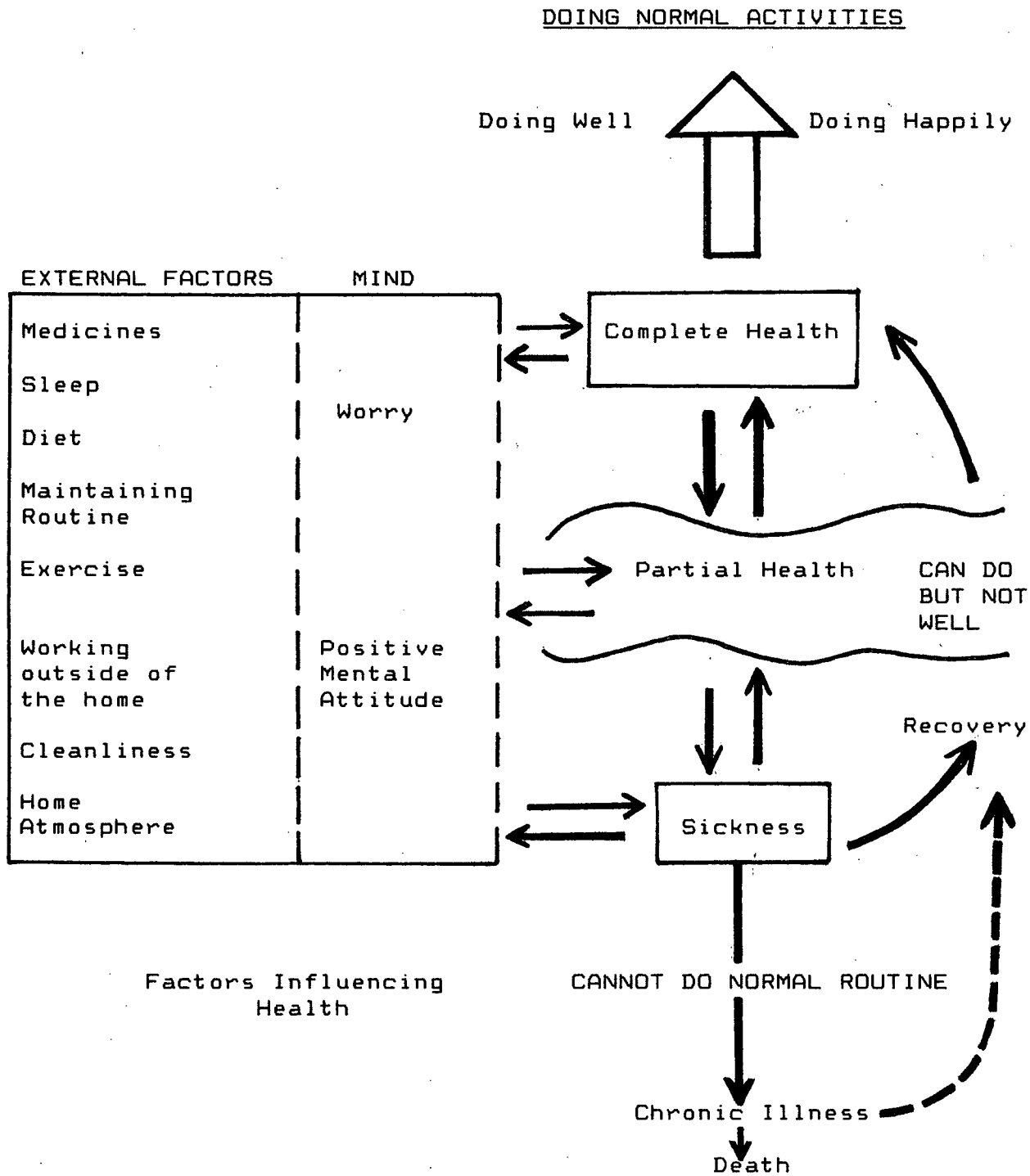

Figure 3: Schematic Description of the Framework from the Participants' Perspective

Health: The Most Important Thing in Life

Participants described health as something of great importance to them in their lives, a resource which allowed them to carry out life activities as well as a source of happiness.

Health was seen as something of fundamental worth to all people. One participant described health as "the first and foremost happiness in life"; others spoke of health as something far more valuable than either worldly wealth or possessions.

The importance of health was explained in terms of how it allows a person to do things. The following accounts illustrate the various perspectives participants offered on health as an essential resource for being able to do everything in life.

P = Participant
R = Researcher

> P: Well, health is very important, you know. I think one should really take care of health first before anything else.
>
> R: Ah huh.
>
> P: Yeah. Because if you're not healthy you just can't do anything. So all your dreams, or whatever you want to do, all your wishes --- so health is I think the first thing to look after.
>
> R: The most important thing?
>
> P: The most important thing, yeah.

.....

> P: That (health) means a lot to you. That means the world to you, you know, you're being healthy and being fit. Because if you are not, doesn't matter what you have got, you have got all the wealth in the world, but if you are not healthy what can you do with it?

.....

> P: That's (health is) the most important thing in life. If

you are not healthy, you are nowhere.

R: Health is the best thing?

P: Health is the best thing in life.

R: The most important thing in life, you're saying.

P: That's right.

R: Because it allows you to do everything?

P: Whatever I want to do.

.....

P: -- Health is important in every case, you know. Whatever you want to do, the health comes first.

The importance of health was described in terms of happiness. One participant stated that his attitudes about health stemmed from his childhood experiences and upbringing in India. He explained that elementary school text books in India commonly contain a lesson or parable about the importance of health in life.

P: When we were child, the first lesson that we were taught in school, if I were to quote that lesson, that's a Gujarati title, a provincial language in India, "Pahelu sukh te jate narya": the first and foremost happiness is the health. --- We always thought that health is the most important thing in life.

These accounts describing the importance of health, and provide a fitting introduction to the following discussion of the overall context within which participants experienced health: doing normal activities.

Doing Normal Activities

Participants' descriptions of the health experience were

located within the overall context of doing normal activities. When the researcher asked participants how they felt about health, or what their experience of health was, descriptions were primarily in terms of being able to do normal activities.

When directly questioned regarding the "feelings associated with health", participants stated that they felt good, or felt happy when they were healthy. These feelings of happiness, contentment, or "feeling good", however, stemmed from being able to carry out the activities when healthy. The following section examines how participants described normal activities.

What Normal Activities Are

As the researcher explored participant descriptions, it became clear that doing daily activities was viewed as a normal life process intimately linked to health. Participants explained normal activities as the daily duties associated with individual life roles and responsibilities, as well as those activities they personally wanted to engage in. Upon further reflection, however, participants generally stated that the things they "wanted to do" were, in fact, their duties and routine activities.

Descriptions of normal activities varied in terms of specific details, as each person's life included distinct personal, family and social factors. The following accounts illustrate how participants explained normal activities in terms of duties and daily routines.

R: So "normal" means --- normal activities means what?

P: The daily life activities.

R: So, how do "normal" and "daily activities" relate?

P: They're the same. You go to school. Do your, you know, regular work.

.....

R: When you were talking about normal activities, you said "normal" duties. Do you see duties and activities as the same thing, or is there any difference?

P: No, they are the same things.

R: The same things. Just a different word to describe the same thing? --- what you do?

P: Um hum.

Another participant elaborated on this point, explaining that "being normal" meant doing action:

R: Being normal then is being able to do your daily duties?

P: Right. Yeah.

R: So its more a being able to do than a feeling?

P: I think so. The feeling comes, you see, if you are doing it.

R: Okay, so being "normal" means doing the things you'd normally do in health -- in a state of health. Such as getting up, and you told me showering, and going out, and working.

P: Right.

This was expanded upon:

R: So "being normal" is in terms of action?

P: Yeah. That's right, action, and then -- yeah, same thing you see.

R: Action and what?

P: And duties

Other participants presented similar views, illustrating the perception that daily routine and duties were viewed as synonyms.

The following accounts describe the nature of these duties:

R: Your "duties". Okay, could you tell me a little bit more about what you mean by your "duties"?

P: Well, these are my duties. You know, I'm supposed to look after my kids, look after my husband, and my mother-in-law. Do what I can do for them.

R: And you can only do those things when you are healthy?

P: Yeah.

.....

P: Well, ah, routine, you know, when you are doing things and looking after your family and you know, staying content. And you know, you think you have done all your duties and all that stuff.

R: Ah, huh. You mentioned duties before when we talked a bit about that.

P: Yeah, um hum.

R: So that's what you mean by a "routine" really?

P: Yeah, yeah. That's right, yeah.

The kind of activities considered to be normal daily routine things were further explained by one participant as follows:

R: So "normal" to you, normal things means again what exactly? Could you elaborate a minute on that?

P: Well, all my things whatever I do, the housework, look after the kids and go out shopping.

Normal activities were described by one participant as those activities a person usually does that do not harm, or adversely affect the body.

R: How do you know what is normal for you and what isn't normal?

P: Okay, there is not a valid chart that this is normal, this is abnormal, --- but the things which you have been doing and which has not adversely affected your otherwise daily activities the next day or something like that. --- Its only for the person to judge from his own daily look

in life, that --- what is normal for him, what is abnormal for him. That person only has to find out.

R: Um hum.

P: Something might be normal for me which would not be normal for you.

R: Alright, could you tell me a little bit more about what "normal" means? What that term means? How you are using it?

P: Normal in the sense I meant, something which you keep doing and which does not hurt you. That's what I mean, normal.

The same participant explained that the work which a person usually does, is normal for him. He described doing his usual professional work versus suddenly taking on a job which he would be unaccustomed to, stating that a person can adapt to activities which at first are not normal for him.

P: --- But say, normal in the sense that I'm used to doing this type of work (his own professional work). And tomorrow if I were to start working in a sawmill, its not normal for me. But its quite right that in course of time I would get used to that.

R: Yes.

P: But in the initial stages it would definitely hurt me, in the sense that every day eight hours work when I come home I feel so tired, which doing this job 10 hours a day I would not. That's what I mean by normal.

R: So I think you're telling me that normal means doing things that don't affect your health adversely?

P: Yeah. As I said, but then those which are normal for me, may not be normal for another person, as I said, because mine is a different type of work. But if I go and work in a sawmill and pull logs ---

R: Yes.

P: --- that's abnormal for me in the initial stages. Quite fine that after a month there, I would become so used to that and I would not feel, and I would say that that's the normal work for me. But its a question of getting

used to what is normal and abnormal.

Participants also described normal activities as the things they wanted to do:

> R: So when you are healthy, what kinds of things are you able to do in your life?
>
> P: Whatever I want -- any --- you know, like if I have the aim for music, or for concert, or for dancing, or for teaching somebody, or you know, helping out, volunteer basis or anything. Whatever.
>
> R: You're able to do whatever you feel like doing, whatever you want to do?
>
> P: Yeah. Whatever I feel like doing, yeah.

Participants spoke of health in terms of a complete health, partial health and sickness continuum, referred to here as the three phases of the health experience. They explained how being completely healthy, partially healthy or sick affected, or altered, their ability to do normal activities. Participant accounts described these three phases of the health experience in terms of how the characteristics, or conditions, of each phase impinged upon, or facilitated carrying out action. The three phase continuum making up the health experience is now examined in its totality, to provide the context for subsequent description of the unique parameters of each phase.

The Three Phases of the Health Experience: Complete Health - Partial Health - Sickness

Participants' explanations of health were inextricably related to the three phase "complete health - partial health - sickness" continuum (see figure 3). All participants without

exception viewed health in terms of complete health and partial health and sickness, although they used slightly different terms to signify the three phases and described the three phases with varying degrees of specificity.

Complete health and sickness were described the most clearly. Sickness was explained as a state diametrically opposed to complete health. Partial health, in contrast, was described rather vaguely in most accounts as a nebulous state somewhere "in between" complete health and sickness.

The following account describes the health experience in terms of its three distinct phases: complete health, partial health and sickness. The participant here refers to the "in-between" phase of partial health as "ill-health".

> P: Maybe if I took being healthy is the first stage, ill-health being the second stage --
>
> R: Um hum.
>
> P: -- and third stage being sickness or ill. Okay?
>
> R: Yes.
>
> P: In whatever order you want to take it. So, if I had only three stages, the third stage is being sick, second stage is being ill-health, and first stage is being perfectly healthy.
>
> R: Yeah.
>
> P: Okay? And you could add any degrees to it. Whatever degrees are there in between. I mean, from one to ten.
>
> R: Okay. That's what I'm wondering right now.
>
> P: Yeah. Whichever way you want to scale it or measure it. In terms of the body.

Other informants described parts of this continuum. The subsequent account focused on the transition from complete health

to partial health. The participant refers to complete health as "health" and partial health as "less healthy", or "getting into a problem".

> P: I'm, I feel okay, you know, I'm healthy, and I want to give a best of care to the patients. But supposing I hurt my back, and then I can't bend, can't do anything and then I would say: Yes, I don't feel good. Whether you can call it less healthy, --- or getting into a problem.

The movement from partial health to sickness was explained in other accounts. In the following description, the participant clearly distinguished health from sickness, but was vague about the "in between" partial health stage (which is referred to here as "unhealth"). The partial health stage was explained as potentially progressing to sickness.

> R: I'm just wondering if you see, you know, that you're healthy, and then if you're not healthy, you're calling that "being sick"? Which I believe you are.
>
> P: Yes. Well, healthy is <u>healthy</u>. And when you are sick you are <u>sick</u>, so.
>
> R: Okay, so the word unhealthy means being sick, or is that something else?
>
> P: No, sick is <u>sick</u>. You've got some ailment or whatever --- I guess it does mean the same thing.
>
> R: Unhealthy means being sick?
>
> P: Yes, unhealthy means --- would eventually mean you are not in full health.
>
> R: You mean so you'd be unhealthy, then if you let that go on --- you could become sick?
>
> P: You could become sick, yeah.

Another participant viewed this progression from partial health to sickness slightly differently:

> P: I mean, it could be, okay, a higher stage or a lower stage

-- whatever you want to call it, of unhealthiness (partial health) makes you sick.

To summarize, health was explained by participants with reference to the three phase health continuum. Although participants described these three phases with varying degrees of specificity, complete health and sickness were identified most clearly and perceived as opposite states of experience. Participants were less precise in their descriptions of partial health.

The three phases (complete health, partial health, sickness) were distinguished primarily by the condition of the physical body, although participants recognized the body and mind as two inseparable aspects of the human person. (The role of the mind in the three phases of the health experience will be discussed separately in the last section of this chapter).

Participants described these three phases of the health experience in terms of capacity for activity. They explained that individual ability to carry out normal activities was affected by the amounts of energy, resistance (to disease and change), independence and control present in each phase of the health experience. Existing measures of these four characteristics of health indicated whether a person was completely healthy, sick, or in the "in between" stage of partial health, and supported the capacity for normal action inherent in each phase (see figures 2 & 3).

Each phase of the health experience will now be discussed. The parameters of complete health are presented first.

Complete Health

Being able to do normal activities well (effectively), with associated feelings of happiness and satisfaction, was the main characteristic that distinguished complete health from partial health and sickness. As will be discussed later in this section, the four characteristics of the health experience (energy, resistance, independence and control) were described as present in the greatest measure in complete health. They were linked to the other distinctive features of complete health described by participants: such as feeling full of energy, being able to do action without getting tired, being able to do things without the help of other people, being in control of one's life, and so on.

Participants described complete health variously as: "general health", "100 percent healthy", "total health", "being okay", "perfectly healthy", "being fine" and "being very healthy". One participant explained complete health as the main component of overall well-being. (Well-being, itself, viewed as a broader concept embracing life activities, and family and personal relationships in addition to complete health).

As stated previously, participants viewed the mind and body as one unit. Complete health meant that both mind and body were healthy.

Body and Mind Together: The Total Unit in Balance and Harmony

Participants described complete health as a totality, a state where they were both physically and mentally healthy. When participants spoke of "health" in general, they referred to the

state of complete health, or general health. The following accounts illustrate complete health as a holistic phenomenon.

P: I never refer to health as partly mentally or partly physically --- because whenever the question of health, if someone refers to it, I always thought it refers to the general health, and it covers the mental as well as physical.

R: Okay.

P: And that's all I always say, "fine".

R: Okay. So you mean health is general health?

P: General health, yeah. Its physical as well as mental, that's how I take it in the entirety.

.....

R: Health in general means what then?

P: Like, um, I'm not suffering from anything and I'm nicely rested, and I'm going around doing everything that I have to --- and mentally I'm prepared for everything, and my mental health is alright. Like I'm thinking straight, and I'm not -- like I won't have to --- "I'm not too tired and I can't do anything" -- that sort of thing.

R: So it seems you're talking about your mental state and your physical, when you say general health? Is that right?

P: Yeah, that's right.

R: Its the two together that's general health?

P: Is general health.

R: How your mind is and how you're physically feeling?

P: Yeah, um hum.

.....

P: I <u>am</u> okay, like I am mentally okay and I'm physically okay.

R: What does "okay" mean?

P: Means like --- I have -- my brain is perfect and my body's perfect.

The body and mind were described as inseparable entities which make up the whole person, and exert an mutual influence on each other. The following accounts describe the unity of body and mind in complete health.

> R: You're considering that the mind is involved in health as well, you said that the two can't be separated.
>
> P: Yes, that's right, yeah.
>
> R: So you see mental health and physical health as separate things, or as together in your health?
>
> P: Together as one unit, because body is one unit, and mind is part of body. Yeah.

.....

> P: They are interrelated, the mind and body, you cannot separate the two.

.....

> P: To say perfectly healthy you have to be healthy both ways, physical and mental. Then you are perfect healthy. If one thing is wrong, like if you are physically sick, you are not perfect healthy. If you are mentally sick then you are not perfectly healthy. So just the way it is, you know. So you just can't define yourself that you are a healthy person either way (if only body or only mind is healthy).

Complete health was further described in terms of harmony between the mind and body, with the "total unit" being in a state of health:

> R: You said that in a state of health, which I believe you said that the mind and body are one --
>
> P: In harmony.
>
> R: --- in harmony, and can't be separated.
>
> P: Yes, that's right.
>
> R: So when you say that you're healthy, you mean the mind and body together are healthy?

P: Yes, the whole unit is healthy.

The way the body and mind influence each other was described in other accounts:

> P: If you are mentally happy and healthy, then only you would be naturally physically healthy as well. If you are mentally unwell, then it definitely affects your physical as well.

.....

> P: Health, you know, mental and physical, are again two components of health, because they are so close to each other.
>
> R: Yes.
>
> P: That's what I mean.
>
> R: "So close to each other" --- again you mean?
>
> P: In terms of how they affect each other. Physical health affects mental health, mental health affects emotional well-being, and my job performance, and how I deal with the family, and how I feel about myself, completely, you know. Its so close you know, that its hard to say what is really what in my mind. But certainly physical and mental health are very close, because they affect each other. You know, if you had stress at work it will affect your stomach; if you eat too much it will affect your mind, you know!

As noted, participants explained that complete health meant, not only being able to do normal activities, but being able to do these activities well and happily. This primary feature of complete health is discussed below.

Doing Happily, Doing Well

Participants stated that they could not perform action well, or at their best level of efficiency and effectiveness, unless they were in a state of complete health. Being able to carry out daily activities in complete health, and thus fulfill life

responsibilities, was described as giving rise to feelings of happiness, contentment and satisfaction.

Doing happily. The following accounts illustrate the happiness associated with doing actions well. In these descriptions the word "health" refers to complete health.

> P: I think, you know, health is important to do, you know all your activities. That makes you feel good.

.....

> P: Like when I'm healthy I feel that I can do too (so) much, you know. I'm active all the time. Like I feel good too, I'm happy, I'm energetic.

.....

> P: Ah, you feel good, you see, you are --- capable of performing the duties and not being sick.
>
> R: Um hum. You mean that satisfaction --
>
> P: Satisfaction.
>
> R: -- comes from doing the things?
>
> P: Yes, that's right. Yeah.
>
> R: And then you feel good. That's what you're telling me?
>
> P: Yeah. And that comes with the health you see.

.....

> P: Most of the time I'm on a real high. Because I feel really good when I wake up in the morning, and I'm ready to face the day, and off I go. And you know, sing my heart out in the morning. You know, I enjoy. Just everything comes from, it stems from good health. And its, of course, you know, related to being both mentally and physically healthy.

