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**The Mindful Self:
Sense of Self and Health-Promoting Lifestyle Behaviours
among Thai College Women**

**A thesis presented in fulfillment
of the requirements for the degree of**

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Nursing**

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ABSTRACT

Wellness educators have faced a great challenge to develop strategies to move people toward the adoption of positive lifestyle behaviours. This research explores concepts of self and the impact of Thai culture on the motivation of young college women to engage in health-promoting lifestyle behaviours (HPLBs) in the context of northeastern Thailand. A sequential mixed methods design enables an exploration of the relationships among sense of coherence, identity status, and HPLBs in the first phase, and an inductive analysis of the impact of Thai cultural context in the second phase. In study A, three instruments: the Health-Promoting Lifestyle Behaviors Profile II (HPLP II), the Extended Version of the Objective Measure of Ego Identity Status (EOM-EIS), and the Orientation to Life Questionnaire (SOC-29), were used with 350 senior college women. Sense of Coherence was significantly correlated with achieving a sense of identity, lessening diffusion identity and engaging in health-promoting behaviours. Although a considerable proportion of the variance (26.7 %) for engaging in HPLBs was accounted for by SOC, identity achievement, and identity moratorium, the magnitude of the unexplained variance was considerable. This led to inductive exploration of other variables influencing HPLBs in Study B. By data-driven thematic analysis, the Model of the Mindful Self emerged from in-depth interviews with 25 college women. The model describes three main themes: (a) the cultural background and the surrounding ongoing influences which impact on the development of Thai women's sense of self and their health-related behaviours, (b) the sense of self and identity formation in the Thai context, and (c) the health-related behaviours that stem from the sense of self. Sense of self and its behaviours are socially constructed within the specific culture in which individuals are embedded. The social phenomena and research outcomes are interpreted under the lens of social constructionism. The knowledge generated by this study provides guidance for teaching about health promotion in Thai undergraduate nursing programmes and also provides a basis for initiating health-promoting programmes based on the individual's sense of self for female adolescents in Thailand.

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A hundred times a day I remind myself that my inner and outer life depends on the labors of other men, living and dead, and that I must exert myself in order to give in the measure as I have received and am still receiving.

- Albert Einstein

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GLOSSARY

Pāli-Sanskrit

A

Abhijāta-putta or *atijāta-putta*: superior-born son

Anatta or *Anatman*: without self entity or empty, state of being not self

Anicca: impermanence, transience, having the nature to arise and pass away

Anujāta-putta: like-born son

Avajāta-putta: inferior-born son

Arogya: non-diseased-ness

Atta, *Bhava*, and *Karma* : self, condition, and the law of cause and effect

B

Brahmavihāras: holy abiding, sublime states of mind, the Four Abodes of the Buddha:

Mettā: loving-kindness, friendliness, goodwill

Karunā: compassion

Muditā: sympathetic joy, altruistic joy

Upekkhā: equanimity, indifference, neutrality, poise

(Thais pronounce *Oo-baehk-khaa*)

D

Dāna: giving, generosity, charity, or benefaction

Dukkha: of suffering and unsatisfactory nature

K

Kataññū or *Katanyu*: gratitude

Katavedī or *Katavedi*: to offer reciprocal kindness to one's benefactors

Khan-ti: to be patient

M

Madhyama pratipad, *Majjhima patipada*: the Middle Path

P

Pañña: discriminative wisdom

Puja: to worship

S

Sila: moral virtue, the basic codes of conduct recommended by the Buddha for his followers, precepts

Samadhi: concentration or one-pointedness of mind, meditation

Samsāra : transition, conditioned existence, the rebirth cycle

Sati : mindfulness, recollection

U

Uppamahoti arnayoung: happiness for living parents

Thai

B

Bplohg-Dtohk or *Bplohg*: make right understanding of the nature of things and let things be

Bun: merits

Bun khun: total benefits that another has bestowed upon one

C

Chaow phoa: a male spirit guardian

D

Doo lae tua eng: to take care of one's self

Doo tua eng: to look at one's self

G

Gruoad nam: to pour water through one's hand during a sermon after making merits to monks

H

Hai wela tua eng: to give time for one's self

J

Jad karn tua eng: to manage one's self

Jai ron: hot mind

Jai yen: calm mind, cool mind

K

Kalatesa: time and place

Kidd buab, *Kid dee*: to think positive, to think good thoughts

Kidd eng tam eng: think and do things by one's self autonomously

Kooy gubb tua eng: to talk to one's self, self-talk

Kreng-jai: to be considerate

L

La: to let things be, to let go, to detach

La tithi: to let go one's thought or one's stubborn

M

Mai Mi Roak Pai Khai Jeb: no diseases, harms, fevers, and pains

Mor-Din-Daeng: Khon Kaen University

Munn jai nai tua eng: to be self-confident

P

Pen baeb yhang: to be a role model

Pen tua khong tua eng: being one's self

Pii, nong, loong, paa, naa, aa: older sister/brother, younger sister/brother, uncle, or aunt. These are pronouns to call others in a seniority-oriented Thai culture.

Ploay-wang: let things be without forming attachment with them

Poom jai nai tua eng: to be proud of one's self

Puao-dee: balance, just-right manner

Pueng tua eng: to be self-reliant, self-reliance

Pure: for

R

Rak tua eng: to love one's self

Roo koon-ka tua eng: to know one's self-value

Roo tua eng: knowing one's self

S

Sabai-jai: eased mind, happy mind

T

Taang Saii Klang: the Middle Path

Tam Bun: to make merits

Tam Dee: to do good deeds

Tam Jai: to accept the way things are

Tam Jai Pen Klang or *Klaang-klaang*: to be neutral, keep in the middle

Tam puer krob krua: to do things for family

Tam puer sung kom: to do things for society

Tam puer tua eng: to do things for one's self

Thamm tua eng: to ask one's self

Tua eng: Self

W

Wang choei: to be stoic

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PART I
CHAPTER 1
INTRODUCTION

This study focuses on college women's health and wellness in the context of Thailand. In particular, it explores health-promoting behaviours among this population and the contribution which the concepts of self and identity make to these behaviours, as well as the impact of Thai culture on the motivation of young college women to take care of themselves and to engage in health-promoting lifestyle behaviours. The meanings of health and wellness are socially constructed within the specific culture in which individuals are embedded. Thus social constructionism provides a broad lens for interpretation, while a mixed method design enables an exploration of the applicability of, and relationships between, measures of 'sense of coherence', 'identity statuses' and 'health promoting lifestyle behaviours' in the lives of young college women in northeast Thailand. This chapter provides a rationale for the research, and an outline of the chapters that follow.

BACKGROUND TO THE RESEARCH

Since the year 2001, health promotion has been increasing in prominence in every sector of healthcare in Thailand. Seminars on this issue took place in several institutions during 2002. As a nurse instructor prior to commencing doctoral study, my experiences in a gynaecological ward at Udonthani Hospital in Northeastern Thailand led to my interest in the area of women's health. Education and socioeconomic status appear to play an important role in the differences in well-being (Ballantyne, 1999). However, little is known about the impact of Thai culture on the motivation of women to take care of themselves and to engage in health-promoting lifestyle behaviours (HPLBs). Yet women, in the developing world of Thailand, have crucial roles as caregivers and health educators in families, and as skilled workers in many areas of the workforce.

Moreover, I had observed that even though Thailand had invested in more infrastructure for medical care, the country was not facing fewer health problems. Writing in relation to the United States health sector, Cashman and Fulmer (1994, p. 52) identified rising healthcare costs with less valuable results for the holistic health of populations:

We have built a system that is heavily dependent on specialists caring for individuals. As a society, we have distributed resources in a way that heavily favors high-technology treatment and discounts low-technology prevention – fully 97 cents of every dollar spent on health goes to cure, three cents to prevention. ..., then, that the system is greatly out of balance, with medical-care costs spiraling higher and higher. Yet efforts to contain costs have contributed to the system's complexity; today, 24 percent of spending is consumed by administrative expenses.