Doing well. The ensuing accounts describe "doing well" as the second aspect of doing normal activities in the complete health state. Being able to do action well was linked to having

both a healthy body and a healthy mind. One participant described this in terms of physical and mental energy (or effort), and explained why both the body and mind need to be healthy to perform action at a high level of effectiveness.

> P: Because to do something good, you have to concentrate on it mentally and physically both. Physically you are doing something, mentally you are putting your concentration into it. So suppose if I'm studying, if I put my both energy together into the study, then I can achieve the top, you know best out of it.
>
> R: Um hum.
>
> P: Otherwise I can't. So that's the way.

She explained "doing something good" more explicitly:

> R: In your mind for you to be completely healthy, the two have to be there --- the physical and mental health together?
>
> P: Yeah, Yeah. Um hum. If you want to do something good. That's the only way you can perform something that whatever you want.

Participants stated that action could not be perfectly executed if only the mind, or only the body was healthy. The following account illustrates this point:

> P: If you are not, if you are mentally healthy and physically not healthy, is still you cannot perform well. And if you are like mentally good and physically not good, then still you cannot perform the way you want to perform things.

As mentioned earlier, participants described energy, resistance, independence and control as four health characteristics directly underlying a person's ability to carry out normal activities in each phase of the health experience.

In complete health, amounts of these four health characteristics are greatest, allowing the individual to do more activities, and to do these activities effectively and easily. As

one enters the partial health stage, the amount of each characteristic decreases. In sickness, measures are very low or totally absent altogether. As one recovers from sickness, amounts of these four characteristics increase again.

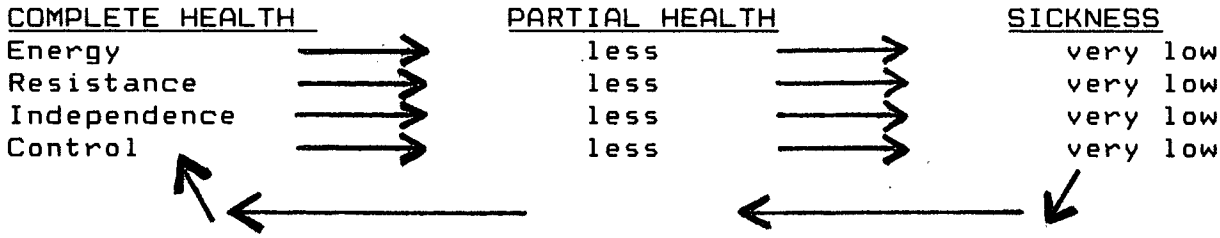

Figure 4: The Four Health Characteristics in each Phase of the Health Experience

These four health characteristics are described within two themes: energy and resistance, and independence and control. The following discussion presents accounts of these two themes in complete health; later sections in this chapter will discuss the four health characteristics in partial health and sickness.

Energy and resistance. In complete health, participants described being able to do activities without getting tired and without effort. They also spoke of having strength and enthusiasm, and not experiencing "any burden" when doing activities.

The ensuing descriptions illustrate how participants described the energy present in complete health, and how this energy promoted doing normal activities.

> P: So basically health means, you know, energy and, you know, with me, the desire to do things and the ability to do them -- to be active in many things, and like to do a lot of running around, and end up taking on things that I really don't have to, because there is that energy. And if I didn't have good health then certainly, I wouldn't be able to do

that.

This energy was further explained in terms of "not feeling tired" when doing activities:

> R: Could you describe -- how a healthy state feels for you personally, or what it means to you?
>
> P: I'm quite joyful all throughout the day. If I keep doing things, there also, so long as I don't feel tired, I feel that really I'm healthy.

Feelings of enjoyment and enthusiasm for work and life were also associated with the energy in complete health:

> P: I mean if good health is not there then, you know, you really don't enjoy anything. There is always that lack of you know, enjoyment, lack of enthusiasm for living, lack of enthusiasm for taking on new projects and life becomes a real drag. You don't have --- because health gives you energy, and you take on things, because otherwise you'd just say: "well, forget it, you know, if I took on any more I wouldn't be able to handle it, so just let's not bother with it". That would prevent me from making friends, or like meeting friends as often and it would have a bearing on everything I do. If I wasn't healthy.

Abundant energy was described as a core feature of complete health, and a prerequisite for doing normal activity. As the following accounts illustrate, the abundance of energy in complete health allows a person to do daily activities without being tired or feeling any "burden":

> P: As long as you're not suffering from any disease, or you are say, if you can carry out all your normal duties, the said activities of life without feeling any fatigue or things like that. Then I think you are a healthy person.

.....

> P: Health to me means no headaches, no tiredness at the end of the day, energy to do things. You know, not just go to work and come home and collapse on the bed. Health means that I should have the energy when I come home to be able to do other things, go for walks and basically feeling good about myself.

.....

P: Listen, if you are healthy you don't feel tired. You don't feel ill at all, and when you enjoy the work you don't feel it. It's more that you don't feel tired, because you are enjoying the work at the same time.

.....

R: So you mean you have a lot of energy? Is that what you are telling me?

P: You have energy. If you are sick, there is no energy to fight with those things -- with your routine work even. But if you are healthy you don't feel it is tiring or burden, or anything you have done extraordinary.

R: You don't feel "a burden" --- when?

P: I'm moving around, everything is great for me.

This energy also allowed the individual to take on extra unanticipated work. Speaking of what he could do in health, one participant said:

P: Not only that (doing the activities you want to do), you could do what you haven't scheduled also when it comes on. Go ahead and do them anyways and not feel (anything).

R: You mean take on extra things?

P: That's right. Take on extra things.

R: And not feel anything.

P: And not feel physically tired about it.

Another participant explained energy in terms of vitality. He saw vitality as the outer expression of inner energy levels. Vitality translated into action, or being able to do activities. Thus, the "healthier" the person, the more vitality he would have, and therefore, the more activity he would be capable of doing. This energy, or vitality, was equated with resistance to both environmental changes and changes within the body.

P: Yeah. Vitality, I mean, --- the vitality should be like this, that a little change in weather, a little change in eating habits --- I mean, out of routine does not make

you sick. If you're going out of routine it does not make you sick.

R: I see.

P: Sometimes I have seen people being sick just because they didn't get enough sleep. Or just because they had to go out and pick up something and forgot to put their jacket on or something like that, and got a cold and got sick. Healthy persons do not, I mean their own health is such a way that they could weather that out and not have the effect of the weather all the way around.

R: I see.

P: Body resistance is more, as a matter of fact. Good health keeps body resistance better.

He expanded on the relationship between energy and resistance in complete health:

P: Yeah, and you don't feel the effect of that non-routine thing (in complete health).

R: And you're saying this is because you have that extra energy, or a special kind of energy?

P: You can call it energy, or the body develops resistance against these things.

Explaining that the body's resistance was a sign of good health, he stated that the energy, or resistance present in complete health was the reason why healthy people do not get colds or flu, even though they might be exposed to the virus.

P: --- and that's your own body resistance which you have developed, and that, to me is a sign of good health. And that comes from right, healthy living habits.

Explaining this same point from a medical perspective, he said:

P: -- Now we'll go to in medical terms. You say your own blood cells fight it out against those viruses, or whatever, and they win out and so you do not get sick.

This resistance to disease and the environment was described by another participant as "not always ailing from something".

P: --- I would see health as not -- always ailing with something, and not always taking medication for something or the other.

Independence and control. Participants described independence and control as two additional characteristics intimately associated with doing normal activities. Independence in complete health had various meanings: not being dependent on other people to carry out personal work and responsibilities, being independent of vitamins and medications, and being generally free of other restrictions on activity or lifestyle. The following accounts illustrate aspects of the independence characteristic of complete health.

One participant spoke of this independence in terms of not using vitamins or taking medicines. She said:

P: Completely healthy is everything is working in your system as it should be, without the aid of artificial means.

R: I see.

P: That's completely healthy. Whereas you know, you can have, you know, 60 different medicines a day and feel really great, but I don't call that health.

R: What would you call that state?

P: I would call that, you know, the state of artificial health. How can you feel good about yourself if you're having so many vitamins and so many medicines to relieve this or relieve that from the system? That's what I mean. Completely healthy is health on your own without the aid of superficial things, which are vitamins which can be acquired by good diets. And without the aid of pain-killers and what-have-you.

The same informant later spoke of being independent of restrictions concerning diet, activity and lifestyle. In this account she described complete health as being 100 percent

healthy.

R: You consider yourself 100 percent healthy now.

P: Um hum.

R: So do you feel you have any restrictions on any part of your life at the moment?

P: Not for now. I can do whatever I want to do. I can run as much as I want. I can eat whatever I want, and I can do just about --- like nobody has told me "you have to take medication for so and so", so I have no restrictions about anything like that.

She explained how a very obese person would not be completely healthy, because of the numerous restrictions placed on him.

P: Well, (if I were obese) my system would be working all right, but I wouldn't consider myself very healthy because you know, I cannot do every --- I cannot run, I cannot play a lot of games, I cannot do a lot of things. I may even put a restriction on myself for eating things, because I want to get back to my normal. I might catch a certain --- something could happen to me. I don't know. My heart --- being heavy is one of the reasons they say --- shouldn't do that because it does cause a lot of heart problems. Being healthy is I think, really being able to do everything without any restrictions.

Notions of independence were very closely associated with the idea of being in control of one's life. Control was described as "being able to plan ahead" or "plan for the future", and also as being able to do something to resolve health concerns so that daily activities could go on in a normal way. In addition, control in health was explained as "being in charge" and "being able to cope". Some participants spoke of control in terms of what aspects of health they could personally control, and what aspects were viewed to be in the control of nature, or God. As with other aspects of the accounts, the male and female study participants provided very similar descriptions of independence

and control in health.

The subsequent narrative illustrates how control, or coping, is related to independence.

> R: It seems you're telling me that when you're healthy you're in control.
>
> P: Well, you know, you need to --- the kind of life you live here, ah, you're on your own, you have to do everything. You don't depend on anybody, or try not to depend on the children, or whatever. You have to be able to work, you have to be able to move around, and you have to be able to --- cope with your day to day life. And how could you do all those things of you did not enjoy good health?
>
> R: So being able to cope is part of being healthy?
>
> P: Oh, definitely! Definitely! Its to cope with your responsibilities, with your obligations, with your commitments, you know. Your whole life depends on your health basically. Everything you do depends on whether you can deal with, fulfill those --- all those decisions depend on whether you can fulfill them. Your job, your work, your children --- I mean really, --- without good health, you just, you don't have a hope! (LAUGHS) You know? With all the, you know, all your --- I don't know there might be some things one can do even though its not perfectly healthy, there may be things you can do, but it does limit you.

Being in control in the sense of being able to plan one's life activities, and not having to put off scheduled programs because of health problems, was described as follows:

> P: Any scheduled routine, I mean generally people have set their routine, from getting up in the morning till going to sleep, to bed. There is a set routine, and then in that time frame they set their own schedules for what they want to do. And if they are healthy, they do not have to worry about changing that schedule or missing things because of ill-health.

.....

> P: That's right. That (health) gives you your own time to your prayers and things, and keeps everything on a certain time and certain place. That is just great.
>
> R: When you're healthy you're able to keep a certain schedule?

P: That's right.

R: Whereas when you're feeling sick ---

P: Feeling sick, you might not get up in time to do the thing. You might not be able to handle the few things which you want to do, but you can't because you are sick.

Another participant spoke of this control more eloquently:

P: If your health is good, then your whole perception is different about life. About work, about family, about what you do, how you view things, planning holiday, planning whatever.

R: And for you personally, what is that perspective like?

P: I don't know, just a sense of, you know, a sense of optimism, a sense of being in control. And you know, there is the feeling that, you know, I can do things, I can do what I want to do, basically.

R: A sense of "being in control"?

P: Yeah. Yeah, being in control of your health, being in control of your life, you're --- sort of being in charge of things rather than dragging your feet.

She further described this perspective:

P: Well, being healthy, you know, is being in control of your life, that's what I feel. In the sense that if you're not healthy you can't make plans, you don't know what your condition will be. You can't take on any jobs. You can't take on anything which requires, you know, depending on the kind of physical and mental condition you're in, you can't commit yourself to anything. If you do, you don't have the energy to do it. So you gradually, you know, have to cut down on things, so you really don't have --- you're going to be so you can't take on anything. But if you are healthy and, you know, you don't think about: "well, of course, you know, I can do this". You just get up and do it. Or you say: "fine, I'll do it". And I just find that that's what control means in terms of health, is the ability to do things and to decide to do things, and make plans and go ahead with them - without which, you know, (without) which health you couldn't do it. What would you do if you were sick all the time?

R: So it seems that there's a certainty, is that what you're saying?

P: Yeah.

R: Because if you're sick, you say you can't plan because you're not sure ---

P: You don't know what you ---

R: -- what's going to happen.

P: Yeah, yeah. I think so. That's what it means. You're certain about your ability to do things, that gives you that control over your plans and future and commitments and everything.

Two participants spoke of the independence inherent in complete health as particularly important for life in Canada. They explained that Canadian society required a person to be independent. In contrast, when they were living in India independence was a less important facet of health, because if they were sick, members of the extended family or servants could do the daily chores.

R: Do you feel that being healthy in Canada entails anything different than being healthy when you were in India?

P: You know, if you are healthy here means everything has to be done by you. There's nobody else. As you think everybody mind their own business. If you are sick, means somebody comes for rest, you might need a glass of water, you might need something. But at home there are all joint families, and they help with sickness and with healthiness. You know, that makes a difference. Because you are in a joint family, and they look after you, and you don't worry that much. You might think that your child is sick, and you have to get up here, but not there (in India). --

R: So are you telling me that being healthy here, means being independent and being able to do things for yourself?

P: For yourself and for the family --- and with happiness, means you are content, and you don't mind and everything is going just great. --- Here you have to be healthy to cope with the world.

A few participants also spoke of control in terms of what they

personally could do to keep healthy. Health was seen as not totally in the control of the individual, but rather in the domain of nature, or in God's hands to some extent. Preventive actions like diet, exercise, keeping active, maintaining a calm, clear mental attitude, and staying contented or happy with life, were regarded as healthful activities under individual control.

> P: Health is something that can't be predicted right? I would say its not in your hands. I mean it's not even in the hands of doctors, or science or anybody. Because if it was, nobody would ever get sick, right? We'd be all healthy for all of their life, right? It's, I mean, it's -- you don't control these things, somebody else does. And, but you still, you know, all we can do is just, you know, do whatever we can to stay healthy.
>
> R: So if you're saying that "someone else" does it. Could you describe to me ---
>
> P: Yeah, that's, you know, someone else -- I mean God!

The participant later clarified what she could personally do to stay healthy:

> P: Well, I guess I've already told you. You said, yeah, control your diet a little, and then do your, you know, try to do a bit of exercise and be content, and try to be happy a little. Do all those things, and then leave the rest in HIS hands, I guess.

Another participant presented a similar perspective:

> P: Nature is not in your control. You can only control your feelings, or your, you know, body - like disease. But nature you can't control, you know. Because maybe its in your destiny that you have to go --- in accident and lose your leg or lose your hand or something. That, Hindu philosophy says is the karmas (past actions), you know. You have to suffer whatever you have done, maybe in your past life or this life.
>
> R: Okay. So you said things like diet and exercise, all those things that you have control over.
>
> P: Yeah! You can do it, yeah. You can meditate, you can fast, you can change your brain (discipline your thinking),

> you can redirect your thinking, you can --- okay, you are not good in study, you can always go to music. If you are not good in music, you can always pick up sports, you know. So these thing I'm talking about which you can do.

To conclude, complete health was presented as the first phase of the health experience. In complete health, both the body and mind are healthy and in a state of balance and harmony. Participants explained that in complete health they were able to do normal activities well and happily. Abundant energy, resistance, independence and control supported this capacity for action. The following section describes partial health as the second phase of the health experience.

Partial Health

Although the partial health phase was described the least clearly, participants agreed that a definite "in-between" stage existed between complete health and sickness (see figure 3).

Partial health was described variously in participant accounts as: "a little bit sick", "not feeling well", "being still healthy, but with a bit of a problem", as less than 100% healthy (80-95% healthy, for example), "more or less healthy" and ill-health. Participants described the experience of a cold or the flu, a temporary headache or other type of short term ache or pain, as being in this "in-between" state of partial health. An important feature of partial health is that the symptoms, or health problems, are short term.

In this state, participants' ability to do normal daily activities was interrupted for a temporary period of time, usually days or weeks. Most participants spoke of the pain, discomfort

and other complaints associated with ailments like colds, flu and headache, for example, in terms of a few days duration. This experience was described as "bothersome".

Bothersome was explained to mean annoying, a nuisance or a hindrance, in the sense that individual ability to do normal activities was interrupted for a short period of time. Participants stated that they were not worried about being in partial health, but that it just "bothered or annoyed" them. (Being worried was something associated with sickness, as will be discussed in the final section of this chapter).

Although most participants saw themselves as completely healthy, partial health was not an uncommon experience. Participants reported having a cold, flu or headache reasonably frequently during the year. Partial health was generally described as leading back to total health. Participants explained that partial health could deteriorate into sickness if the small health problems didn't go away spontaneously, or were left untreated.

Partial health is discussed below in terms of (1) capacity for doing normal activities, described here as "can do with effort, but not well", and (2) as temporary and bothersome. In partial health, the four health characteristics were described as present in lesser amounts than in complete health. These characteristics are discussed within the next portion of the text describing normal activity in partial health.

Can do with Effort, But not Well

The following accounts describe participants' perceptions of partial health as a state where they could still do normal activities, but with effort and with less effectiveness than in a state of complete health. In this phase, participants described "not feeling like doing anything".

In partial health, something is slightly "off", either physically or mentally. Consequently, the total "unit" or person is not regarded as completely healthy. This condition of being " a little bit sick" results in less effective activity and tiredness when doing activity.

Some participants described this experience as "dragging themselves" through the day's work. At this time, participants perceived themselves as still healthy because they could still do things, although not as well or as happily as in complete health. They saw themselves as still healthy because the condition (cold, flu, headache) was temporary and considered "no big deal", as it would go away more or less on its own, with little or no intervention.

The following accounts illustrate how participants described partial health, and their ability to do normal activities in this phase.

> P: Sometimes you're a little sick, you can still drag around when its a certain time of age. Means the person has some responsibilities. You've got to do a few things whether you are well or no.

.....

P: If say, you've got up with a headache, you'd still be

> healthy, you know. It doesn't take away from it. It's just a bit off.

One participant described the fact that when she was sad, she didn't consider herself perfectly healthy. At that time she could not do daily activities as well as when in a state of complete health:

> P: Like I can't say that time (in partial health) that I'm, you know, perfectly healthy. Because I cannot perform things good, and my speed is slow that time, like the way I do things.

Describing the miserable experience he had with the watering eyes and running nose associated with developing allergies, one participant explained how partial health refers to the condition of the body. Here partial health is denoted by the term ill-health.

> R: So are you telling me that ill-health for you, is in terms of the body?
>
> P: Yes. Because with the mind I could still rationalize and try to rationalize things. Okay. And have no problem because I still maintained all my, all the routines of work, and so a reasonable thought process. But body remains miserable because of whatever chemical changes happen in the body.

The four health characteristics underlying activity in partial health are described below.

Decreased energy and resistance. Partial health was characterized by decreased amounts of energy and resistance. The low energy in partial health was described in terms of being tired, or fatigued. The following account illustrates this:

> P: (Any change) in normal healthy habit, whether its in chemical food intake, or physical change, I mean it will even make me ill, ill-health, or tired ---tiredness is a sign of ill-health.

Partial health was further described in terms of lowered resistance to diseases and external environmental changes. One participant viewed this lowered resistance as the result of chemical changes occurring in the body, due to the stress arising from mental worry. He described this state of lowered resistance as a time when the body is in a "low vitality mode". Mental stress, or worry, was seen as the primary cause of lowered physical resistance. It was his experience that in partial health a person becomes allergic to things such as dust and foods, because his resistance is low. In this account, he also explained how partial health can deteriorate into sickness, or move back to complete health. In this account the term "ill-health" denotes partial health.

R: So in this state of ill-health, the body's lost its resistance?

P: Yes. Body has lost its resistance to fight any kind of change happening, and chemical change it gets exposed to.

R: So this state of ill-health can become sickness?

P: It could!

R: If it gets worse?

P: It could.

R: And would this resistance then change as well in sickness?

P: Yes, it would go lower. It will decay.

R: It will decay?

P: Yes.

R: And so when a person, in this state of ill-health then, if a person's resistance improves, then he'll become healthier?

P: That's right. Yes.

Decreased independence and control. Decreased independence was described in terms of imposed restrictions, or limitations on activity and lifestyle. One participant described partial health in terms of being restricted in doing normal activities, and having to take medicine for the pain related to a torn knee cartilage. The pain she experienced was itself a limitation, as it interfered with her ability to do action. She still saw herself as healthy, although not completely healthy. Her independence was reduced by these restrictions on her daily life, and she described feeling "a bit handicapped". In the following account, she referred to partial health as "not being a 100 percent healthy".

R: You gave me the feeling that you didn't see yourself as completely healthy at the moment.

P: I'm not completely a hundred percent healthy, because I really cannot use my knees a hundred percent. And if I stress it too much, if I go running down the stairs or, like I used to do all kinds of things. I can't. I cannot sit on the floor, I cannot squat, I cannot bend my knees. And I feel a bit handicapped, you know, in the sense that I can't use, I cannot do things that I could, as easily. So other than that I'm not, I'm not unhealthy, I don't feel that my health is a problem right now. But that's a small -- you know, it is a nagging pain, because I'm not used to not being able to go up and down the stairs as I feel.

R: So to do with your knee again, is it the limitation in action that you are looking at? Or is it your --- you said you feel "handicapped" --- or is it both of these things?

P: It's both of these things. Because there is that feeling of not being a hundred percent. And also the actual pain, if I'm sitting on the floor, or you know, --- I like to, the music I play or sing, I have to use, sit on the floor and bend my knee to be able to play the harmonium, whatever, the tamboora.

R: Yes.

P: And its a problem. Because you know it pains. I have to sit on a cushion. And a year ago I would have not thought twice about these things and the small discomforts. But now I have to think about it. I have to find a cushion, and I have to find something to rest this knee on. Then I can sit in the proper position. But also there is the fear, or -- that I may never have full use of my knee as I had before. And it's, you know, when I go in and out of the cars, in the car its a bit of a strain to get in and out. I can't do things as freely. Movements have become a bit restricted.

The same informant explained this from a different perspective after her knee was much improved. In the ensuing account, she reflected on why she felt she was in partial health when her knee had restricted movement and she was on pain medication.

P: I just don't have anything (no pain medication) now. And sometimes it just hurts a little bit. So I am much healthier I feel than I was when I saw you last. Because now I am not having Entrophen (medication). And my knee is much better, it's not hurting, so that's what I'm trying to say. I was only partially healthy, although there was really nothing drastically wrong with me. But I didn't feel healthy because I was having four of these tablets a day.

R: Yes. Yes.

P: And now I think its over a month I haven't had any, and I just won't have it unless I'm dying or something! (LAUGHS) You know, unless its really necessary. So I mean, in my mind health is related to --- I mean, if you're having medication to curb some sort of pain in your system, then how can you call yourself completely healthy?

Another participant described this restriction on lifestyle and activity in terms of the condition of her husband who had open heart surgery.

R: You said your husband is restricted in his activities, and therefore you're considering him 80 percent healthy?

P: Um hum. Even 90 percent, because he really takes care of himself very well, but he has certain restrictions. He cannot eat too much fried food. He cannot eat too much sweet food. Like --- and he cannot lift too much weight. He's not

allowed to do that. Normally he's very healthy. I wouldn't say anything about him not being healthy, but inward I know, I'm always scared, let me say that, that I don't know what could happen to him. That's it.

She stated at another time:

P: Well, he is very healthy, like if he changes his way of eating and does not care about himself, and eats just about everything, and he eats a lot of salt, he eats a lot of sweets, and he is not going to be healthy, he is always going to be ailing with something or the other. He might be bedridden for all I know, but right now he is healthy. But if you ask for a doctor's opinion, he is healthy, but he's not --- he cannot say that he is a 100 percent healthy.

R: So you consider him healthy now, but not a 100 percent healthy. Could you tell me the difference between those two things in your mind?

P: Well, if he didn't have this health problem about his heart, he would be doing just everything that I do. I do a lot of running. I eat just about everything I feel like. I don't restrict myself about not eating anything or not doing it. I eat a lot of sweets, I eat a lot of fried food. He does not eat that. So that's why --- he eats less salt. He's on medication.

R: Yes. Yes.

P: So these kind of things they do reflect on you as not being a totally healthy person.

Another account described the experience of having an elevated temperature and how this condition restricted activity. At this time the participant felt that he could not do the work well, because he did not feel like doing anything but lying down.

P: If I'm running a temperature and still I have to work in the house, I might do it because I have got to do it. But I might not be able to do it with sincerity, or I won't be able to do it that good. That put restriction on my activity output.

R: Why won't you be able to do it well?

P: Okay. Because my mind is not attuned to that.

R: Okay, your "mind is not attuned"?

P: Mind is not attuned to that, or secondly when I am not well I naturally feel lazy, I feel like lying down, rather than do some laborious work.

In a later interview he explained that "mind not being attuned" meant not feeling like doing activity. He stated:

P: You don't feel like doing anything altogether, and just lie down or something like that.

R: So "mind not attuned" means ---

P: Mind not attuned means you don't feel like doing it. Yeah.

R: Because your body want's to lie down and rest?

P: That's right.

One participant described the limited control a person has over his condition in partial health.

P: Well, like if you are a little bit sick, like I said you are a little bit sick with the flu and colds and all that. Of course you can have medication for that, right? And stay in bed and rest. And that's all, that's what you can do to control it.

Temporary and Bothersome

As described in the introduction to this section, participants viewed partial health as both temporary and bothersome. The following accounts described partial health as bothersome because of the lessened ability a person has to do normal activities in this phase of the health experience.

R: You said that, I believe, a cold "bothers" you, but it doesn't worry you?

P: Bothers you, that's right. Um hum.

R: And I'm still not completely clear on the difference between "bothering" and "worrying".

P: Bothering means its annoying. You know, its annoying you, you say, I mean "what is it" you know. I can't do what I'm supposed to do, I can't do what I, you know, like to do. But

worrying is something when you sit there and you say "what is going to happen now"? Right? That kind of stuff.

R: So you mean worry is, worrying about being sick? Worrying about whether its going to be more serious?

P: Oh, yeah. That's right.

R: So I think that you were saying that someone who has cancer, say, they would be worried?

P: Yeah.

The temporary nature of "not being able to do things" in partial health is illustrated in the following accounts describing the experience of the flu, headache, fever, backache and similar ailments. These ailments were described as minor sicknesses that would go away.

R: And when little things come, like a little bit of pain with a headache, for instance, then you're healthy but you have that temporary ---

P: Temporary phase of being unable to do things maybe, but you can still be fine. After a while it goes away and you're alright.

.....

P: You are a bit sick, temporarily, yeah.

R: Temporarily sick.

P: Yeah, but you're not really, you can't really call yourself (sick) --- it just bothers you inside. For you know, -- you know, its only temporary. But still it bothers you for a little bit. You know, you can't do --- get up and do things for others and for yourself. Or you know, you become --- somebody else has to you know, cook for you or do things for you.

.....

P: If its a constant on-going problem then I would call myself unhealthy (sick). If it is just flu or a little bit of pain, or a little bit of diarrhea, that's not --- I'm still healthy.

R: You're still healthy.

P: That's just a temporary pain, you know. And I don't worry about it. I think I'm going to get over it.

.....

P: That's a temporary illness, like its not an illness -- it's not you're not healthy. It's just -- I don't know what causes a headache, but that's a very temporary thing that you're taking (medication), and if you take that and your headache is alright, you're fine. That's a very temporary thing according to me.

.....

P: Again, it's temporary, right? You know it is going to go away. You have fever, you have flu, but again you're worried that you're going to pass it on to the kids and other members of the family. But still you know that it's not a big deal, it will go away. It's just something you get in every season.

Partial health meant a temporary deviation from usual performance of normal activities. One participant explained that when her daughter was very tired for a few days, she could not carry out her normal activities in a usual fashion. This was indicative of a short term illness.

P: Either she's got a fever, of she had something to eat ---something that is not --- that is bothering her, that is a short-term illness, but not a long-time, a long-term, something. But it is, again it's deviating from her normal day activities --- normal life, so it is different, I should say. And once she's taken her medication for it she'll be all right. So that is health to me, to be able to resume your everyday activities in a normal sort of way.

To summarize, partial health was described as a somewhat unclear phase "in-between" complete health and sickness. Participants denoted this state by different terms. All participants, however, considered partial health a temporary and bothersome experience related to lessened ability to do normal activities. In partial health, participants could still carry out normal activity, but

less well and with more effort than in complete health. Decreased energy, resistance, independence and control were the health characteristics underlying action in this phase of the health experience. The following portion of this section presents participant descriptions of sickness - the third phase of the health experience.

Sickness

Sickness was clearly described as a state where a person is totally unable to carry out normal activities, and incapable of independent action. This inability to do action was associated with having little or no physical energy. Participants stated that they did not want to do anything and, in fact, could not do anything in sickness, because the body needed to rest and recuperate.

Participants had relatively little experience with sickness. Some described an episode of sickness in their life, usually in childhood. Others were aware of the sickness experiences of family members or friends. One informant said that his discussion of sickness was really theoretical since he had never "felt" that he was sick. He described having typhoid as a child, but in retrospect he did not consider that a sickness, because as a child he had not taken the illness seriously.

Sickness was viewed as a serious situation where "something" was wrong inside the body. This "something wrong" was attributed to disease, chemical changes within the body, or action from external agents (like viruses). In sickness the body was

described as in a state of very low energy, with very low resistance to change and disease.

In sickness, participants described that they did not feel like socializing because of aches and pains. They had to force themselves to do things. Being dependent on others, because action is very restricted, a sick person is literally unable to carry out normal activities. Participants explained that a sick person is dependent on others to meet personal needs, as well as fulfill family responsibilities. Accounts also described the sick person having little control over action and the disease process.

In contrast to partial health, sickness was viewed as something long term, or permanent. Any condition that went "on and on and on" was viewed as a sickness. Cancer was unanimously and emphatically identified as a sickness, because it was perceived as very serious, and either permanent or incurable. Participants explained that a sick person would worry about the uncertainty of his condition, and about <u>why</u> symptoms were persisting so long and he was not getting better.

Being sick was frequently associated with being bed-ridden, although being in bed <u>itself</u> did not mean one was sick. Participants described being in bed as "being sick", because when a person was in bed he could <u>not do</u> his daily activities. In other words, <u>being bed-ridden denoted not being able to do anything</u>, and this inability to do action was what signified sickness. Participants explained that a sick person was generally, although not necessarily, in bed because he had no

energy or inclination to do anything. As with complete and partial health, descriptions of sickness focused almost exclusively on the physical body.

In this discussion, the sickness experience will be described in terms of (1) not being able to do activities, and therefore not being able to fulfill responsibilities, and (2) as something serious, permanent and worrisome. The section concludes with a brief presentation of participant accounts describing the possible outcomes of sickness: return to health, or decline to chronic illness and death.

Cannot Do, Cannot fulfill Responsibilities

Participants viewed a sick person as someone unable to do normal daily activities and independently fulfill life responsibilities.

> R: So it seems you're telling me that when you're sick, you're not able to do things.
>
> P: Not only (not) able to do things, you see. There is something --- the pain is there, constant pain. Let alone the work, you see. Your body's not able to do anything.

Loss of one's ability to do normal activities had different meaning depending upon one's duties and responsibilities. The more a person was prevented from meeting his/her responsibilities, the sicker he/she was perceived to be. For example, one participant described that the same condition (breaking a leg) meant "being a little bit sick" when she was a child, but meant "being seriously sick" for her as a wife and mother. She explained that breaking a leg now meant sickness, because she had so many current responsibilities to family and others; whereas

when she was a child she had no responsibilities other than going to school.

> R: What I'm wondering about here is, you know, say when you were seven and you had this broken leg, and you felt it wasn't really sickness, because it wasn't disrupting your school work, etcetera. But now for you, say you broke your leg now, and you had to be in bed?
>
> P: That's right, I would call myself really sick then.
>
> R: Why that difference between when you were seven and now?
>
> P: Because I had no responsibilities then. And I have lots now. And if I were to be in bed with a broken leg, say for a few months, even for a month, that would be a lot.

Participant accounts also explained that being sick in Canada was more serious than being sick in India. This perception was again linked to personal roles and associated duties and responsibilities. Participants explained that in India, being sick was less "serious", and did not lead to feelings of worry or depression, because family members or servants were there to complete the daily chores. In contrast, in Canada, being sick (and therefore dependent) was regarded as more serious because extended family are frequently not available to assist with work.

> P: --- At home, if you are sick still you are not worried. You are still okay, because you know everything is looked after. There you depend on elders and servants. That makes life easier. Even if you are sick, you don't feel that burden. Here, if your husband is not home, and you need the grocery in the house and you are sick, you have to feed the kids --- you have to get out whether you like it or no.

It is apparent from participant descriptions that the meaning of not being able to do daily activities during sickness was linked intimately with the need to fulfill personal life

responsibilities. The four characteristics of the health experience underlying activity in sickness are discussed below.

Low energy and resistance. Participants viewed "not being able to do action" as the primary feature distinguishing sickness from the other two phases of the health experience. Low energy and low resistance were associated with this incapacity for action. Participants associated sickness with tiredness, weakness and abnormal changes in the body, which led to deviations from normal routine ways of feeling and doing things. Accounts described the low energy present in sickness:

R: So you mean in sickness then, the energy level is less?

P: Yes, it is. Lower than the normal person.

This low energy manifested as tiredness. One participant explained that the tiredness in sickness indicated that there was something that needed to be treated.

R: So if you're sick, then, this tiredness comes?

P: Yeah. Tiredness comes. Or some other, I said you might have stomach upset, you might go to the loose motion or constipation, or things like that. It gives me the idea that: okay, there is something that needs to be rectified.

The following accounts elaborated on being tired and not doing activities.

P: -- (when sick) just I take little bit, you know. I slow down my life and relax and sit down. Don't do too much, you know, activity.

.....

P: You feel lethargic and then you think, you see, there's no strength in you.

.....

R: You've told me you feel lethargic and weak (when sick).

P: Um hum. I don't feel like doing anything.

The relationship between the low energy in sickness, and being bedridden was explained as follows:

R: You're bedridden because the body's --- you have to recuperate?

P: Yeah, you use up that energy to make that body feel better, to recuperate.

R: So all your energy when you're sick is going to recuperate the body?

P: Yeah.

R: Whereas when you're healthy, you can use that energy for things other than (recuperation of) the body?

P: That's is right. Yes.

One participant described the need for extra energy during sickness. He explained that the diet of a sick person needed to be altered in order to increase the store of available energy.

R: So you say that when you're sick, your body isn't able to handle that extra work?

P: Any work!

R: Any work.

P: Yeah, because it puts all its energy to recuperate itself, than putting energy to do other work. Yeah. I think whatever energy is there and trying to heal you from inside to make you feel better. And that, I mean is where nutrition comes in. I mean you require extra nutrition to feed yourself.

R: When you are sick?

P: When you are sick. You do require extra nutrition to supplement the same energy as --- to make you feel well. I mean to make you feel better then, the opposite of being ill, okay? And then to do some activities.

Sickness was perceived as a state arising if symptoms such as pain were neglected. One participant advanced that view that symptoms

of "something wrong" in the body warned of developing sickness.

> R: So something wrong with your body means sickness? Is that right?
>
> P: Wouldn't say sickness. But that's a sign of coming sickness. Yeah. Because if you neglect it thereafter, then quite possibly you might be sick at a later date. Or you might be aggravating the sickness, you can put it that way.

Older people were perceived as more prone to becoming sick, because their resistance is lower than that of a younger person.

> P: But my mother-in-law, she catches it (a cold) every time the kids get it. So she's sick with them anytime they are sick. So I guess when you are older you catch them (colds) --- you've got less resistance in your body and take medicine more.
>
> R: So, when a person gets older, you think that they would get sick more?
>
> P: Un hun. I think so.

The participant went on to explain that a cold would have different meaning for herself as a young wife and mother, and her older mother-in-law. A cold would mean partial health to her because she would still be able to do some activities. However, a cold would mean sickness to her mother-in-law because she would have less resistance, and be capable of less activity than a younger person.

> R: You'd still say yourself that you were healthy with a cold (partial health) at a younger age, but the same cold when you were older ---
>
> P: You'd call yourself sick, yeah.
>
> R: You'd call yourself sick, because you wouldn't be able to do things? Is that right?
>
> P: Um hum. That's right.

Partial health was described as a state characterized by decreased

independence and control. Sickness, in contrast, was explained as a state characterized by dependency and lack of control.

Dependency and lack of control. Dependency in sickness meant both limited activity and actual dependency on others. Participants felt that they were sick when their normal life activities were severely impeded or restricted. The following accounts describe the limited activity indicative of sickness.

> P: If you are sick, you won't be able to perform all your everyday chores or your --- whatever you have to do. You are sick then, yeah.

One participant described this further, stating that although he had no personal experience with sickness, he had seen other people who were sick.

> P: If cancer is there it will limit because of the pain. Or pain, or stress. I haven't experienced that, okay. So I don't know what happens with cancer. I honestly don't know. --- I mean I have seen other people being in pain and very sick. I mean in very much pain and not able to do things which they want to, and be in bed.

Another participant elaborated on the meaning of being sick:

> P: I thought being sick means you are in bed in the hospital. --- being sick means once you are bedridden and in the hospital and you are not able to attend to your day to day duties, or your day to day routine, not duties.
>
> R: -- Okay, you say sickness is say, being bedridden and not being able to do your normal routine.
>
> P: That is right, yes.
>
> R: So you're saying that when you're in ill-health (partial health) you're still able to do your things?
>
> P: Yes, yeah.
>
> R: Whatever routine is there. Okay. So sickness is determined by physically being limited in terms --
>
> P: Physically -- to physical limitations of the body, that

I'm so much in pain, or my body temperature is so much that I have to rest it (the body) some more. Okay?

R: Yeah, okay.

P: That's' being sick.

A sick person was described as incapable of independent activity, and therefore in need of attention and care from others.

P: Sickness, I mean --- a sick person needs a lot of attention.

.....

P: Well, by dependence, I mean you rely on others if you're unable to do things. You know, if you are sick for a lengthy period of time, somebody would have to take care of you. Or you won't be able to do something, so you're always relying on others.

The relationship between dependency and control was described as follows:

P: It all, you know, relates to what I feel about being in control. When you are depending on somebody else, or even a simple thing, like you know, if something, I can bend my knee and go underneath things to get them out. I couldn't do that four months ago. I was --- always would have to get somebody in the family to say, you know: "I've dropped this thing there, can you reach out and get it for me". --- So dependency and limitation, they are both, you know contrary to being in control.

Feelings of helplessness, loneliness and fear were other aspects of the loss of control associated with sickness.

P: Sickness would mean, helpless, a feeling of being helpless. A feeling of being dependent on others, a feeling of fear, loneliness. Scary. Illness means --- something I don't want to think about it. And I'm talking about serious illness. I'm not talking about a headache or a cold. I'm thinking in terms of prolonged illness, even like breaking an arm, or something which makes me an invalid, or makes me handicapped, or in some way, you know, that I'm dependent on others.

R: --- so you're talking about dependency. Being dependent and being helpless, you say.

P: Yeah. And again, losing control. Because I've been a

> single parent for 11, 12 years, and make all the decisions, and down goes things, and sort of, you know, always looked after myself most of the time. So it's that, you know, feeling that: well, what if this happened, what would I do?

Another participant expressed a similar perspective:

> R: What is it like when you are sick?
>
> P: Oh, you are depressed and you can't do anything, and you are helpless.

The loss of control associated with sickness was also explained in terms of not being able to do anything about the situation, and not being able to carry out scheduled activities. The following accounts illustrate these two views:

> P: And like cancer, or heart disease, you see --- and then, you're suffering with it, and at that same time, you know, you can't do anything about it.