This is also the case in the Thai context. A bio-medical approach to health and illness has not led to wellness in the society, and of course, it is high cost. The concept of health maintenance has been untenably based around medical practice and hospital-based care (Cowen, 1991; Hilton, 1993).

Studying and teaching physiology and nursing for the last ten years to student nurses had made me realise that bio-medical paradigms are inadequate to answer the question as to how people stay well; and that behavioural psychology, social sciences and social interactions are likely to have a great contribution to HPLBs. I also experienced three years as the head of the Department of Student Activities in my college and saw numerous health problems among college women. Even though these students were studying health-related issues, many of them had anaemia, and some had severe problems dealing with stress. That experience made me wonder “what, apart from knowledge, makes people commit to healthy behaviours?”

Antonovsky (1987), from his salutogenic perspective, suggests people “think in terms of factors promoting movement toward the healthy end of the continuum,” and that “the question one asks – about movement toward pathology or movement toward health – determines the hypotheses.” (Antonovsky, 1987, p. 6). So, asking about healthy aspects would yield answers for healthy examples. This perspective drove my inquiry to conduct this research by asking questions about people's well-being rather than their lack of well-being. I realized that a potentially prolific framework for the development of nursing theory through research could be

developed from wellness or the salutogenic perspective rather than the pathogenic one (Sullivan, 1989).

Wellness has been defined as “the process and state of a quest for maximum human functioning that involves the body, mind, and spirit” (Archer, Probert, & Gage, 1987, p. 311) as well as “the active process through which the individual becomes aware and makes choices toward a more healthy existence.” (Hettler, 2006, p.1). Hettler (1984) proposed a six-dimensional model of wellness including physical, intellectual, emotional, occupational, social, and spiritual wellness. Physical wellness and healthy behaviours – such as exercise, good eating habits and avoidance of drug and alcohol abuse – are important to address during the college years as this period is crucial in the development of a healthy lifestyle (Archer et al., 1987).

The focus on wellness has revealed a range of considerations regarding the concept of empowering individuals to maintain their health and well-being. For example, Witmer and Sweeney (1992) proposed various characteristics desirable for optimal health and functioning expressed through the five life tasks: spirituality (oneness, purposiveness, optimism, and values); self-regulation (sense of worth and control, realistic beliefs, spontaneity and emotional responsiveness, intellectual stimulation, problem solving and creativity, sense of humour, physical fitness and health habits); work (psychological, social, and economic benefits); friendship (social interest and connectedness; social support, interpersonal relationship, and health); and love. Life forces are family, religion, education, community, media, and business/industry. The authors derived a wheel of wellness and prevention based on findings from social, psychological, medical, and behavioural sciences to reflect the characteristics of healthy persons. They propose ‘*global village*’ ecology and a cosmic consciousness emphasising the interconnectedness of all things. The implication of a wellness perspective is that one component of a person could not be treated without keeping the balance of all components (Westgate, 1996). This knowledge gives a foundation for considering the individual’s self and surroundings when thinking of health promotion.

Even though level of well-being is not directly tested in this research, it is an expected secondary outcome of HPLBs. The terms *wellness* and *well-being* are used interchangeably in this study. Cowen (1991) described the term ‘wellness’ as the simultaneous presence of two clusters of indicators: earthy indicators such as

eating well, sleeping well and doing one's mandated life tasks well; and the more ethereal indicators such as having a sense of control over one's fate, a feeling of purpose and belongingness, and a basic of satisfaction with oneself and one's existence. Therefore, the concept of well-being has been conceptualised in two different ways. One approach focuses on hedonic or subjective well-being and equates it with happiness. Another approach focuses on eudaimonic well-being and essentially equates it with being fully functioning. In fact, the two dimensions of well-being, hedonic and eudaimonic, are substantially intersected (Ryan & Deci, 2002). The contribution of Sense of Coherence (SOC) and achieving a sense of self to well-being has been well evidenced (Boman, Bjorvell, Langius, & Cedermark, 1999; Kang, 2000; Rukin, 1997). Although engaging in healthy lifestyle behaviours contributes to being healthy, and components in HPLBs such as spiritual growth and stress management seem to be interrelated with characteristics implicit in SOC and sense of self, there have been few studies in which these characteristics have been linked to predict HPLBs.