.....

> R: When you're healthy you know for sure you can do all those things you're planning. Whereas when a person's sick they're not able to carry out their routines.
>
> P: Yeah, that's true, yes. I think its difficult for anybody, because now you have one more thing to take care of -- their own body and their own health. And if its not up to what you had scheduled --
>
> R: What's "not up"? You mean your body?
>
> P: Yeah. Your body. If you're not feeling well. or you're ill, then you cannot do many things which you wanted to do, hoping that the body will cooperate with you, with your schedule.

<u>Permanent, Serious and Worrisome</u>

As noted earlier, participants explained sickness as something continuous, long-term or permanent. Sickness meant something serious. Participants described feeling uncomfortable, generally being in bed, not being able to do anything, and being

worried.

The ensuing accounts illustrate sickness as a serious, long term condition. In sickness "something is wrong", and often incurable. Participants described the difference between partial health and sickness, emphasizing the serious, long term nature of sickness.

P: I'm sick, something's really wrong with me.

.....

P: A short term illness is like if somebody's got the flu. I wouldn't call that a serious sickness. You go there (to the doctor) and you take medication. You go to the doctor, the doctor gives you the medication, and you take care of that little flu or whatever -- it might just be a bug. And if you're alright --- you're normal again it's alright. But if you prolong being sick for a long time, you are sick. And you've got a high temperature, that is being sick, because that is not your normal day to day activity. You have a high temperature, you <u>are</u> taking medication for it, and you <u>are</u> lying down in bed, and so you <u>are</u> a sick person at that time until you resume your normal everyday activity.

.....

P: You know, sickness is much more serious than the kind of limitation I have now (torn knee cartilage). I think in my mind sickness is, you know, 104 degree temperature, or a very serious cough, or you know, prolonged state of affairs.

.....

P: Like I had a cesarean section and that was just temporary, because the weakness was only temporary. I got over it, and I forgot about it. But supposing, you see, now somebody like, have a chest pain continuous, you know, and then say three or four times, you know, and perspiring and having chest pain, and there is something wrong. And then you don't call yourself healthy. There is something wrong and you have to have the investigations, and go to the doctor.

.....

P: I mean sickness is a more serious term for me than partial health. Yeah. Sickness means that I am not able to do on a regular basis, or I am in great pain. Sickness is more serious, has a more serious connotation than partial health

does you know.

.....

R: So when would you go from being healthy to being sick?

P: Sick? Oh, supposing you see, something wrong, like I've got a gall bladder thing, or I can't digest my food, or I have some kind of ulcer, or a pain in my chest. So you are not, you see.

R: Then you are not what?

P: Then you are not healthy, you see.

R: Then you are not healthy ---

P: No.

R: Why not?

P: Because you see, there is a reason that why you are having these pains, there's something wrong in your system.

.....

P: Being sick is if your illness doesn't go away for a long time, or permanently.

The following accounts of the sickness experience described the worry associated with constant pain and not knowing what is going to happen.

P: Constant pain going on. So at that time the mental worry also comes. That relates with the physical sickness.

R: How does it relate?

P: Because you see, you don't know what's going to happen. --- Your mind is wandering, you know, whether you're going to have surgery, whether it's going to be successful, whether you're going to get through. So many things, you see, go through your mind.

R: At the time you are sick?

P: At the time you are sick.

.....

P: If its constant pain week after week, week after week,

you don't feel good. And you are worried. And you're feeling some aches ---: "what's going to happen, the pain is still there, whether I am going to have surgery, what's going to be done. Doctor takes X-rays and he can't find anything, but the pain is still there. So that's when I say that, you see, you call yourself that you're not healthy.

R: You're not healthy.

P: And there's something there.

.....

R: When would you really be sick then?

P: When someone's got cancer, as I already told you. Or heart disease or something like that. Yeah, you get worried about that and that really worries you.

Cancer was the condition described most frequently in participant accounts as meaning a person was sick. In fact, some informants equated only cancer with sickness. Tuberculosis, small pox, and more commonly chest pain and heart disease, however, were other conditions perceived as meaning sickness. One informant mentioned "regular" bleeding from the stomach as indicative of being sick, and something "to worry about", because of the on-going nature of the symptom.

Sickness was described as a "major thing", while conditions labelled as partial health were described as "minor things". The following accounts provide descriptions of cancer as a major thing because it meant something incurable and permanent.

R: I just wanted to understand a bit better --- why you said something like cancer was a major thing.

P: Yeah. You know, somebody is, yeah, that sick, you know they're not going to ever get better, right? So that is not minor. Its major.

R: Its major because you said "they're not going to get

better"?

P: Yeah, that's right.

R: I'd like to understand a little bit better how you are seeing the two things: the difference between something minor and something major?

P: Well, that's major because you know that what it is lead(ing) you to. And if its minor, you know its something that is going to go away in a few days, a few weeks, say.

.....

P: Sickness I always thought that it's really something very serious. If for example the things which, of course I have never personally experienced, but something like say cancer or TB, or some such thing.

.....

R: You mentioned cancer and all those kinds of illnesses.

P: Yeah, well yeah, when somebody has that, I guess that you will call them sick, yeah. Nothing can be done for it.

Participants described return to health, or chronic disease and death, as the two outcomes of sickness. The next portion provides accounts illustrating perspectives on these two outcomes.

Return to Health, or Chronic Illness and Death

The vast majority of accounts described recovery to health from sickness. A few participants, however, did speak of the fact that a sick person could die if (s)he was unable to get treatment, or if the body's resistance was very low and healing could not take place. Participants also indicated, albeit implicitly, the possibility of sickness progressing to chronic illness. The following accounts illustrate the two main aftermaths of sickness: return to health and death. The first account explained recovery to health.

P: In the situations like, like supposing -- I won't say forever, but when I'm suffering from something, like I'm sick. I'm running a fever or something, if I have to go to

> the doctor then I'm not a healthy person at that time. Once I'm recovered I am a healthy person.

Another account described the decline towards possible death, linked with the body's decreased ability to resist internally or externally caused sickness.

> P: It (the cause of the sickness) could be an external source also (as well as an internal source). A bug which I haven't seen, made me sick with the flu, okay? Which got deteriorated into worse and worse and I died because of that. That must be sickness. Okay? My body not able to take it.

To conclude, sickness was described clearly by participants as a state characterized by not being able to carry out normal activities, and therefore not being able to fulfill personal responsibilities. Low energy and resistance, along with dependence and lack of control, were explained as the characteristics underlying the very limited activity in sickness. In contrast to the temporary, bothersome nature of partial health, sickness was perceived as serious, permanent and worrisome.

Understanding the characteristics of partial health and sickness clarifies the parameters of complete health, and provides a vision of the total health experience as a three phase continuum. Complete health, partial health and sickness were defined and understood by participants in terms of being able to do normal activities.

Two possible consequences of sickness were described: return to health, or chronic illness and death. Participants generally had little personal experience with sickness, but were cognizant of the sickness experiences of other persons. The final section of this chapter presents participant accounts describing the

influence which the mind and other factors exert on the total health experience.

Influences on the State of Health

Within the overall frame of "being able to do normal activities", data analysis revealed two distinct categories of description of health: (1) the complete health - partial-health - sickness continuum, and (2) the factors influencing the total health experience (see figures 2 & 3). The previous section presented participant descriptions of the three phases of the health experience. This section discusses the factors which participants considered to influence health.

The role of the mind will be presented in most detail, as it was described by participants as the factor exerting the greatest influence over health. Exercise, diet, sleep and cleanliness, use of medicines and maintaining routine, will be briefly described as external factors exerting a lesser influence on the total health experience.

The Mind: Body-Mind Interaction

Although participants explained health as a integrated experience based upon the inseparability of body and mind, they nonetheless singled out the condition of the mind (or mental attitude) as the factor most affecting a person's health. It is therefore important to discuss the ways that participants explained the role of the mind in health, and rational to focus on the role of the mind as a separate theme for discussion.

Participants provided a holistic description of health in terms of a balance between body and mind (see figure 3), with both body and mind involved in the three phases of the health experience. As discussed earlier, participants described the three phases predominantly in terms of the physical body, focusing primarily on how the condition of the body impacts upon a person's capacity for doing normal activities. Participant accounts, however, also described how the mind influences complete health, partial health and sickness. Accounts unanimously described a reciprocal interaction between the mind and the body, with mental health seen to affect physical health and visa versa.

Participants acknowledged the role of the mind in health. The vast majority of participants felt that the mind exerted the greatest influence on the total health experience, affecting the individual's ability to do normal activities and fulfill responsibilities in daily life.

The mind was explained to have both a positive (beneficial) and a negative (destructive) influence on health. According to participant accounts, the mind can either assist in the maintenance and improvement of health, or exert a detrimental effect on health.

Worry, described in relation to stress in some accounts, was considered capable of making a healthy person less healthy, and ultimately sick. In contrast, a positive mental attitude, characterized primarily by freedom from worry, was viewed as beneficial to health. Participants stated that this positive

mental attitude could help a person remain completely healthy, assist a partially-healthy person to regain complete health, and even heal the sick body. Participant accounts of the effects of worry are presented below.

Worry

Although worry was explained in various ways in participant accounts, it was basically equated with mental agitation; a state opposite to the calm mental condition found when the individual cultivated a "positive mental attitude" (described in the following section). Being affected by, or reacting to, external circumstances and life situations, lamenting over the past and being anxious over the future were described as the fundamental causes for worry. Worried thoughts were viewed as capable of making the body less healthy. Worry was viewed as a factor which drains away a person's physical and mental energy, and therefore decreases individual resistance to illness.

Some participants equated worry with mental unhealth, or sickness. Several participants referred to stress as the result, or effect, of worry. One participant described the way stress can ruin health:

> P: Yeah, because if you're under pressure all the time, it's (stress is) a mental condition, it becomes like a --- and it just has a chain reaction over everything. And you know, you get frustrated, and you can't deal with it (stress) so you get depressed, or you get angry. And then that's how my ulcer condition started, is because I didn't know how to deal with it. And I just thought about it and thought about it and never really acted. So I think it did almost ruin my, you know, health.

As noted, worry was equated with mental sickness in some accounts.

P: That's when you'd say that your mind is sick, right? Because you have lots of worries in there.

This negative mental attitude was also described in terms of "loss of mental balance". One participant viewed loss of mental balance in terms of "being controlled" by feelings (emotions):

P: When mental balance is not there, that's the way they (people) become sick.

R: So for you, if you had the physical health, but you lost your mental balance, then you would say that you were mentally sick?

P: Yeah. Yeah. That's the time you become sick, you know. Something overcome, you know, your thinking power, you know. Maybe is the depression, maybe is greed, maybe is the jealousy, maybe anger, or maybe revenge feeling, you know.

This negative mental state involved on-going worry, not just temporary worry about life situations. The following accounts explained how mental worry decreases the body's resistance and generally affects health.

P: Mind is the thought process which, in this ill health, (partial health) brings out chemical changes in the body, which makes body non-resistive to all outside effects, like allergies.

.....

P: Well, if you don't keep yourself happy, of course you can get worried. And worries are not good for your health. You know, they give you ulcers sometimes. As I told you last time, you can get ulcers if you worry too much.

.....

R: Would you feel you were healthy if you had any kind of worries?

P: No. I wouldn't really because it is not a -- normal state of mind at that time. So I have these worries and it could affect my health as well, in the sense that if my mind is worried I might not eat properly, I might not do my chores properly. And that could affect my body.

The participant clarified this point:

P: -- if you're mentally not healthy, if you're worried about something all the time, it does affect your (physical) health as well.

A clear description of worry as a factor adversely affecting health was provided by another participant. Speaking of a traditional Indian saying about the effects of worry, he related worry with stress, and mentioned the opposite mental attitude: keeping happy.

R: I am wondering what the equivalent word in, say, Hindi would be for stress?

P: "Chinta"

R: Oh, so thinking!

P: Yeah, "chinta".

R: Okay, so I was wondering if I could get a better understanding of what you were saying, by not using the english word.

P: Yeah. You know what "chinta" means? Worry. You know, worry?

R: Okay.

P: And somebody might have told you "chinta" and "chita" are two things. "Chita" destroys or finishes the dead body. You know what is "chita"?

R: I'd rather have you translate it.

P: "Chita" is the cremation thing. Where you put the body with the logs.

R: Yes.

P: --- and put fire to it. That's "chita". That destroys the dead body. "Chinta" destroys the life. Okay?

R: So that really shows the importance that's placed on this stress then in terms of health and illness.

P: Yeah. That is right. Yes.

R: And so that's something that you learned as you were

growing up, or heard then?

P: Um hum. The song is, I mean, appropriate "don't worry, be happy"! It is very appropriate.

The same participant explained how worry leads to mental stress.

P: Stress is again the attitude towards it, towards that thing, how you want to react or counter act. I mean, okay --- First thing is your thought process, okay? I could be worried about my mother's leg.

R: Yes.

P: And if I am so much worried that my rational thinking goes off, and I start shouting at my children and at my wife and things like that, is stress. --- Worrying about something (that) might happen, or has already happened beyond our control. I mean "what if" scenario.

R: -- I'm still not sure about how you're defining stress. Are you saying stress is a lot of worry? Or irrational worry?

P: No. No. That worry causes, in your thinking, stress. Worry is creating stress. How would I meet my tomorrow's payment? Okay.

R: -- So the worry, that's there in the thoughts, can cause this stress or tension, which ---

P: Yeah. Which will change your chemical, body's -- body chemicals to react differently. Chemical changes in your body it brings. I mean that's what causes allergies.

The role of mental attitude in health was further explained in another account. Reacting negatively to external events was viewed to cause stress.

R: So this attitude you have plays a role in your health?

P: That is right. Attitude to the external things. I mean to me you are an external person. And what you said, I react -- how I react, or counter react my attitude towards -- I mean you might be drinking tea, and I don't like you drinking tea while I am sitting here. Or you might be scratching your head, and to me its, it might bother me. I react differently. So reaction to that also causes either stress or happiness reaction, or counter action to other people's action or words or whatever.

The following accounts illustrate the beneficial, or positive, influence the mind exerts on the total health experience.

Positive Mental Attitude

Participants described positive mental attitude as essentially opposite to the state of worry just described. Although this mental attitude was described variously in participant accounts, the basic characteristic emerging from the data was being free from worry.

Participants further described this attitude as having "nothing bothering you", not taking things seriously, being optimistic, seeing the positive side of life, being content with what one has, and keeping happy. Being in control of one's feelings, or emotions, and not reacting to (or worrying about) life events and small physical problems were described as other aspects of this positive mental attitude.

One participant described how positive mental attitude involved feelings of "being healthy at all times", despite having small health problems. He felt that this attitude kept him healthy, and also helped him regain health when he was in partial health or sickness.

> P: Even if there is some (health) problem, okay, that it will take care of itself in course of time, so its fine. That's what I feel. And that is why I say that mental attitude gives you --- helps you being healthy.

He explained further how thinking can affect health, stating that thinking you are healthy, makes you healthy, and thinking you are sick, makes you sick.

> P: I definitely feel that the mental attitude which you

develop, it definitely helps your physical body as well. Because over a period of time I have always thought: yes, if you think that you are healthy, you really are.

He elaborated on this as follows:

R: I was wondering if the mind can either harm the body --

P: Yes.

R: -- or it can work in a positive way and help the body heal or keep healthy?
P: Positive way, yeah. That's right. That's what I feel. Because several times I see that, okay, if I really want to be sad in my life all I need to do is sit like this for a couple of hours, and you will see that two hours later you will feel that you really are, there is something wrong somewhere.

R: You mean just staying sitting for two hours?

P: Yes, sitting two hours <u>thinking</u> that you are unhappy. It definitely affects your health.

R: Because you start to really believe that you are unhappy?

P: Yeah, that's right.

R: So, keeping positive thoughts, you could say ---

P: Yeah, keeping positive thoughts does help, power of positive thinking.

R: Power of positive thinking. So do you feel that the mind actually can heal the body? If we use the word heal, or cure things?

P: Ah, not either heal or not cure --- but it definitely contributes to both processes I would say.

This attitude was attributed, at least in part, to the participant's upbringing in India and associated family influences. He explains how he acquired this mental attitude.

P: This is not a very conscious effort to train it (the mind) as such. But I believe in it, and that is how it has happened.

R: Okay. And you --you'd say you believe in this because of your past? You were saying like with your grandfather

talking about (ayurvedic medicine) ---

P: Because of the --- yes, partly because of the influence, partly because of whatever we studied in the schools.

R: So the whole educational system?

P: Or my father's influence might have worked to a great extent on me. My father is one of my type, who would never say even if he is suffering from anything. Nobody would know in the family altogether.

One participant linked this attitude to the tenets of Hindu philosophy. To her the most important aspect of this mental attitude was "being in control of the feelings, and not letting the feelings control you". In contrast to the view of the earlier participant, she linked this control of emotions with conscious training of the mind, which she described as "training the brain".

P: Actually this thing which I'm discussing with you, its the Indian philosophy -- that meditation start, yogas you must have heard, yoga and meditation? They are all for training the brain.

She elaborated as follows:

P: --- that's the way (through yoga and meditation) you train your brain (mind), so like nothing bothers you.

R: Okay.

P: Happiness or sorrow, you take everything, you know, as they come and go. Like that.

R: Okay, so you're telling me that to "train your brain" then this meditation practice is important?

P: Right. -- so your brain doesn't wander like for nothing here and there, you know.

Explaining this "training" further she stated:

P: -- You have to practice it. Like practice it, not to -- like you should overcome, your brain (mind) should overcome all those feelings, not those feelings should command your brain, you know.

This mental balance, or attitude, was related to not being overly affected by surrounding situations, and not letting things bother you. Positive mental attitude was further described as a mental state characterized by inner balance and clear rationality.

R: So mental health means having control over your mind?

P: Having control over your mind, yeah.

R: And not, as you say, getting ---

P: Disturbed over, say --- getting emotionally upset over something for any reasons, either emotionally or otherwise.

.....

P: Yeah, if the balance is not there, this thing (bad news) will affect me more or longer time.

.....

P: Nothing bothers me too much. And even if something, you know, sometimes somebody does bad to me, or says something bad to me, it doesn't hurt. I don't take that thing too deeply, you know.

A few participants viewed working outside of the home as a factor contributing to this positive mental attitude. Economic gain was not mentioned in relation to this work. Both salaried employment and volunteer work were described in this context. One participant explained that doing work outside of the home was "mental therapy", as it provided a change of atmosphere.

R: I wondered if you could just elaborate on that for a few minutes, about what you mean by "mental therapy"?

P: Like you see --- Yeah, I'll tell you. Some of my friends, you know, when I talk to them, "Oh, we are both staying at home, you know". And then they complain, you know, just "I have to go to the doctor because I have this ache, and I got, you know, backache or headache". I say, listen you have to change your atmosphere. You have to go out and meet other people. Or even working for a few hours, part time, I said. That will change your mental attitude. So that, you see, you're not thinking all the time about yourself.

She went on to say that this work helped her to stay mentally active, and that this mental attitude was important to her health:

> P: So this is what I said, that its a mental therapy, you see. Work is a mental therapy.
>
> R: And that for you is important in being healthy?
>
> P: Right.

Even as worry was sometimes referred to as mental sickness, or unhealth, this positive mental attitude was referred to as mental health in some accounts. The following account described the beneficial effect of an accepting, calm mental attitude. One participant called this attitude being "mentally fine".

> P: If you are mentally fine, I think it reduces your sufferings to a great extent that's what it is. As I said, the way I approach the life, okay, it had to happen and it did happen, okay. Then now I have to face it. And then, see it reduces my sufferings, it eases the burden on my head.
>
> R: So this attitude of acceptance?
>
> P: Attitude of acceptance and ultimately try to solve the (problem) -- form a resolution to solve the problem.
>
> R: So that would be there when you're mentally healthy?
>
> P: Yes. That would be there when you're mentally healthy. And if you're mentally healthy, physically you might be sick, but still that (mental attitude) also helps recover your body. Or if not recover the body, at least it definitely helps reduce your sufferings.

He elaborated on this perspective:

> R: You talked a lot about how worry can disturb your health. For instance you said worries over a small physical problem, that mental attitude can cause physical problems.
>
> P: Yeah. That's right. Yes.
>
> R: Is that the same thing you're talking about now?
>
> P: Yeah, that's exactly what I'm saying. That yes, if you

are -- if you have some small physical problems also, perhaps you can say, ignore these problems. Ignore in the sense not that you don't go to a doctor, or don't try to get it healed. But what I mean is that you know what to do with it, rather than say, if you are, if you don't have control over your mind: "Oh, my god! what have I to do this --- there". Whereas if you have a control, all that you would do is okay, go to the doctor --- you try to control the pains or something. Or even if you have the pains, you know that "okay, this is the problem, it <u>has</u> happened". But you have to <u>face</u> it and you have to bring -- solve it subsequently, rather than just crying over it all the time.

R: "Rather than just crying over it all the time". So that means worrying about it? Or being anxious?

P: Yeah. That's right, yeah.

This mental attitude was also described as a positive view on life. The following accounts illustrate this:

P: Things happen inside, and that makes you happy or sad at times. But still you know, you try to --- something that bothers you, your mind, and you still, you know, try to be happy. Say, look for the good side of it, and there's nothing there. Look at your kids and be happy with them. Right? --- I just feel happy with what I've got. I look at my kids, and my mother, and so I, you know, feel happy with them.

.....

R: You said that in health this thinking positive was very important. And I was wondering exactly what you meant by "thinking positively"?
P: To me thinking positively means to try and see if things are not, you know, always try and see what is going for you. What is --- okay, I'll give you an simple example okay? Say if you had plans to go to a movie with somebody. At quarter to seven somebody calls and says "sorry. I can't go". And you really were looking forward to it. Rather than saying, you know, "that's it, my whole evening is ruined, you take the opportunity to think, or sit down and read a book, or, you know. That's what I think is positive thinking, is to make the most of what is <u>there</u>, rather than be depressed or disappointed with life because of what we don't have.

Participants explained that keeping a happy attitude and not being affected by things, was another facet of this beneficial mental

attitude.

> P: Staying happy means that you are not worrying about things and you just have a happy attitude towards life, and you know. That would -- yeah, keep you healthy, in that state of health. Yeah. You know, you are not worrying about things and, let things happen and not let them affect you, that's the idea.

.....

> P: Well, keeping yourself happy, you know, doing your --- again the same sort of thing comes, you know, doing your routine chores and doing your duties, and keeping yourself content and you know. Not let anything worry you, the things do come that you know, nag at you. But just try to keep yourself away from it, and know that they are going to pass away, or whatever.

Several participants related this beneficial mental attitude to a happy home and family environment. Keeping a good atmosphere in the home was considered very important in health.

> P: Home atmosphere is very important too. A good relation with all the family members is also very important - to have good health mentally, as well as physically. If there's peace and harmony and everybody is going to be very happy, and, you know, the normal way. But if there is any kind of friction in the house, that would bring mental worries and mental -- and then it might -- it could lead to other kind of problems as well. So all this does contribute to being healthy.

.....

> P: If you are happy in a life with your family --- with your children, that affects (health) a lot too.

One participant explained that it was often difficult coming to Canada from India, being away from the extended family, and having no one to talk to about personal problems. Describing that the worry associated with keeping personal concerns bottled up inside was detrimental to health, he agreed that a mind free of worries helps to keep a person healthy.

> R: So then this not being able to tell your problems could give rise to this worrying?

P: Yes. It could give rise to the worrying. It could give rise --- and those worrying also it -- it definitely affects your body as well ultimately.

R: Right. So keeping your mind free of worries, worrying about things, will help your physical health?

P: Yeah. That's right.

Absence of worry (or mental stress) was specifically described in one account as something contributing to health. The participant described the important role of the mind in the health experience.

R: So you're telling me that the body stays healthy as long as the mind doesn't have any stress in it?

P: Yes. As far as the health is concerned.

R: "As far as the health is concerned"?

P: Yeah.

R: So that means the mind is really in control of the body's health?

P: It is.

R: So for you, the mind determines whether the body is healthy or not? Is that what you're telling me?

P: Mind does not determine if the body is healthy or not. Mind is the cause which creates its affect of health on the body.

R: Creates (complete) health or ill-health (partial-health)?

P: Both ways.

R: Both ways?

P: Mind is the cause, the thought process, thought process is the, I mean -- and the stress in it, or not having the stress in it. Okay. Having --- it will affect changes in the body('s) health.

In summary, participants explained that the mind exerts a two-fold influence on the three phases of the health experience. Worry (often manifesting as stress) was described as detrimental to

health, while a positive mental attitude (characterized primarily by freedom from worry) was described as having a beneficial influence on health. As noted previously, participants explained that the mind exerts the most powerful influence on the total health experience.

The other influencing factors described in participant accounts are now discussed in the concluding portion of this section. In contrast to the mind, which is viewed as an internal influencing factor, these other factors perceived to influence health are referred to as external factors.

External Factors

Diet, exercise, sleep, cleanliness and use of medicines, as well as maintaining a routine, working outside of the home and home atmosphere, were perceived as other factors influencing complete health, partial health and sickness. Although they are referred to as "lesser influencing factors" (in contrast to the role of the mind), they were nevertheless explained as significant influences on the health state.

Accounts describing work outside of the home and home atmosphere were already presented in the previous section in relation to positive mental attitude; these two factors will thus not be presented again in the current discussion. The nature of each of the other lesser influences will now be described through participant accounts. Participants' descriptions of these factors reveal the importance of preventive health behaviors.

Diet and Exercise

After the mind, participants described diet and exercise as the most significant factors influencing health. Diet and exercise were viewed to be very closely related to each other, being almost always described together rather than as isolated entities.

> P: I think diet and exercise both should be very closely monitored, to ... you know, have good health. So just not one or the other, they both should be done.
>
> R: The two together, diet and exercise?
>
> P: That's right. Because you can eat, you know, really healthy food, and yet feel sluggish if you don't exercise. So you have to complement your diet with exercise.

Diet. Participants saw diet as something very important for health. Improper diet was described as a major cause of sickness. Proper diet, on the other hand, was viewed, not only as a factor involved in keeping a person healthy and preventing disease and sickness, but also as aiding a person's recovery from sickness to health.

The following account describes how wrong eating habits contribute to sickness.

> P: We learned that most of the disturbed, say, physical disturbances or whatever it is, are due to your ill diet. Okay? So if your diet is not proper, or you digestion is not proper, then only most of the illnesses you get.

He further explained that, when he was sick as a child, ayurvedic doctors in India strictly advised what foods to take and what foods to avoid in order to heal the body. He spoke of sickness in terms of "disturbances" in the body:

> P: That's why I said that your diet also is responsible for

> most of the disturbances in your body. And that's how if you avoid those diets (wrong foods), it helps by itself (to heal the body).

Although the nature of a "proper" diet was described variously in the accounts, participants agreed on basic principles. Most participants explained that a proper diet was made up of a balance of proteins, carbohydrates, fats, fruits and vegetables. They were not concerned about scientifically established amounts of each food group, but rather estimated the amounts of each food necessary for a balanced diet. Both vegetarian and non-vegetarian Indian meals were seen as nutritionally balanced. Many participants used Western foods extensively in their diets. All participants had adequate economic resources to provide the foods required for such a balanced diet. The following account illustrates a common perspective on proper diet.

> P: A proper healthy diet for me would be -- excess of anything is not a healthy diet. And moderation of anything is -- you know, -- I like to eat a lot of sweets, or whatever you can call it, -- but a normal amount is just all right. But if I start eating just sweets and candies everyday, its not -- its going to tell on my health and my teeth and everything in later years. And that is not a very healthy diet because it does not, it does not give you everything that you require for a healthy body. You must have some meat, you should have some cereal, you should have some milk, you should have fruit and fresh vegetables -- that's a proper balanced portion of these is a healthy diet.

The benefits of fasting, as well as limiting intake of sugar and salt, was described by another participant:

> P: I keep fast twice a week (on liquids and fruits) just to -- clean, you know, the system. And then I try to control sugar and salt. I don't take sugar in my tea. I look after my health.

Advocating a naturopathic perspective on diet, one participant

explained "proper" diet rather differently. To him a proper diet meant eating foods which "the body craved after". He felt that a person has a natural inclination to eat the foods which the body needs for health, as well as a natural instinct to not overeat.

> P: When you feel an urge to eat something, it only shows that your body needs those particular things. And then only you feel an urge for it ... But time comes when you feel that "oh, hey, that's enough, I don't think I need to eat more". But because you like its taste, if you keep eating it, that doesn't help you at that time. And then it adversely affects your body.

Diet was linked intimately to the body's store of energy. As noted previously, participants explained that diet needed to be altered during sickness. A liquid or semi-liquid diet was recommended for the sick person, to provide the body with a source of quick energy to promote healing, recuperation and provide extra energy for doing activities. Several accounts described milk as a food of special importance to the diet. Milk was described as a very wholesome food, and the food of choice during sickness because it is rapidly assimilated and provides a quick source of energy to the body. The following accounts illustrate this perspective:

> P: I definitely believe that its (milk) a very healthy diet, partly because --- I don't know why, we have been brought up like that. And we were always told -- I think even in the school it was taught that you must have a good amount of milk everyday.

.....

> R: Would you change your diet, would you, if you were sick?
>
> P: Yes, I --- diet or supplement with vitamins, and I might drink more milk. I might eat different diet. It could be semi-liquid diet. And liquid doesn't mean liquor! More milk, and different, I mean, so everything you could digest it better. Like I won't eat meat, as its hard to digest.

R: So you're saying these things, milk and liquids, they'd be easy to digest when you're sick? Is that what you mean?

P: Yes. And give you more energy, and faster energy.

"What" foods were eaten and "when" they were eaten was also a point emphasized in many accounts. Participants explained that foods should be eaten at set meal times, and in moderate amounts.

P: Eating proper food, yeah, and doing things in time too. Like lunch time you have to eat in time, and you know, no matter if you eat little or more -- and just take whatever you, and do things in time, you know.

R: What do you mean "do things in time"?

P: Try to do, okay, some people have habit they will get up 11 o'clock, then they will spoil their whole routine. So lunch time, they will have breakfast, and dinner or snack time they will eat lunch!

.....

P: Eat a proper diet at proper times, and not just eat any time you feel like it -- just open the fridge and eat something.

.....

P: If you keep eating it (a food you feel like eating), that doesn't help you at that time. And then it adversely affects your body.

It was felt that lighter foods should be taken in the early part of the day, and that this pattern of eating contributed to a person's vitality. One participant described this as follows:

R: Are there other things that you think are important for you, to maintain --- contribute to this vitality that's part of health?

P: It again comes to eating habits. What you eat and when you eat. I mean, I would not eat any meat items before lunch. Okay. On my breakfast, I'll have a very light breakfast. Very light means a cup of tea, or a cup of milk, or a cup of juice --- and maybe a piece of fruit. And lunch will be also very light -- its not a big lunch, I mean.

R: So all these things you're doing, having a light breakfast and a moderately light lunch are contributing to having you

have that feeling of being energetic?

P: That is right.

One participant spoke of taking foods which were in season; this practice stemmed from upbringing in India.

R: So you grew up taking the foods that were in season?

P: Yeah. Fruits and food what is in season, and what grows most at the farm, that's the main.

R: So, here also you tend to take foods that are in season?

P: Okay, here habit is still that same.

Temperature and freshness of foods eaten were described as other important aspects of a healthy diet. One participant explained that attitudes about proper diet were instilled in him during his upbringing in India. He described that very cold food, or stale food, is not healthy. Fresh food, in contrast, was described as healthful.

P: Right from our childhood, we were never given any cold stuff to eat altogether.

R: Could you describe what you mean by "cold"?

P: Either that is actually refrigerated or -- one is refrigerated -- that is anything that is extremely cold is never consumed. Secondly, anything that is stale is never consumed.

R: Stale. How would you determine "stale"?

P: Something that is, something which you store up in the fridge or somewhere for days together. Or in a freezer and put it for days together. Or canned foods and things like that, we never knew. Everything is fresh.

He explained how he still observed these practices in Canada.

P: I usually don't drink very cold water, sometimes I do take these pops and other things, but still if I have to drink water also, I do take cold water but not that very cold one.

The following accounts illustrate perspectives on exercise.

Exercise. Participants unanimously perceived exercise as essential to maintenance of health. Accounts varied, however, in terms of the type of exercise advocated. Walking and jogging, as well as traditional hatha yoga exercises and breathing techniques, were described as beneficial to health. One participant saw exercise as a way of coping with stress. The accounts presented below illustrate some of these perspectives.

> P: I've always been active, and always ... not, not you know, rigorous exercise, just a regular balanced ... in moderation, you know. Go for long walks or something, swimming, or whatever. Do something on a regular basis.

Exercise was perceived as enhancing the body's vitality and resistance; with exercise itself viewed as one aspect of a healthy life style. The importance of increasing cardiac output through physical and breathing exercises was described by one participant:

> R: You just said that this resistance comes from doing several things, or living a certain way.
>
> P: Yeah. Living a certain style of lifestyle. Generally we have been taught in our society ---that getting up before sunrise and having a bath and cleaning up, and all cleaning, and then doing a little bit of exercise -- you can call it yoga or whatever you can, exercise which relates to the body. Okay? Like breathing exercise.
>
> R: So when you say "relates to the body", you mean using the body?
>
> P: Yes, using the body.
>
> R: You mean physical exercise?
>
> P: Yes. That's right. Your physical exercise, that physical exercise also includes breathing. And like, again, if you want to bring, include the medical terms here, I mean the -- I'll be saying you have to pump up your cardiovascular system.

R: Okay. Yes, yes.

P: But its the breathing exercises, in a way, which also does that similarly. And some other exercises, and the same exercises which give you -- without that much strain on your body -- still the same vitality. But one essential part is, I mean, having, getting up before sunrise and having bath before sunrise, gives you external energy.

It was also explained that people vary in terms of the amount and type of food and exercise they require to be healthy.

P: Some people could become healthy with less exercise than some people, who could, to some it might take more exercise and food, or chemical intake (foods). As compared -- that's totally (dependent) upon your own physical requirements, body requirements.

R: And what about these requirements?

P: As I said, different foods, and more exercise, a different type of exercise. That's again a physical requirement, I mean.

R: I know. But I mean why, or how, do you see this being different from person to person? What would the reason be?

P: Because everybody's body structure is different. And chemical body, internally chemical reaction to different chemicals is different.

R: I see. So some people will need more diet and some more exercise.

P: That's right, yes.

Sleep and Cleanliness

Although participants mentioned sleep and cleanliness only briefly in their accounts, they nonetheless attributed importance to these two influences on health. The importance of sleep for physical and mental health was described in one account as follows:

R: So it seems that sleep has an effect on your physical health as well as your mental health?

> P: It does, yes. It rests my mental -- because I'm not thinking, maybe unconsciously I <u>am</u> dreaming or whatever, I don't know. I can't say about that, I have no idea what goes on -- but I feel that my brain is getting a little bit of rest as well as my body's getting rest. So next morning when I wake up, the vitality is again back and I can start work again.

Another participant described how sleep helps a person carry out his/her duties:

> P: If you don't have a good sleep, naturally, you know, you are not capable of performing your duties during the day. So ... if you're not sleeping every night, in case of insomnia or something, you're not going to stay healthy. ... Your duties that you have to perform the next day ... supposing you have had a good sleep, you know, you're capable of doing (the duties) better. If you haven't had it (sleep), you are just doing it, but not in a proper way. That's what I think.
> Cleanliness of one's person, as well as the surrounding environment, was described as another factor influencing health.

The following accounts explain the importance of cleanliness:

> P: Cleanliness. You should keep yourself clean, otherwise it does bring a certain kind of --- maybe it could bring skin disease. Like dental health is very important, too. If you don't wash your hair then there can be -- certain problems could come. So, cleanliness is very important too, on your person as well as in the house.

.....

> P: When you get up, you brush your teeth, you take a bath, and you change your clothes everyday. Like my children never wear the same clothes the next day. It has to be washed before they can wear the same clothes ... So I think that it is a necessity to be healthy, because if you don't brush your teeth, naturally germs go in, and that sort of thing I believe in. To be fresh. And that's the way I start a day for myself. And I keep the house clean so that, you know, my kids like to play on the floor so I would like to have the floor clean. So that, I mean, that's the way I take health as.

<u>Use of Medicines</u>

Accounts described use of both Western and traditional Indian medicines. Some participants used Western medicines exclusively,

others used both Western and Indian medicines. One participant explained that herbal medicines were important in maintaining his health, particularly in relation to preventing constipation and promoting proper digestion of food.

> R: So you're telling me that you feel that herbal medicine works much better (than Western allopathic medicines)?
>
> P: Oh, definitely much better. --- I have always trusted these medicines only.

He elaborated on the type of herbal medicines he used and why:

> R: You don't like to take any of these traditional Western medicines (like aspirin)?
>
> P: Any of those pills. Not only Western, I don't take -- and that's where the concept of naturopathy comes -- I don't take even ayurvedic medicines also so often. I have a few medicines brought over from India. And it really works extremely well. Only a couple of them. One is known as "harde". Now, that's a sort of laxative, okay? --- but nor a real laxative, but it loosens up your motions, and motion is really good. And that helps you very much. Now this is one thing which I take occasionally. And there is another one, it is known as "sudarshan". That's an extremely bitter powder. And that powder, if you are having temperature or something, it helps you a lot. In cases of flu or something, it helps a lot.

Accounts describing use of Western medicines, referred almost exclusively to the use of aspirin as a common way of treating temporary complaints such as headaches, backache and fever.

> P: Like if I had a headache I just took an aspirin and that would go away. I wouldn't need to go to a doctor for that. Or a slight fever, I could just take an aspirin, and that would be alright.

<u>Maintaining Routine</u>

Maintaining one's usual daily routine was described as an additional factor influencing health. The following account describes the importance of keeping a routine, or doing things

regularly. The participant explained maintaining a routine of regular exercise.

> P: Then, like you do things regularly, and everything. Like if you exercise regularly then it affects; it doesn't affect if you do once a week, or, you know, do maybe, you know, sometime in the evening and, or, sometime in the morning. --- Keeping a routine is good thing to become healthy person.

Doing "something different than the routine" was viewed as leading to sickness. The ensuing account described this:

> R: So actually this seems to be important, that to keep your health you need to maintain your routines?
>
> P: Maintain your routines is very important.
>
> R: And whatever that routine is you can change it slowly?
>
> P: You can change it slowly, but you cannot make a sudden change and not feel the effect of it on your body.
>
> R: So, in order to keep healthy you need to maintain the time you get up, and what you eat, and the routine of how much exercise you have?
>
> P: That's right.
>
> R: And when you don't keep that routine going, you can get into ill-health (partial health)?
>
> P: Yeah. Then body has to react to that <u>change</u>, and then the vitality goes <u>down</u> because its trying to cope with that change, energies are diverted towards coping (with) that change and adjusting towards that change. Because now the body will accept similar changes that next time happening. So the energies are going there, so energies are not there for other things which are happening around the body, in the environment.

In summary, participants described diet, exercise, sleep, cleanliness, use of medicines, maintaining a regular routine, working outside of the home and home atmosphere, as additional factors influencing the three phases of the health experience. Diet, exercise, sleep, cleanliness, use of medicines, and

maintaining a regular routine have been described through the participant accounts presented in this section. The accounts presented in the previous section on positive mental attitude included participants' descriptions of the influence which working outside of the home and home atmosphere exert on health. Of these minor influencing factors, diet and exercise were given the greatest importance in participants' accounts.

Summary

This chapter has presented the results of the study in the form of participants' accounts of their experience of health. Analysis of data revealed "doing normal activities" as the overall context within which participants explained the health experience, and led to the final structuring of an analytic framework which organized the presentation of data in this chapter.

Within this overall context, participants offered two levels of description of health. Firstly, they described health according to the three phases of the health experience (complete health, partial health and sickness). Secondly, health was described in terms of the factors perceived to influence health.

Health was perceived as a holistic phenomenon involving both body and mind, the two being linked together as an inseparable whole unit and making up the total person. Participants described the three phases of the health experience primarily in terms of the physical body. In contrast, descriptions of the factors influencing health focused largely on the role of the mind,

although other minor factors (such as diet and exercise) were also described.