One's wellness exists along a continuum curve and moves toward the positive end or negative end over the life span, and continues to change over time (Cowen, 1991). Dunn (1961) delineated wellness as a 'dynamic striving' inbred in individuals that drives them to achieve their highest potential. Nonetheless, understanding the motivation that drives one to learn to live a life focused on wellness is also crucial. Savolaine and Granello (2002) in the USA, commented that all wellness models generally place emphasis on meaning and purpose in life. Even though meaning is given an essential role in identifying individual wellness, little study has been done to explore the link between meaning and the construct of wellness in a distinctive context. Moreover, gender differences may play important roles in practice. As Depken (1994, p. 58) in the USA noted:

While wellness definitions, models, wheels, ladders, and pies abound, there are no wellness models that have included gender, race, or class in their definitions. While the jargon of the wellness movement appears to be inclusive and women-centered, the models themselves make no attempt to elucidate that gender plays an important part in our lives and in our health. In all of these models discussions of gender and its impact on health or health behaviour are conspicuously missing.

When studying wellness by gender, Rodin and Ickovics (1990) assert that women should not be treated as a homogenous group. Socioeconomic status, education, and culture play crucial roles in health differences. It has been suggested that

studies of wellness and health promotion in the 21st century should focus on selected populations (e.g. age-related, gender-related, or diagnosis-related) in differing community settings (Curry, Hogstel, Davis, & Frable, 2002). The significance of identifying a wellness model for a specific cultural context is that such a model will guide healthcare professionals to promote individual and community health in ways that do not produce resistance in that context. Although the multidimensional items for wellness are similar for all people, the components for each item may be different, and there will obviously be differences between genders (Depken, 1994). This implies the relevance, in this study, of examining wellness and health promotion through gender- and context-specific lenses.

HEALTH PROMOTION AND HEALTH-PROMOTING LIFESTYLE BEHAVIOURS

There is considerable agreement that health is an issue of social justice and not only a fundamental human right, but also the right (and duty) of people to participate in the planning and implementation of their healthcare (WHO, 1978). The central ideology of the new public health, empowerment, is conveyed from the Ottawa Charter's definition of health promotion as the "process of enabling people to increase control over and to improve their health" (WHO, 1986, p. 1). Lifestyle is believed to be an important factor affecting health. For promoting health, the assessment of lifestyle as a correlate of health has been emphasised (Kagee & Dixon, 2000; Stinger, 1982). Therefore, it is essential to know which factors influence HPLBs among a given population, and the barriers to undertaking such behaviours in a distinctive cultural context.

Lifestyle refers to a way of living or the behaviours by which people conduct their daily activities (Stinger, 1982). This definition implies that lifestyle has measurable behavioural dimensions. Walker, Sechrist, and Pender (1987, p. 77) defined health-promoting lifestyle as "a multidimensional pattern of self-initiated actions and perceptions that serve to maintain or enhance the level of wellness, self-actualization and fulfillment of the individual." The concept of *healthy lifestyle* is described in terms of two complementary aspects which may have different underlying motivation: health promotion with the desire for well-being as the impulsion for behaviour; and health protection – or prevention of illness – with avoidance of illness or injury as the incentive for action (Pender 1982, 1987). A

health promoting lifestyle consists of various dimensions such as proper nutritional habits, interpersonal relations and social connections, exercise, stress management, health responsibility, spiritual well-being, adequate sleep, and avoidance of harmful substances (Kaplan, Cassel, & Gore, 1977; Reed, 1983; Walker et al., 1987).

Health promotion is based on the premise that behaviours and the circumstances in which we live, impact on our health. At the individual level, unhealthy behaviours – in particular, poor nutrition, low levels of exercise, smoking, alcohol misuse, and high risk sexual activity – have been identified as being associated with disease (Crossley, 2001). Unhealthy lifestyle is reported to be overtaking infectious disease in industrialised and some developing nations as the leading cause of death (World Health Organization, 1996). Although several popular explanatory models of health behaviour are currently used to initiate health promotion programmes, many behaviours in specific groups remain resistant to intervention (Kearney & O’Sullivan, 2003).

The most common models used in health-related research, such as the health belief model (Becker, 1974), the health-promotion model (Pender, 1982, 1987), social learning theory (Bandura, 1986), and self-efficacy (Rosenstock, Strecher, & Becker, 1988) are believed to be inadequate for explaining and modifying health-related behaviours (Burton & Hudson, 2001; Crossley, 2001; Kearney & O’Sullivan, 2003). Crossley (2001) asserted that behaviourist and cognitivist models used to guide health promotion and education that are based on traditional psychological approaches are inadequate to deal with the complexity of health-related behaviours.

One way to study health-related behaviours is by exploring people’s sense of self linked to well-being. A number of qualitative studies of identities related to healthy or risky behaviour choices that people engage in, indicate that people behave in ways that uphold the identities they value, the so-called ‘alternative rationalities’ (Crossley, 2001, p. 167). Achieving a sense of self or identity has also been shown to contribute to well-being (Kang, 2000; Marigliani, 1997; Meeus, 1996; Rukin, 1997). Gender differences in identity formation have also been reported (Archer, 1989a). To date there has been little research linking sense of self and identity formation to HPLBs.

Health-promoting behaviours may be measured by using the Health-Promoting Lifestyle Profile II (HPLP II). The HPLP II is a questionnaire that assesses an overall view of “a positive approach to living that leads individuals toward realizing their highest potential for well-being.” (Walker et al., 1987, p. 76). The strong predictors for likelihood of engaging in health-promoting behaviours include perceptions of control over health, personal competence, definition of health, and health status (Pender, Walker, Sechrist, & Frank-Stromborg, 1990). Pender (1987) later revised the Health Promotion Model to include commitment to a plan of action as an additional factor influencing health-promoting behaviours. However, this factor has been little studied in relation to health-promoting behaviours (personal communication, 20 October 2004). While exploration and commitment are considered to be crucial for individuals to achieve their sense of identity (Bennion & Adams, 1986; Marcia, 1966), the correlations of these two components of identity achievement with HPLBs have not been measured.

Factors determining health-promoting behaviours have been studied mostly by utilising the determinants proposed in the Health Promotion Model. Perceived health status was significantly predictive of total HPLP II, exercise, stress management, and spiritual growth; and gender differences have also been identified in health practices (Larouche, 1998). Among Thai college students, friends and individual characteristics such as gender, perceived risks and perceived benefits were significant factors impacting on health-promoting behaviours; knowledge was not found to have a direct effect on health-promoting behaviours, but affected attitude toward health behaviours (Trumikaboworn, 2004, p. 252). High school students in Central Thailand were reported to practise health-promoting behaviours at a moderate level. Grade and perceived benefits to action were positively associated with health-promoting behaviours. Perceived barriers to action were negatively associated with health-promoting behaviours (Tongsong & Taitae, 2003).

To understand the motivation for people’s engagement with healthy or risky behaviours, Crossley (2001, p. 171) proposed the term “*psychological survival strategies*” which are the lifestyle options people choose as powerful mediators between the self and the world to accommodate to the stress and demands of life. He proposes that both healthy and risky behaviours are two sides of the same coin representing “attempted resolutions of the contradictions of a culture which inculcates a chronic sense of emptiness and meaninglessness, producing a

subsequent need or desire to get rid of that feeling.” (p. 171). Crossley’s ideas are consistent with the earlier work of Antonovsky (1987), who proposed that a strong sense of coherence (SOC, with components of comprehensibility, meaningfulness, and manageability) contributes to people’s ability to stay well in the midst of risky circumstances. While Antonovsky emphasised the salutogenic concept of SOC and designed the tool to measure and predict movement toward the health end of the health/disease continuum (Antonovsky, 1993), most research has used the concept in predicting individuals’ well-being in stressful events and ill health. It is accepted that coping competency and spiritual health contribute to one’s well-being and it has been suggested that “Sense of Coherence is the intermediate position joining the coping model and the spiritual/existential issues” (Strang & Strang, 2001, p. 113). While spiritual growth and stress management are essential components in HPLBs, to date there is little evidence to suggest that SOC could predict HPLBs as a means for people to stay well.