Complete health was explained as a state where the total person (both body and mind) was healthy and able to carry out normal activities well and happily. In partial health, participants were still able to carry out daily activities, but less well and with more effort than in complete health. In sickness, participants explained that they could not carry out normal activities, and therefore could not fulfill personal duties and responsibilities independently.

Partial health was viewed as temporary and bothersome, while sickness was described as serious, permanent (or long term) and worrisome. Energy, resistance, independence and control were described as four characteristics of the health experience. These four health characteristics supported individual capacity for doing normal activities in each phase of the health experience.

Health was perceived and experienced by participants primarily in terms of capacity for normal action. Health was described in relation to the three phased continuum making up the total health experience. Descriptions of the characteristics of partial health and sickness clarified the nature of complete health.

The results of this study constitute a description of the essential meaning of health for the Indo-Canadians involved in this investigation. This description represents the popular domain of Kleinman's explanatory model. The following chapter

discusses the results of the research in light of relevant literature.

CHAPTER 5 : DISCUSSION OF THE FINDINGS

The framework presented in chapter four represents the fundamental meaning of health for the Indo-Canadians who participated in this study. The framework illustrates some of the explanatory models of health located within the popular sphere of Kleinman's cultural system model (see figure 1). The study findings indicate that there is some agreement between the conceptualizations of health held by health care professionals and those held by the Indo-Canadian participants in this study.

Health was revealed as constructed in both ethnocultural and social contexts. This is a significant finding of the study. The researcher started the current study with the intent of investigating the influence which ethnicity and culture exert on health definition. The data, however, indicate that social environment also plays an important role in the way people construct health.

In this chapter, the study's findings will be discussed and related to relevant literature. A brief examination of the data in light of Kleinman's explanatory model framework introduces the content of this chapter. The following discussion focuses on three main themes: (1) normalcy and health, (2) conceptualizations of health, and (3) factors influencing health. These three themes correspond to the three fundamental components of the framework presented in the preceding chapter: namely - doing normal activities, the three phases of the health experience and

factors influencing the health state (see figures 2 & 3). Some of the literature cited in chapter two is reviewed again in this discussion of the study's findings. The significance of socio-cultural context in construction of notions of health is emphasized in this chapter's discussion.

The Explanatory Model Framework

Kleinman (1978a,b, 1980, 1984) states that social and cultural context structure the individual's explanatory model for viewing health and illness. As illustrated in Kleinman's model, each of the three domains (professional, popular and folk) has its own perspectives on health and illness (see figures 2 & 3). Effective communication and health care is encouraged when clients and health professionals share similar views of health and illness. On the other hand, difficulties in clinical communication and ineffective health care are likely to exist when lay and professional perspectives remain distant from each other.

The descriptions of health presented in the accounts of participants represent the popular sphere of the model, and encompass the individual and family based beliefs, roles and behaviours associated with the experiences of health and illness. Participants' beliefs regarding the factors which influence health, and related health promoting lifestyles, appear quite similar to those held by other groups in North American society. These similarities appear to be based on socio-economic situation rather than culture. Therefore, we cannot say that people's

notions of health and illness are constructed solely by ethnocultural context.

Doing Normal Activities: Normalcy and Health

Study participants emphasized the term "normal" in their accounts of health. Analysis of the data showed that participants employed the term "normal", and concepts of normalcy, in two distinct ways: they spoke of (1) doing normal activities, and also (2) viewed health as a normal state of being. The following section discusses the concept "normal" in terms of normal activities in health.

The Socio-Cultural Construction of Normal Activities

Participants described "doing normal activities" as the primary characteristic of health. Normal activities could be carried out in both the complete health and partial health phases of the health continuum. Consequently, participants viewed themselves as healthy in both of these two health states.

Participant accounts described "normal activity" in four ways: as (1) duties and responsibilities to family, society and occupation; (2) activities which one personally wished to engage in; (3) everyday routines, or activities, usually carried out in the course of day to day life; and (4) activities which do not harm the body, and which a person is accustomed to doing everyday without adverse effect.

These four meanings of normal are very closely related, if

not essentially the same, since participants explained that activities carried out daily were synonymous with personal duties related to life roles. Furthermore, the vast majority of participants described these daily duties as activities they personally wished to engage in. Participants most frequently described normal activities as duties, responsibilities, or "what I usually do".

Although it can be assumed that engaging in daily life roles and tasks is a common, if not universal, outcome of health for all individuals, participants in this study placed particular emphasis on the importance of health for fulfilling personal family duties and responsibilities. The following discussion of duties and responsibilities in Indo-Canadian society is therefore germane to the study results. Most literature in this area is confined to the life context of Indo-Canadian women.

Family, Duties and Responsibilities in Indo-Canadian Society

A survey of the literature shows that the duties and responsibilities which study participants described as "normal activities" are largely associated with Indo-Canadian family structure and traditional cultural values. Social context (most notably socio-economic status and educational level) also appears to have influenced participants' definition of the roles and responsibilities that they considered important to fulfill in their daily lives.

Many of the reports and studies on the Indo-Canadian community have focused primarily on women (Anderson, 1985a, 1987;

Anderson & Lynam, 1987; Khosla, 1981; Majumdar & Carpio, 1988; Naidoo, 1980, 1984) and attitudes of Indo-Canadian parents towards their children (Yoshida & Davies, 1985). Literature on the perspectives of Indo-Canadian men is lacking.

Khosla (1981), in a report of South-Asian women in Canada, describes the importance of family and family duties, or dharma, to the Hindu woman. Describing cultural role expectations, she states:

> Based upon the concept of Dharma, or duty, the Hindu woman is socialized to believe that her main contribution in society is to her family; her primary responsibilities consisting of home-making and child-rearing. For the married woman, appropriate role obligations dictate that her ultimate goal as a wife lies in attaining the status of a good daughter-in-law. (p. 178-179)

Naidoo (1980), in a study of role perceptions, found similarly that Indo-Canadian women place high value on fulfilling traditional family roles and duties, and emphasize the importance of a happy family life and home atmosphere. The Indo-Canadian women in Naidoo's (1980) study, also reported roles and a sense of accomplishment stemming from a balance between roles both inside and outside the home. This view would likely be endorsed by many Anglo-Canadian women as well.

Concurring with the findings of Naidoo (1980) and Khosla (1980), the majority of female participants in this study subscribed to the traditional perspective that life

responsibilities center around the family and home. The word "duty" was employed by many of these women in their accounts of health. The majority of participants in this study perceived normal activities, as well as the actual carrying out of these activities, almost exclusively as family centered activities, or duties. The two male study participants also spoke of the importance of looking after their families, although they did not emphasize this theme in their accounts of health.

Some participants also reported an interaction between contemporary and traditional roles, and explained normal activities as activities carried out outside as well as inside the home. A few female participants described the importance of having a fulfilling career outside of the home.

In a later study, Naidoo (1981) reported that well-educated, professional Hindu men and women who had resided in Canada for approximately 10 years "saw their roles as continuous with similar roles in the home country" (p. 85). Although the participants in this study possessed similar background characteristics to Naidoo's (1981) study sample, they frequently said that life in Canada required them to carry out different roles than they would have engaged in in India.

It is clear from the data that the social circumstances of people's lives influence how they view health. As noted, participants in this study frequently related their views on health to the fact that they live in Canada, rather than in India. Many participants described independence as a very important part

of health, explaining that life in Canada requires them to be independent because they are largely, if not totally, removed from the support of extended family. For example, some female study participants spoke of the fact that they never had a job before coming to Canada; explaining that in India employment outside of the home would be socially inappropriate and/or unnecessary.

Participants sometimes referred to health as a "normal" state of experience. Although participants emphasized "normal activities" in their accounts of health, they also used the concept "normal" to describe the health experience itself. The following discussion of normalcy and normalization in health is significant to the study's findings.

The Socio-Cultural Construction of Normality and Normalization in Health

Participants described themselves as "normal", or in a "normal condition", when they were able to carry out normal activities. In other words, it appears that participants viewed health implicitly as a state of normalcy.

In line with the work of Anderson (1981a), the data from this research reveal "normal" and normality as concepts constructed within an ethnocultural and social context. This perspective differs from the view that notions of normality are "culture-bound" (Ahmed, Kolken & Coelho, 1979; Offer & Sabshin, 1966, 1984).

Offer and Sabshin (1984) advance four perspectives of normality. They propose that normality may be explained as: (1)

health (reasonable health, not optimal health); (2) utopia (optimal functioning or self-actualization - an unattainable ideal); (3) an average (conceiving of the middle range as normal, and both extremes as deviant); and (4) normality a transactional system (or process of change occurring within a complex, changing environment). Two of these perspectives on normality (normality as reasonable health and a transactional system) are of interest to this discussion, as they appear somewhat similar to the views articulated by some participants in this study.

The partial health state described in this study resembles the "reasonable" health state which Offer and Sabshin describe as normal. In partial health, participants were still able to do normal activities although they were not completely healthy. In clear contrast to Offer and Sabshins' (1984) perspectives on normality, however, participants viewed <u>both</u> partial and complete health as normal states of health. They also felt that complete health (the highest state of health) is a state attainable by all people, rather than an unattainable ideal.

The data also contain descriptions of normality which bear some similarity to Offer and Sabshins' perspective of normality as a transactional system. One study participant explained that so-called "abnormal activities" could "become normal" with the passage of time. The data from this study do not support the other two conceptions noted by Offer and Sabshin (1984) that normalcy means unattainable optimal health, or a statistical average.

Every society has "acceptable standards" of what is regarded as "normal" health. Frequently, what a cultural or social group values is considered as "normal" (Miles, 1978). The participants in this study defined health in terms of a valued capacity for "doing normal activities". They viewed complete health and partial health as "normal" states; sickness, in contrast, was described as "abnormal". This view appears quite similar to biomedical perspectives on normalcy and health (Redlick, 1976; Sebag, 1979).

Participants' perspectives on "normal" states of health are similar to Twaddle's (1974) view that a range of less than perfect health exists which may be defined as normal. Although complete health and partial health were recognized as two distinct phases of the health continuum, participants nonetheless perceived them to be the same, or "normal", in the sense that the individual could <u>still</u> engage in normal activities in both states. Furthermore, when a state of complete health was regained after a period of partial health or sickness, participants stated that they were "back to normal". In contrast, sickness was seen as "not normal" because they could not carry out normal activities at that time.

The perspectives of participants in this study are not unlike views presented in the literature that society generally views health as an experience which is not totally "symptom-free". According to Miles (1978) and Zola (1966), each society considers certain ubiquitous conditions as part of normal health. In some

Western cultures, for example, backache, loss of hair and tooth decay may be considered within the parameters of normal health, reflecting a particular socio-cultural norm of health. In other socio-cultural contexts it might be otherwise. Within some contexts, minor aches and pains may not be considered as "deviations from health" or as affecting overall health status. Rather, these common complaints may be seen "as compatible with good health ... (and) part of normally accepted 'health'" (Miles, 1978, p. 10-11).

Participants in this study viewed the minor complaints associated with partial health as "normal", and considered themselves to be healthy in this state. Even when they were suffering from a cold or fever, participants felt that they were "still healthy", and explained that life was still going on normally because they were able to continue with their normal activities. These perspectives appear similar to the views held by much of North American society. Consequently, it seems that Indo-Canadians, with socio-cultural backgrounds similar to the participants in this study, perceive health in much the same way as many other North American groups.

The extent to which symptoms disrupt normal activities is another determinant of their compatibility with conceptions of normal health. Miles (1978) states that people "tend to accept symptoms as part of normal health" as long as they fall within "social definition", and "the more so if the symptoms are minor, do not arise suddenly and do not disrupt everyday activities" (p.

37). This is a significant point. The data indicate that the meaning which participants assigned to symptoms was often related to life context. Some participants in this study explained that the same symptoms have different meaning, depending upon the individual's life responsibilities and the duties associated with his/her age-related life roles and family status. For example, one participant explained that what is called "health" and "sickness" changes according to a person's age and life situation. She explained that breaking a leg was more serious for her now as a wife and mother than when she was a child, because now she "had so many responsibilities"; as a child she had no responsibilities apart from school work. She also stated that a common cold was more serious for her mother-in-law than for herself, because older people are "feeble" and any small sickness makes them "a lot sick" and puts them in bed. According to this study participant, what is viewed as "sickness" at one point in the life cycle, may "not be viewed as sickness" at another point in the life cycle.

Normality cannot be viewed as an absolute. Anderson (1981b) explains that "normal" and "abnormal" are not given facts or given states. She proposes that the two concepts cannot be objectively identified or defined, and cannot be clearly distinguished from one another because any discussion of normality makes implicit reference to concepts of abnormality. According to Anderson (1981b), notions of "normal" and "abnormal" are "interpretive schemes" which allow us to adjudge, evaluate, and give meaning to everyday life events. She further describes this perspective as

follows:

> We know from our everyday experience that although we cannot define what normality is, it is constantly operating as an interpretive schema in our lives. Notions of 'normal' and 'abnormal' are deeply embedded in the natural attitude of daily life, in our ways of seeing the world, and in our ways of managing ourselves so that we can display conduct which can be read as evidence of our cultural competence. (Anderson, 1981b, p. 235)

The data show that participants in this study used the term "normal" in the common sense of "usual" or "everyday". Recent research on perceptions of chronic illness (Anderson, 1981a; Anderson & Chung, 1982) and normal and disturbed family dynamics (Anderson, 1981b) has reported similar usage of the term.

Normalization

Normalization is a concept linked closely to notions of normalcy. A brief discussion of the normalization process is relevant to the study results for three reasons. Firstly, study participants described the activities which they could carry out in health, as "normal activities". Secondly, they defined both complete and partial health as "normal", or healthy, conditions because they were able to carry out their normal activities in these two states. Finally, some participants explained that they never saw themselves as sick even though they experienced physical symptoms.

According to Anderson (1981a), normalization is a process

which emphasizes normality and "deconstructs", or removes, the disease label by making a particular event or condition "normal". In the normalization process, conditions are seen as "normal", or usual, and part of the everyday scenario. Anderson (1981a) described normalization in terms of treating a chronically ill child as a "normal child", and coming to view chronic illness as non-deviant and part of normal daily life.

Wolfensberger (1972), advances a contrasting view on normalization. He discusses normalization primarily with reference to institutional context, and speaks of normalizing (or humanizing) the living conditions in institutions and societal attitudes towards persons considered by society as deviant. Wolfensberger equates the term normative with "typical or conventional" (p. 28), and speaks of sickness as a deviance from normalcy.

The findings of this study suggest that participants normalized their explanations of partial health and sickness. For example, participants described the partial health state as "still normal" and nothing to worry over or be concerned about, even though they experienced some deviation from the complete health state. Although participants described having a small physical complaint (such as a cold, the flu, fever, backache or headache) in the partial health state, they considered themselves as "essentially healthy" or "still healthy" at this time, rather than sick. This view that partial health was <u>still health</u>, and therefore <u>still normal</u>, is explained by the fact that participants

could still carry out normal activities in the partial health state, although not as well or as happily, and with more effort than in complete health.

One participant emphasized that "he never saw himself as ill or sick", but rather "always felt that he was healthy" despite experiencing minor physical symptoms. He informed the researcher that "if you think you are healthy, you <u>are healthy</u>". He always said he was "fine", and felt that he had never really been sick. This account provides one illustration of how study participants constructed the notion of normal.

The following section will address the second major theme of this chapter: conceptualizations of health. The discussion emphasizes literature describing the health-sickness continuum and dimensions of health, since study participants conceptualized health as a two dimensional experience involving (1) a three phase continuum (complete health, partial health and sickness) and (2) the influence of the mind and other factors.

This discussion illustrates how study participants' views on the health-sickness continuum are both similar to and different from the perspectives offered in the literature. The uniqueness of participants' health descriptions lies in the emphasis they placed on "doing" in health, as well as their conceptualizations of health as a multidimensional phenomenon. Participants' descriptions of health include a unique arrangement of many of the health dimensions described in the literature.

Conceptualizations of Health

The Health-Sickness Continuum

A review of literature examining conceptualizations of health as a continuum is pertinent to this discussion, as it provides further insight into the unique manner in which study participants viewed health. The health-illness continuum has been conceptualized variously in the literature (Antonovsky, 1987; Fisk Matsal, 1980; Lerner, 1973; Rogers, 1970; Roy, 1976; Seedhouse, 1986; Smith, 1981; Tripp-Reimer, 1984c; Winstead-fry, 1980). The work of some of these authors is discussed here. (The literature generally refers to illness, rather than sickness, as the polar opposite of health - the two terms are used interchangeably in this discussion).

Conceptions of the continuum differ in terms of whether health and illness are viewed as dichotomous variables, or interfacing, continuous concepts linked together by a range of various combinations of health/illness along the continuum. Smith (1981) describes the characteristics of the health-illness continuum as follows:

> A continuum is an unbroken sequence of things arranged so that between any two points there is always an intermediate point. The variations between health and illness are smooth. There are no discrete points. Health then becomes a comparative term, rather than a classificatory (either/or) term. (p. 44)

Roy (1976) offers a different view. Explaining the health-illness

continuum in terms of adaptation and holism, she conceptualizes a continuum made up of seven distinct stages: (1) peak wellness, (2) high level wellness, (3) good health, (4) normal health, (5) poor health, (6) extreme poor health, and (7) death. Roy holds that an individual may be located anywhere along the continuum at any given time, and that adaptation occurs as the individual moves in either direction along this continuum. In line with this perspective, participants in this study explained that they could move in both directions along the continuum. However, they conceptualized three phases, or stages, within the continuum rather then the seven outlined by Roy.

Participants described health as a state regainable from sickness. They described two possible outcomes of sickness: (1) return to health and (2) chronic illness and death. As participants' accounts contained only implicit reference to chronic illness, it is unclear whether they perceived the possibility of a return to health after chronic illness (see figure 3). Tripp-Reimer's (1984c) description of health as a continuum variable mentions death as one consequence of illness, and reflects other aspects of the views held by study participants. She states:

> Although the continuum may consist of a sequence of states ranging from health to illness (or sometimes death) it is essentially a bipolar construction. Absence of pathological symptoms constitute one pole and abnormality (variously termed disease, sickness, illness or non-health) constitutes

the other. (p. 102)

Participants did not see health as an isolated entity. They rather defined the total health experience in terms of a three phased continuum. Within this continuum, participants described varying degrees of health (complete health and partial health) in relation to sickness. Health and sickness were conceptualized as continuous, polar concepts on the health-illness continuum, and participants generally described health in terms of its opposite, sickness. These views are similar to current perspectives found in the literature describing health in terms of a range of health/illness states along the continuum (Kass, 1981; Roy, 1976; Seedhouse, 1986; Smith, 1981; Tripp-Reimer, 1984c; Twaddle, 1974). Participants' views are consistent with Tripp-Reimer's (1984c) position that the individual "may range along this continuum in various combinations of health/illness" (p. 102).

By envisioning health as a comparative concept, it becomes possible to "speak of more or less health, of an individual being healthier at one time than at another, or of one individual being healthier than another" (Smith, 1981, p. 44). The gradations of health located along the continuum are structured by the particular human conditions or traits under evaluation at a given time. These various ways of conceiving the health-illness continua, or gradations, are models of health (Smith, 1981). The particular gradations on the continuum described in participants' accounts of health are in terms of capacity for doing normal activities, and the underlying health characteristics

(energy, resistance, independence and control). These gradations constitute, or form, the three phases of the health experience: complete health, partial health and sickness.

Lerner's (1973) description of health sheds additional light on the findings of this study. Lerner proposes that individuals place different values, or weights, on various points within the continuum. This point is significant in view of the fact that concepts of normality are constructed in terms of socio-cultural values. Lerner describes the subjective valuing of the health experience as follows:

> ... human beings subjectively attribute different weights to various points along that continuum; that is, life at different ages or at its various stages appears to have different 'meanings' to people, and therefore different values or weights. Further, that meaning, value, or weight varies according to cultural factors and value systems and is therefore socially defined. (Lerner, 1973, p. 9)

The work of Majumdar and Carpio (1988) was discussed earlier in chapter two. Aspects of their quantitative study are presented here to provide additional insight into how the health accounts of participants in this study resemble those described by other Indo-Canadians.