Cognitive factors, such as SOC, may play an important role in determining health-promoting behaviours. A high level of SOC was reported to be associated with HPLBs among adults in various rural industrial sites in the USA (Johnsen, 1992). White collar workers with high SOC were found to be more likely to engage in healthy behaviours, such as regular exercise, than blue collar workers (Poppius, Kalimo, & Heinsalmi, 1999). Sense of coherence, self-efficacy, and personality factors were also studied relating to health behaviours such as cigarette smoking (Von Ah, Ebert, Ngamvitroj, Park, & Kang, 2005). However, SOC did not play a role in predicting smoking behaviour. In Thailand, SOC was found to be a predictor of HPLBs among colorectal cancer patients (Suteerawut, 2001), and associated with psychosocial adaptation among high school adolescents (Chotikapong, 2006). It is unclear whether or not SOC could be used to predict the level of HPLBs in healthy college women in the Thai context. Identity development has been found to be significantly related to the SOC of the elderly in Sweden (Rennemark & Hagberg, 1997). However, no literature exploring the relationship of SOC to identity formation in adolescents has been found. It is not known whether or not the addition of identity formation would increase the power of SOC to predict the HPLBs of Thai college women. In this research I explored concepts of self, health-promoting lifestyle behaviours and the impact of Thai culture on the motivation of young college women in Northeastern Thailand to take care of themselves and to engage in health-promoting lifestyle behaviours. Brief

information about the country and the region is now provided to introduce the reader to the context of the study.

THAILAND AND THE NORTHEASTERN REGION

Thailand covers an area of 514,000 square kilometres occupying the western half of the Indochinese Peninsula and the northern two-thirds of the Malay Peninsula in south-east Asia. It is bordered by Laos to the north and north-east, Burma to the west and north-west, Malaysia to the south, and Cambodia to the east (Figure 1.1). The country is divided into five regions: Central, North, East, South, and Northeast. The Northeast region is the largest land area, covering 170,000 square kilometres, 33% of the total area of the country. This region has approximately one-third of the total population of the whole country and is divided into 19 provinces.

The Northeastern region is culturally different from the rest of the country because of the geographical separation by the Phetchabun Mountain rim, which has been a barrier to communication with the Central region in the past. Its culture has been integrated with that of its neighbours, Laos and Cambodia, and the specific dialect of the region, *Thai Isaan*, differentiates the Northeast people from those of the rest of the country. Most of the research in this thesis took place in Udonthani province in Northeastern Thailand, 564 kilometres northeast of the capital, Bangkok. People in this area are of lower economic status than those in other areas of Thailand; most are Buddhist, farmers, and speak the local dialect instead of central Thai. However, Udonthani is the 3rd largest province in the Northeast of Thailand in terms of economy. It has a total area of 11,730 square kilometres and is recognised as the 11th largest of all 76 provinces of Thailand.

There are five institutes for undergraduate level education in the province. They are Ratchapat University, The College of Physical Education, Technology Ratchathani Institute, Boromarajonani College of Nursing, and the Santapol Institute. Most of the students in these institutes come from the north region of Northeastern Thailand. The nearest university is Khon Kaen University in Khon Kaen province (Figure 1.1), approximately 120 kilometres away.



Figure 1.1 Map of Thailand

WOMEN'S HEALTH IN THAILAND

Thailand has been in transition to urbanisation. During the past few decades Thailand has been one of the world's fastest growing economies. A key part of its success is its focus on social development and the empowerment of women. Generally, socioeconomic improvements substantially raise people's health status via three main routes: income improvements; educational level of adult females; and generation and utilisation of new knowledge (WHO, 1999). Although empowering and educating individual women may be the key to social development, and women have both productive and reproductive roles in communities, research to date in northeastern Thailand has focused mainly on women of low socioeconomic status (Jongudomkam, 2001).