Indo-Canadian and Other Ethnic Canadian Perspectives

Majumdar and Carpio (1988) found that Indo-Canadian women's perspectives on health were both similar to and different from the health perspectives of (Euro-)Canadian, and Philipino and Latin

women living in Canada. A brief account of the health images provided by the Indo-Canadian women in Majumdar and Carpios' study is of interest, since the participants in this study expressed similar, although much broader, views on the health experience.

Majumdar and Carpio found that Indo-Canadian women defined health primarily in terms of mental health (55%). Physical health (27.8%) and social health (16.7%) were viewed as less important dimensions of health. Lifestyle was not included as a dimension of these women's perceptions of health. Lifestyle, however, was given the most importance (61.9%) in descriptions of health maintenance. Social health (14.3%) and physical health (23.8%) were emphasized less in this area, and mental health not at all. Conceptualizations of disease causation included all the four categories of health definition (lifestyle, social, mental and physical), with lifestyle (50%) and physical aspects (33.3%) being emphasized the most in these women's descriptions (Majumdar & Carpio, 1988).

In support of Majumdar and Carpios' (1988) research, the findings of this study reveal physical health, mental health, and social factors as components of the Indo-Canadian health experience. In contrast to Majumdar and Carpios' (1988) findings, however, participants in this study included lifestyle factors in their perceptions of health, and also emphasized the important role which the mind plays in both the maintenance and regaining of health, as well as causation of sickness.

The results of this study concur with Majumdar and Carpios'

(1988) finding that social health is a component (described as family orientation) of Indo-Canadian conceptualizations of health maintenance and explanations of disease causation. Participants in this study described the importance of a happy, harmonious family life and home atmosphere for maintenance of health. On the other hand, they considered an unhappy, stressful family life and home environment detrimental to health, as well as something which contributes to partial health and sickness.

Yoshida and Davies (1985), in their investigation of childbearing and childrearing among immigrant Canadian families, found that Indo-Canadian parents described healthy children as energetic, happy and well nourished. In contrast, these Indo-Canadian parents described a sick child as unhappy and irritable, with loss of appetite. The data from this study concur with perceptions of health as a state where the individual is energetic and happy (Yoshida & Davies, 1985). Participants in this study, however, described four characteristics of the health experience: energy, resistance, independence and control.

The following section examines four conceptions, or models, of health. Presentation of these four models illustrates aspects of the health experience described by the participants in this study, and assists the reader in appreciating the uniqueness of the participants' health images.

Four Conceptions of Health

Smith (1981), Laffrey (1986) and Woods and coworkers (1988) provide conceptualizations of health based upon four fundamental

models of health: (1) Eudaimonistic, (2) Adaptive, (3) Role-performance and (4) Clinical. Each of these four models represents one way of conceptualizing the health-illness continuum, and has a distinct "health extreme" and "illness extreme".

According to Smith (1981), these various dimensions of health are conceived to overlay the basic health-illness continuum. Arranged hierarchically, they encompass all the various ideas and conceptions of the health phenomenon. An overview of the basic characteristics of each model is warranted.

The eudaimonistic model, derived from the work of Maslow (1968, 1970), is associated with notions of general well-being, and self-realization, and presents a holistic view of the human being. Health is conceptualized as a person's realizing his/her fullest inner potential. The health extreme of the health-illness continuum is "exuberant well-being", and the illness extreme is "enervation and languishing debility" (Smith, 1981, p.45).

The adaptive model is based on the work of Dubos (1959). The health extreme of the continuum is seen as ability to function using adaptive mechanisms, and effective physical and social functioning. Conversely, the illness extreme of the continuum is inability to cope with the changing environment, and subsequent failure in adaptation. Drawn primarily from the work of Parsons (1979), the role-performance model emphasizes performance of social roles. The health extreme of the continuum is "performance of expected roles with maximum expected output", and nothing

impeding effective performance of individual roles. At the other end of the health-illness continuum, the illness extreme is conceptualized as "failure in performance of one's role" (Smith, 1981, p. 46).

Criticized as being the most narrow in its perspective, the clinical model focuses on familiar biomedical views of physical and mental normality or abnormality. The health extreme of the continuum is "absence of signs or symptoms of disease or disability as identified by medical science". The illness extreme is "conspicuous presence of these signs or symptoms" (Smith, 1981, p. 46). Smith (1981) proposes that these four models provide alternate, although not mutually exclusive, health images that view the individual "within broader and broader contexts". The eudaimonistic model is holistic and most inclusive, embracing the concepts found in the other three models (Smith, 1981, p. 47).

In terms of Smith's (1981) hierarchy of health models, participants in this study presented explanations of health focusing primarily on the role-performance model. Normal activities approximate concepts of health as role-performance. Participants' rich descriptions of health, however, also embraced ideas of health advanced by the clinical, adaptive and eudaimonistic models. Building on the work of Smith (1981), Laffrey (1986) provides descriptions of health which more closely approximate the findings of the current study.

Laffrey (1986) reported descriptions of health incorporating health dimensions from each of the four health models, or

conceptions. Utilizing the four models of health (Smith, 1981), Laffrey (1986) developed four conceptions of health: (1) clinical health conception, (2) functional/role performance conception, (3) adaptive health conception, and (4) eudaimonistic health conception. She found that one dimension of health can "stand out" in peoples' descriptions of health. This was the case in the health descriptions of participants in this study. They focused on health as functional capacity, although their accounts also included description of other health dimensions.

Many of Laffrey's (1986) structural items (associated with these four conceptions of health) are supported by the data in this study. For example, participants in this study described "not having to take medicines" and "not being sick" as aspects of health. These descriptions are consistent with some of the structural items noted in Laffrey's research (for example, "do not require pills for illness" and "not sick" associated with the clinical health conception) (p. 111). Some of the functional role performance health conceptions cited in Laffrey's research were also supported by the findings of this study: (for example, "fulfill daily responsibilities", "able to do what I have to do", "able to carry out daily responsibilities", and "fulfill role responsibilities") (p. 35).

Participants in this study described health in terms of what Laffrey calls the clinical health perception when explaining that health means "nothing is wrong", and sickness means "something is wrong" in the body or mind. Study participants also explained

health in terms similar to Laffrey's (1986) function/role performance conception when emphasizing health as ability to do normal activities. A consideration of Laffrey's (1986) descriptions of control, or coping, as a further characteristic of the health experience, suggests that participants' views on health to some extent reflect adaptive health conception. Participants' descriptions of health in terms of feelings of happiness, contentment, harmony and enthusiasm for life, resemble the eudaimonistic view of health described by both Laffrey (1986) and Smith (1981).

Woods and coworkers (1988) combined the four models of health proposed by Smith (1981) with the conceptions of health offered by Laffrey (1986), to describe the meaning of health to Asian, white, Black, North American Indian and Hispanic women in the Pacific North West. Many of the health images discussed in the research of Woods and coworkers appear quite similar to the descriptions of health presented by participants in this study (see Appendix F for a list of the health images described by Woods and coworkers which participants in this study included in their accounts of the health experience).

When speaking of the absence of disease, the doing of normal activities, and being happy, participants in this study incorporated the "negating", "doing" and "being" dimensions described in Woods and coworkers' (1988) study. These terms ("negating", "doing" and "being") represent the dominant dimensions of the clinical, role performance and eudiamonistic

health images respectively. The similarity between the health images described by the participants in this study and those presented in the research of Woods and coworkers (1988), suggests that some dimensions of health may transcend both cultural and social differences. This finding was also an outcome of Woods and coworkers' (1988) research.

As participants narrated their perceptions of health, it became increasingly clear that this group of Indo-Canadians view health as an integrated experience involving both the body and mind. This is an important finding of the study. Participants described the fundamental, unitary relationship between the body and mind, and also described the body and mind in relation to external factors (such as diet, exercise and sleep) which influence health. The ensuing section briefly discusses the holistic view of health offered by the study participants.

Holism: Body and Mind Together

Participants' perceptions of health, as a unity of body and mind, reflect traditional Indian views that health is an experience where the different aspects of the human being are in a state of harmony and balance (Obeyeskere, 1977, 1978; Vora, 1986). Current holistic health literature expresses similar views of the nature of the individual, and the experiences of health and sickness (Flynn, 1980; Kreiger, 1981; Sarkis & Skoner, 1987).

Study participants clearly identified the inseparability of mind and body, and described the meaning of this total (body-mind) unit in health and sickness. Harmony and balance of the whole

person, within him/herself and with the environment, was a major theme arising from participants' accounts of health. Participants emphasized health as a positive quality, or state, structured in two dimensions and framed by the overall context of doing normal activities. Health as the absence of disease was only one minor facet of participants' descriptions of health. Study participants presented a holistic vision of health, with multifaceted description of the environmental, social and personal factors which influence the total health experience.

In the next section, some of the factors which participants viewed as influencing the health experience are presented in light of relevant literature. These factors constitute the second dimension of health described in participant accounts (see figures 2 & 3). This discussion focuses on the role of the mind in health, and further reveals the holistic nature of the study participants' views on health.

Factors Influencing Health

Some study participants explained that factors such as diet, exercise and mental attitude were under their personal control to some degree. These influencing factors were seen as things they could "do something about", or things "they could control". In contrast, disease and sickness were sometimes described as being under Divine control.

Although limited data were gathered on participants' views of control in health, the results of this study are similar to

Majumdar and Carpio's (1988) findings that Indo-Canadian women expressed greatest feelings of control over their health in the area of health maintenance, mental and social health. Physical health deficits were viewed as something the individual had little control over (Majumdar & Carpio, 1988).

Participants in this study described the mind as the most important factor influencing health. As discussed in chapter four, the mind was viewed as having both a positive and negative effect on health.

The Mind and Health

The vast majority of participants described a positive mental attitude, (characterized by absence of worry and stress, calmness and control over the emotions, and actually "thinking one is healthy"), as beneficial to the maintenance and improvement of health, as well as recovery from illness. On the other hand, they viewed a mental attitude characterized by worry, stress and "thinking one was sick", as exerting a detrimental effect on health and actually leading to sickness.

The following section discusses various aspects of the interaction between the body and mind. Literature on the relationship between the mind, stress and immune response is relevant to the study findings since this theme was given importance in some participants' accounts of health.

Mind, the Immune System and Resistance

The mind is seen as both a "healer" and a "slayer", creating either health or sickness (Wolf, 1986). As discussed above, study

participants described this twofold capacity of the mind in their accounts of health.

Many participants described their perception that the mind influences the body's resistance to sickness. They specifically related stress to increased susceptibility to sickness. Participants explained that stress, or worry, has a damaging effect on immune function and resistance to disease. Their descriptions of the effect which mental state exerts on the body and immune function, appear similar to current views on health and sickness (Ornstein & Sobel, 1987; Selye, 1979a,b; Shaver, 1985).

The role of the mind in resistance and susceptibility to illness has been well documented in recent health literature focusing on the field of psychoneuroimmunology (a synthesis of psychiatry and immunology) (Najman, 1980; Risenberg, 1986; Rogers, Dubey, & Reich, 1979; Selye, 1979a,b; Shaver, 1985). Some researchers propose that stress exerts an immunosuppressive effect and thus increases vulnerability to disease (Rogers, Dubey & Reich, 1979; Selye, 1979a,b), and that the individual is able to influence the immune system to some degree (Risenberg, 1986). Mood states and psychological experience (especially stress), as well as such variables as age, sex, prolonged sleeplessness, race, pregnancy, and circadian rhythms, have been linked to alterations in immune function. Depression and bereavement, for example, have been associated with decreased immune competence. Conversely, feelings of control over one's life, and happy affect, are

perceived to positively influence immune function. The importance of the individual's sense of control over stressful situations has been emphasized in the literature (Rogers et al., 1979).

A number of study participants linked mental attitude with resistance to disease and promotion of health, describing the effects of psychological stress rather than physical stress. It is of interest that their perspectives are similar to those advanced in the writings of Selye (1979a,b) and other authors (Risenburg, 1986; Shaver,1985).

Positive Mental Attitude

Selye (1979b) contends that the stress associated with any particular situation is largely determined by the way stressor agents are "perceived, interpreted, or appraised" by the individual (p. 60). According to Shaver (1985) and Risenburg (1986), cognitive response to the external environment is an important modulator of stress and immune function. The way that the individual responds, or reacts, to external situations influences his/her experience of stress.

A number of participants in this study described the importance of cultivating a non-reacting mental attitude to combat or remove stress, and thus promote and maintain health and assist in recovery from illness. They referred to this process variously as "training the brain", "not worrying" about life situations and small health concerns, "thinking positively" and "not letting feelings control you". Their perceptions are in line with Selye's (1979b) comments on "a mind-over-body approach" to dealing with

stress. He states :

> Stress is a matter of perception and, that being the case, that the body can be instructed to react at a proper level by educating the mind. It is becoming increasingly evident that the human body is pliable, changeable, and capable of being altered through mental conditioning. (1979b, p. 76)

In this study, participants related family support with development of a positive mental attitude. A brief discussion of the importance of family support in prevention of stress (or worry) and promotion of health is presented next.

Family: a moderator of life stress. Social support has been described as a moderator, or buffer, which protects the individual from the effects of stress (Cobb, 1976; Hammer, 1983). In this study, participants emphasized the importance of a happy family atmosphere and the support of extended family in the health experience.

The views expressed by the participants in this study are supported by literature describing the importance of social support networks in promoting the health of immigrant groups in Canadian society (Lynam, 1985). As noted earlier, family network has been emphasized as an important support system in Hindu Indo-Canadian culture (Ahmad, 1981; Khosla, 1981; Naidoo, 1980, 1981). In their previously noted study, Yoshida and Davies (1985) found that Indo-Canadian and other ethnic Canadian families valued family support highly and described the loss of traditional family support systems (associated with immigration) as a source of

stress. Imbalances in personal, family and social life, and spiritual life have been described as contributing to mental disorders in Hindu culture in both India and Canada (Ananth, 1984; Singh, 1985).

The accounts provided by many study participants described relationships with extended family, and the importance of these relationships in the health experience. Participants explained that the loss of support from extended family often leads to worry, or stress, because (1) the individual is unable to express his/her concerns and feelings to family members, and (2) lacks help with the carrying out of daily tasks if he/she were to become sick. Participants described these situations as negatively affecting their health, and making "being sick" more of a problem. These situations contributed to their view that sickness means dependency, and health means independent activity.

A few participants in this study felt that Indo-Canadians growing up in Canadian society might be socialized differently (than those growing up in India), and therefore might not find such a need for confiding their concerns exclusively to close family members. Hence, the importance of family support in health described by study participants (who were first generation Indo-Canadians), might not prove so important to second generation Indo-Canadians if traditional family structures are not maintained.

Other Factors Affecting Health

As noted, one of the main findings of this study is that the

way the participants explain health is similar in many ways to how other people speak about health - including health professionals. The following discussion relates to this finding.

It has been mentioned that socio-economic and educational context play a significant role in the construction of health. The participants in this study were generally well educated, and the vast majority were living according to Western upper-middle class standards. Indo-Canadians who do not speak English, who are uneducated and working in menial jobs, may very likely hold views on health which are different from those described by the participants in this study. In light of this, the current discussion of factors influencing the health of study participants becomes more meaningful.

Participants in this study described several factors, in addition to the mind, which they perceived to influence the health experience. This section briefly examines literature discussing a few of these influencing factors.

Nutrition, stress management and exercise have been described as the most common themes in Indo-Canadian descriptions of lifestyle factors (Majumdar & Carpio, 1988). The results of this study concur with these findings and also expand on this description of "lifestyle factors", or factors which influence health. In addition to diet and exercise, participants in this study described mental attitude, cleanliness, sleep, use of medicines and maintenance of routine, as well as work outside of the home and home atmosphere as additional factors influencing

health. As discussed in chapter four, some health accounts described mental attitude as it relates to control of stress, or worry; hence, the participants' views on mental attitude in health may be somewhat similar to what Majumdar and Carpio (1988) call "stress management".

A discussion of all the factors which study participants described as influencing health is beyond the scope of this discussion. In the concluding sections of this chapter maintenance of routine, diet and exercise, and the use of medicines in the health experience of Indo-Canadians and other cultural groups will be briefly examined.

Maintenance of Routine

Shaver (1985) described the fact that disruption of usual body rhythms by environmental or mental factors, is linked to changes in behaviour, affect and cognition. Participants in this study expressed the rather similar perspective that it is important for a person to keep a suitable, fixed daily schedule of activities. They described this practice as "maintenance of daily routine(s)". This was one factor they described as influencing the health experience (see figures 2 & 3).

Participants explained that a person should stick to established daily schedules to keep healthy and avoid illness. One participant explained that he caught a cold because he had run outside without a jacket and omitted his usual practice of taking a short rest after work - these were things he "didn't usually do".

Diet and Exercise

Food and proper nutrition were other aspects of the participants' health accounts which, to a large extent, bear striking similarity to the views of Western health care professionals described within Kleinman's framework (see figure 1). It should not be concluded, however, that all of the study participants' descriptions of diet mirrored established Western perspectives - they did not.

As illustrated in the accounts presented in chapter four, study participants sometimes expressed views on diet which more closely approximate the traditional Ayurvedic and naturopathic perspectives of India, and classical Chinese perspectives. Some study participants saw diet very much as a way of treating disease and illness and promoting health, rather than just a source of nutrition.

The use of food to treat and prevent disease has been described within traditional Chinese culture (Anderson & Anderson, 1978; Koo, 1984), Indian culture (Obeyesekere, 1977), Vietnamese and Cambodian culture (Fishman, Evans & Jenks, 1988) and Malaysian cultures (Dunn, 1978). Transcultural nursing literature has also focused on the relationship between diet and health (Leininger, 1970b; 1988). Diet and exercise have been described as lifestyle factors influencing the health/wellness status of individuals (Shaver, 1985).

Leininger (1988) explains the close relationship between food and culture. She proposes that promotion of healing, treatment of

disease, maintenance of health and prevention of illness through culturally determined food practices and dietary regimens, is a universal practice across cultures (Leininger, 1970b). Special foods are used during illness to assist in faster recovery to health (Koo, 1984). In Chinese culture, ill health is related to energy imbalance and concomitant lowered resistance, leading to greater susceptibility to disease. Convalescing Chinese patients are given certain foods to promote recovery; certain foods are seen as beneficial and others as detrimental to health (Koo, 1984).

The data from this study illustrate that participants regarded food as very important in health maintenance and disease prevention and treatment. Participants explained the need for dietary modifications during times of sickness to provide increased energy and "faster energy" for promotion of healing and recovery. "Faster energy" was explained as the energy resulting when foods are easily digested and rapidly absorbed into the circulatory system. Consumption of a nutritious diet and avoidance of overeating were themes emphasized in participants' explanations of diet as a factor influencing health. Fasting, and dietary supplementation were also described as behaviours which exert a positive influence on health, prevent sickness and aid in recovery from sickness. A number of study participants also mentioned the importance of avoiding excess quantities of sugar, fat and salt to keep healthy.

Although beliefs in the intrinsic hot and cold properties of

foods, treatments and health conditions are common in India (Parker et al., 1978), and have been documented in previous descriptions of health elicited from the Indo-Canadian community (Yoshida & Davies, 1985), participants in this study did not support this perspective in their accounts of the health experience. Study participants referred only to the actual physical temperature of foods, rather than "hot" and "cold" as intrinsic qualities in the sense traditionally described in Ayurvedic medicine (Obeyesekere, 1977) or Indo-Chinese and Vietnamese culture (Ahern, 1974; Fishman, Evans & Jenks, 1988; Koo, 1984).

Participants' descriptions of exercise also resemble Western views to a considerable extent. Although a few participants described engaging in hatha yoga (physical exercises and breathing techniques), the majority of study participants mentioned walking, jogging and other recreational activities typical of Western middle class society.

Use of Medicines

The views presented by study participants on the use of medicines in health and sickness also reflect socio-cultural context. Their health accounts illustrate traditional Indian perspectives as well as perspectives endorsed by Western health care professionals.

One participant emphasized the necessity of a regular yearly check-up with her family physician, and placed considerable importance on the results of the medical tests conducted at that

time. The majority of study participants stated that they would "go to the doctor" for treatment, or if they suspected that they were getting sick. Participants did not feel that they needed to go to a doctor if they were just suffering from a cold or other minor health complaints (such as described in the partial health state). It is of interest that participants never described seeking the services of nursing professionals.

Other study participants presented a different view on the use of medicines and the health care system, supporting self care practices rather than the use of Western medical treatment. The two male participants strongly advocated use of traditional Indian remedies for the prevention and treatment of sickness and promotion of health. Some of the literature discussing self care practices in Indian culture is mentioned here in conclusion.

Nichter (1978) in his study of self care practices in rural India, noted the frequent use of special diets and home and ready-made medicines (laxatives, vitamins and tonics) for treatment of common ailments such as colds and upset stomach. Parker, Shah, Alexander and Neumann (1979), in other studies of self care practices in India, also found that special diets, fasting and dietary supplements were used by rural populations in India. Yoshida and Davies (1985) reported the use of herb and folk remedies by Indo-Canadian families to relieve common discomforts during pregnancy and the post partum period, as well as for treating their children. Participants in this study similarly described a number of these self care practices in their

accounts of the health experience.

Summary

In this chapter the study's findings have been discussed in relation to relevant literature. The discussion centered on three main themes: normalcy and health, conceptualization of health and factors influencing health. These three themes of discussion are derived from the three main components of the organizing framework presented in the preceding chapter (see figures 2 & 3).

As detailed in chapter four, participants explained health as a two dimensional phenomenon framed by the overall concept of doing normal activities. Health was described as a means to doing normal activities. Being able to do normal activities was viewed as the goal, or outcome, of being healthy. Participants described normal activities as everyday duties, responsibilities or routines.

The uniqueness of the participants' health descriptions rested in their emphasis on "doing normal activities" as the hallmark of health, and their descriptions of the four characteristics of the health experience (energy, resistance, independence and control). Previous studies have not reported similar description of these four characteristics underlying activity in health.

The findings of this study illustrate that health is constructed in both ethnocultural and social contexts. A major finding of the study is the fact that the health perspectives

participants are similar in many respects to the views held by Western middle class society. This similarity is particularly evident in participants' descriptions of diet and exercise, and their perspective that health is not totally "symptom free". The participants' clear descriptions of health as a holistic experience involving a unity of body and mind is another important finding of this research.

Participants in this study used the term normal in the sense of "usual", "common", or "everyday". Being healthy was regarded as "being the way one usually is", and doing normal activities was explained "as doing what one usually does". Previous research has described similar use of the term "normal" in situations involving chronic illness and family interaction (Anderson, 1981a; Anderson & Chung, 1982).

In support of previous research on health conceptualization, participants described health in terms of various health dimensions overlaying the health-sickness continuum. Participants viewed health as a continuum comprised of three distinct, yet continuous phases. Within this continuum, complete health and sickness were seen as polar concepts, (the health and illness extremes), with opposing characteristics.

Health was equated primarily with social health and functional role capacity, although participants' accounts included aspects of all four health conceptions described previously by Smith (1981), Laffrey (1986) and Woods and coworkers (1988). Complete health was described as the acme of health, and unlike

previous conceptions of optimal health as an unattainable utopia, complete health was seen as a fully realizable state. Participants described partial health as a distinct health phase located between the two continuum extremes. These views support earlier research findings describing a range of health/illness phases along the continuum (Roy, 1976; Tripp-Reimer, 1984c; Twaddle, 1974). Partial health was considered as part of health, rather than as part of sickness.

The health images elicited from participants in this study reflect the values of Indo-Canadian society in general, as well as some aspects of traditional Indian health perspectives. Participants emphasized the importance of personal duties and responsibilities to family and society, viewing these activities as the essence of normal activities.

The closing chapter of the thesis will provide a summary of the study, and state conclusions to be drawn from the data. Implications for nursing practice, education and research will also be presented.

CHAPTER 6: SUMMARY, CONCLUSIONS AND IMPLICATIONS OF THE STUDY

Summary and Conclusions of the Study

Summary

This study has investigated the meaning of health to Indo-Canadians. Although cross-cultural literature and research are focusing increasingly on the health perspectives held by various cultural groups, very little information is available on Indo-Canadian perceptions of health. Qualitative research in this area is particularly lacking.

The Indo-Canadian perception of health was chosen as the focus for this research because it is important that health care professionals better understand the unique perspectives on health held by this cultural group. For federal government policies advocating health for all Canadians to be successful and true to formal policies of multiculturalism, continued investigation of the distinct perceptions on health held by Canada's various cultural populations is imperative.

As Canadian society becomes increasingly multicultural in nature, research on the meaning of health is critical if Canadian health care is to be effective and culturally relevant. Health promotion programs are realizable for all segments of Canadian society only when health is appreciated as a concept inextricably linked to the historical, social and cultural factors in the individual life context.

The background to the problem presented in chapter one

emphasized the reality of continued immigration into Canada in the future, and focused on Indo-Canadians as a significant cultural group within the Canadian mosaic. The research problem addressed in this study arose from consideration of health as a multidimensional, culturally grounded phenomenon, and recognition that health care professionals need to become aware of the validity and uniqueness of the Indo-Canadian health experience.

Literature was reviewed in chapter two to provide the background for viewing the current research. Three major areas were examined in the literature review: theoretical perspectives on health and illness offered by authorities within the different branches of learning, India's traditional beliefs on health and illness, and literature on Indo-Canadians. The review illustrated the lack of information available on Indo-Canadian health concerns and perceptions on health. The socio-cultural literature and research reviewed constituted particularly significant background information for the study, illustrating health as a construct defined and described variously within different social and cultural contexts. These studies indicate the current discrepancy between the perspective on health held by most health care professionals, and that held by clients from various socio-cultural backgrounds. As literature on the Indo-Canadian perspective on health was essentially unavailable, a number of research studies investigating how other cultural groups view health and illness were discussed.

Chapter three presented the methodology of the study.

Kleinman's explanatory model (1978a,b, 1980, 1984) was the basic framework supporting this research. Kleinman's explanatory model proposes that the professional, folk and popular domains explain phenomena differently, and that problems can arise in clinical communication when there is conflict between the perspectives of these three domains. Kleinman's framework directed the researcher to utilize the phenomenological research approach to investigate the meaning of health to Indo-Canadians. Phenomenology was an effective and appropriate research methodology for this study, where the aim was to describe and explain the individual experience of health.

Participants were recruited through an informal network of colleagues and acquaintances. Prior to the formal research, a pilot study was conducted with two informants to determine the suitability of trigger questions to be used in the interviews to elicit in-depth description of health. Theoretical sampling methods resulted in a final study sample comprised of eight informants (6 women and 2 men). Data were collected through 15 open-ended, semi-structured interviews conducted in the participants' homes.

Participants were Indo-Canadian adults between the ages of 28 and 56, who had resided in Canada for 6 1/2 to 21 years. Most participants were in their mid-40's, and had resided in Canada for approximately 12 years at the time of the study. Participants were of a similar socio-economic status, and the majority possessed professional levels of education. Participants were all

of comfortable means, and for the most part their living environment approximated that of middle-class Canadians. The vast majority of participants had come to Canada directly from India. Interviews were conducted by the researcher in English. All interviews were tape-recorded on an audio-recorder, and transcribed verbatim.

The phenomenological method of Giorgi (1975) and Colaizzi (1978), as described by Knaack (1984), guided the analysis of research data. Data collection and analysis were simultaneous and overlapping (Lofland, 1971). Data analysis began as soon as data were collected, in accordance with the process of constant comparative analysis inherent to the phenomenological method.

Transcripts were read and re-read during the initial steps of analysis to provide the researcher with a general vision of the participants' explanations of health. During data analysis, natural meaning units formed clusters of data themes and categories. As these categories and themes were refined, a definitive analytic framework evolved from the data. This analytic framework organized the presentation of the results of the study, and represented the essential meaning of health to Indo-Canadians. This description of health constituted the popular domain of Kleinman's explanatory model.

In chapter four, the essential structure of health for Indo-Canadians was described within the overall context of doing normal activities. No differences were evident in men and womens' descriptions of health. Male and female participants provided

similar accounts of the phenomenon, although specific details varied according to individual life contexts.

Participants viewed health as a holistic phenomenon, with body and mind inseparably linked together. Health was described in two dimensions. Firstly, health was seen in terms of a three phase continuum comprised of complete health, partial health and sickness, representing the total health experience. Energy, resistance (to disease and environmental change), independence and control (over one's life and physical condition) were described as four characteristics of the health experience underlying action in each phase of the continuum. Secondly, health was perceived in terms of factors influencing health.

In complete health, participants described being able to carry out normal activities well and happily, and therefore being able to fulfill the responsibilities and duties associated with personal life roles. Health in this phase was characterized by abundant energy, resistance, independence and control. In complete health, participants described feeling happy, full of energy, optimistic about life, cheerful, not worried about anything, and feeling like they could do anything they wanted to do.

In partial health, participants explained that they could still carry out normal activities, but less well (at a lower level of efficiency) and with more effort than in complete health. The partial health experience covered minor complaints such as colds and the flu, and was described as temporary and bothersome.

Partial health was viewed as temporary because the minor health problem lasts for only a few days, going away by itself, or with minimal intervention. Partial health was described as bothersome because participants found it annoying that their ability to do normal activities was interrupted, or hindered temporarily. In this phase, decreased capacity for doing normal action was associated with decreased energy and resistance, and decreased independence and control. Participants described lack of enthusiasm and lack of motivation for doing action; basically not feeling like doing anything, and having to drag themselves through daily activities.

Participants viewed sickness as a state in which one would be totally unable to carry out normal activities, and could not fulfill ones responsibilities independently. Sickness was viewed as serious, worrisome and permanent (or long term). Participants frequently associated sickness with "something wrong" in the body. The very limited action in sickness was associated with low levels of energy and resistance, dependency and lack of control. Participants described feeling that they did not want to do anything, and also could not do anything. They felt that the sick body needed to lie down, to rest and heal.

On the second dimension of health description, the mind was explained as the most significant factor influencing health. Worry was perceived as detrimental to health, while a positive mental attitude was perceived as beneficial to health. Diet, exercise, sleep and cleanliness, use of medicines, maintaining

regular routines, working outside of the home, and home atmosphere, were also described by participants as factors influencing health.

Research findings were discussed in light of relevant literature in chapter five. This discussion highlighted the fact that health and sickness are constructed in both ethnocultural and social contexts. The health perspectives of the Indo-Canadians in this study were found to be quite similar to those held by Western middle class society. The literature reviewed supported this finding.

For the participants, normal activities meant the "usual" or "everyday" routines and work associated with culturally defined life roles and responsibilities. Participants' views of health emphasized "doing normal activities". Their health descriptions included images of the health-sickness continuum and health dimensions discussed in recent literature (Laffrey, 1986; Smith, 1981; Woods et al., 1988).

Conclusions

Three main conclusions can be drawn from this study. Firstly, the participants emphasized "doing normal activities" as the primary feature of health. Secondly, they viewed health as a holistic experience where body and mind are inseparably linked together, and influenced by personal and environmental factors. Thirdly, their conceptualizations of health were constructed within social and cultural contexts.

Implications of the Study

This study investigated the unique perspectives on health held by Indo-Canadians of the Hindu faith, with the purpose of contributing to health care professionals' understanding of this view on health. The findings of this study have important implications for nursing practice, education and research. These areas are described below.

Implications for Nursing Practice

The findings of this study have specific implications for nursing practice. In accordance with the principles of cross-cultural theory, this study supports cross-cultural knowledge of health and illness as essential to provision of therapeutic, culturally relevant nursing care. The study findings also indicate that the influence which the client's social circumstances exerts on health perception need to be given equal recognition. In terms of specific skills, nurses need to understand clients' unique, socio-culturally determined explanatory models of health and sickness, and structure nursing care and health promotion programs in accordance with these perspectives.

The nurse requires knowledge of Indo-Canadian perspectives on health, as well as the skills to effectively incorporate this knowledge into everyday practice. According to the participants of this study, health means being able to do daily activities and fulfill the responsibilities associated with life roles. The study findings direct the nurse to be sensitive to the distinct

Indo-Canadian views on health when assessing, planning and implementing nursing care with Indo-Canadian clients. The nurse cannot assume that all Indo-Canadian clients hold that same views on health and illness. The results of this study show that Indo-Canadians of comfortable social circumstances, and possessing higher levels of education, may hold views on health which are similar to Western middle class society in general. Indo-Canadians from different social environments, however, may hold dissimilar health images although they share a common cultural background with other Indo-Canadians.

Health promotion and prevention programs for the Indo-Canadian community may be more effective and relevant if socio-cultural perspectives on health are incorporated into all aspects of program planning. The study participants' descriptions of health imply that the success of health promotion programs for the Indo-Canadian community may be enhanced if health is recognized as an important resource for doing daily activities, fulfilling responsibilities, and being happy.

Health was conceptualized in the study as a two dimensional phenomenon embracing both the three phases of the health experience and factors influencing health. The importance participants placed on diet, exercise, cleanliness and sleep, medicines and maintaining daily routines, suggests that nurses might effectively incorporate these factors into the content of program plans for promoting health in the Indo-Canadian community. According to Tripp-Reimer (1984b) "it is no longer sufficient for

investigators to state that the nurse should be sensitive to the culture of the client", rather "it must be made clear how cross-cultural nursing research findings (can) be articulated with the functions of assessment, diagnosis and intervention" (p. 254).

Given nursing's fundamental valuing of the client as a unique human being of unconditional worth, inseparable from his/her personal historical, social and cultural background, growing recognition of the client's explanatory models of health is an inevitable and crucial aspect of future nursing care. The following implications for nursing education arising from the study findings, are associated with the need to foster development of cross-cultural knowledge in the nursing profession.

Implications for Nursing Education

The primary implication for nursing education arising from this study is that nursing students need to be exposed to cross-cultural theory and principles. As nursing students are taught how to care for clients from various backgrounds, they need to be educated concerning clients' unique perceptions on world phenomena.

Nurse educators need to design nursing programs which recognize the explanatory models on health and illness held by Indo-Canadians and other cultural groups within Canadian society. Nursing programs need to be designed to provide care which is safe, effective and culturally relevant to the client. In order to meet this goal, cross-cultural content needs to be included in both undergraduate and graduate nursing curricula. This

perspective has been supported in recent nursing literature (Branch & Paxton, 1976; Leininger, 1978; Morse & English, 1986; Murillo-Rodhe, 1978; Orque et al., 1983). Educational programs also need to focus on health and illness as phenomena constructed within social, as well as cultural, context.

Nursing research guides nursing practice and education. The implications for nursing research arising from this study are presented below in the final section of this chapter.

Implications for Nursing Research

This study has contributed to nursing knowledge about how Indo-Canadians view health. Although cross-cultural investigation of the meaning of health is increasing, further research in this area is necessary. Attention also needs to be given to further exploration of the ways that social context interacts with culture to construct perspectives on health. In light of the findings of this study, the additional following areas are suggested for future research:

(1) Replication of the current study to gain deeper insight into the meaning of health for Indo-Canadians of the Hindu faith. For example, the relationship between chronic illness and health (with particular focus on specific outcomes of chronic illness) is an area which warrants additional investigation.

(2) Further research on the two dimensions of health described by the participants in this study, as core aspects of the Indo-Canadian explanatory model for health.

(3) Investigation of the meaning of health to Indo-Canadians using

all male and all female sample populations, to further clarify if perceptions of health are influenced by gender differences.

(4) Investigation of the perceptions of health held by non-Hindu Indo-Canadians, and other cultural groups making up Canada's multicultural society.

(5) Further research on the meaning which different cultural groups ascribe to the various terms used to describe the health experience (such as health, wellness, sickness, illness, disease), and the differences which cultural groups perceive between the meaning of english terms and equivalent "native language" terms.

Leininger (1985) provides us with a futurist's view on qualitative research and the nursing profession:

> The turning point has been reached for nurses and especially nurse researchers to chart new directions and methods for alternative ways to know and understand human beings. More and more, we shall see that qualitative research will become the method of choice to fully know the health, care and general lifeways of people. Nurse researchers must awaken to the importance of qualitative methods in order to develop a distinct and relevant body of substantive knowledge in nursing. (p. 24).

It is hoped that Leininger's predictions become a reality. Ongoing qualitative research will continue to reveal the inseparable and fundamental relationship between culture and health. Phenomenology is one appropriate research methodology for such enquiry, and ought to claim a primary position in future

nursing research.

Given the results of this study, and the supporting discussion of extant literature and research presented in this thesis, there is undeniable argument for ongoing and emphasized enquiry into the socio-cultural context of health. The ultimate success of the Canadian health care system may rest on its sensitivity to the meaning which health and illness hold for the various culturally, ethnically and socially diverse populations which make up the Canadian mosaic.

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Appendices:

Appendix A

Information regarding the Study

My name is Robyn Thompson. I am a registered nurse working towards my Master's degree in nursing at the University of British Columbia. I am interested in learning about what health means to Indo-Canadians, so that health care professionals may better understand Indo-Canadian health beliefs and practices and provide better health care.

The purpose of my study is to learn how you view health and how you experience being healthy. I am inviting you to participate in this study. If you agree to participate, I would like to interview you in your home so that I can learn about your views.

Each interview will be tape-recorded so that I can pay full attention to what you are telling me. Each interview will last for approximately one hour. I would like to interview you 2-3 times so that both of us can discuss your views in detail. Interviews will be arranged at times which are mutually convenient to both of us.

The interviews I hold with you will be discussed only with my teachers at the University of British Columbia. Your name will not be identified in any conversation or written material.

Your decision to participate or not in this study, WILL NOT AFFECT ANY MEDICAL OR NURSING CARE THAT YOU MAY RECEIVE. If you decide to participate in this study, YOU MAY WITHDRAW FROM THE STUDY AT ANY TIME WITHOUT ANY CONSEQUENCES TO CARE PROVIDED TO YOU

Appendix C

Initial Trigger Questions

These initial trigger questions were revised subsequent to the pilot study.

1) What does health mean to you? ... What is the experience like for you?

2) What do you do to gain a sense of ease and wholeness?

3) When do you consider yourself to be healthy?

4) What things are important to you in life?

5) When you are healthy, what things are you able to do and accomplish?

6) What is your experience in everyday life when you are not sick or suffering from any illness?

Appendix D

Final Trigger Questions

1) What do you think about health?

2) What does health mean to you? ... What is the experience like for you?

3) When do you consider yourself to be healthy?

4) What things are important to you in life?

5) When you are healthy, what things are you able to do and accomplish?

6) What is your experience in everyday life when you are not sick or suffering from any illness?

Appendix F

Health Images included in the Health Descriptions of Participants in this Study

(Adapted after Wood and Coworkers, 1988)

Clinical

-No tiredness
-Not ill or sick, disease free
-No pain
-NORMAL
-Not bedridden
-NOT SUSCEPTIBLE TO DISEASE

Adaptive

-Don't let things get you down
-ACCEPTANCE OF LIFE'S SITUATION(S)
-Ability to cope
-ABLE TO TAKE ANYTHING MENTALLY
-IN CONTROL
-CONTROL OVER LIFE
-CONTROL OVER MIND, AND BODY
-Self-discipline

Role Performance

-ABLE TO DO WORK, DO USUAL FUNCTIONS
-ABLE TO PERFORM
-ABLE TO DO THINGS
-Able to function without fatigue
-Predictably being able to do things
-Able to be as active as you want

Actualizing Self

-Able to achieve goals

Practicing Healthy Life Ways

-EXERCISING
-EAT BALANCED DIET
-good nutrition

Positive Self-Concept

-Feel good about self

Cognitive Function

-Think rationally
-Clear headed

Body Image

-Look good

Positive Affect

-POSITIVE MENTAL ATTITUDE
-Sense of well-being
-HAPPY
-Cheerful
-Feel good

Social Involvement

-Involved in community
-Able to enjoy family

Fitness

-Strength
-Able to be active
-ENERGETIC

Harmony

-Calm
-In harmony
-Life in balance
-NO WORRIES
-Peace of mind
-BODY/MIND IN HARMONY
-Content

NOTE: The health images which participants in this study emphasized the most are shown in capitalized terms.