The most commonly identified health problems related to lifestyle in the area of women's health are anaemia and HIV infection (United Nations Educational, Scientific and Cultural Organization, 1995). Anemia prevalence in pregnant and non-pregnant women aged 15-49 years is 40% (Ministry of Public Health, 1996). This reflects the fact that health promotion and education improvement are needed. Currently, interventions initiated to solve iron deficiency anaemia have been put solely in a prevention and control perspective, and confined to pregnant women and school children (Winichagoon, 2002).

Health status and health risks among Thai women are particular to the region. Nevertheless, women in all regions exhibit health risks according to their lifestyles. Women in the northeastern region, the area of this research interest, have the shortest life expectancy at birth compared to women in other regions, and more commonly suffer from diseases of the liver such as liver cancer and liver cirrhosis (Punyaratabundhu, Narksawat, Podhipak, & Jirawatanakul, 1996). The people of the Northeastern region have a distinctive culture developed from their style of living. The northeasterners in villages have their ancient culture and traditions, which are unique. However, with a more educated background, the younger generation has been gradually exposed to Western culture and has changed their living style to a more urbanised one. Urbanisation has been reported to affect women's health more than men's (Fleury, Keller, & Murdaugh, 2000; Ostlin, 2002). Furthermore, as transportation, communication, media, and education have been developed, the Northeastern region is now in transition. Because of its location bordering Laos and Cambodia, the Northeastern region has become a

significant point for travelling to the Mekong countries. Tourism has also been a factor that promotes changes in this region.

A study by Sharps, Price-Sharps, and Hanson (2001), revealed that college women in Udonthani province preferred a very slim body size compared to men in the same area and compared to women and men of the same age in the United States. The Western stylistic values which currently permeate Thailand's culture might affect the nutrition habits of Thai women adolescents. Thus, eating disorders such as anorexia or bulimia could become health problems among Thai women. Nutrition issues are potential problems affecting health behaviours and status, and even the country's productivities. Moreover, women play important roles in care giving, and as food providers, modelling eating habits and health education in families.

Research into women's health behaviours in Thailand is limited. Studies which have been carried out on college women have focused on sexuality (Pornchaikate, 2002; Trumikaboworn, 2004), and stress management and adaptation (Trumikaboworn, 2004). Studies among middle-aged women have focused on reproductive health (Cohn et al., 2001; Hirozawa, 2001; Kaewsarn, Moyle, & Creedy, 2003; Saowakontha et al., 2000) and work-related health (Jongudomkarn, 2001); and studies among older women have been limited to menopause issues (Chirawatkul, Patanasri, & Koochaiyasit, 2002; Sunsern, 2002). These findings influenced my decision to study health-promoting lifestyle behaviours. Only one study has focused on self-image and health of women and this has been done with older women (Jamjan & Jerayingmongkol, 2002).

The number of students enrolled in undergraduate study has continuously increased. Therefore, university students are a significant target population for public health and health promotion research (Gyurcsik, Bray, & Brittain, 2004). Thai women in late adolescence comprise 53% of the enrolments in university and professional courses. Although the literacy rate of Thai women (91.6%) is quite high (United Nations Educational, Scientific and Cultural Organization, 1995), it does not necessarily mean they have high health literacy or are committed to a healthy lifestyle.

College women are potential human resources for society. However, when they leave home to attend college, live in a dormitory and provide food for themselves,

lifestyle changes might contribute to their health problems. Even though there has been evidence that freshmen university students reduce their caloric intake significantly, their body weight – however – significantly increases (Butler, Black, Blue, & Gretebeck, 2004; Hajhosseini, Holmes, Mohamadi, Goudarzi, McProud, & Hollenbeck, 2006). Total physical activity among college women also decreases (Butler et al., 2004; Gyurcsik et al., 2004).

The evidence around health-related behaviours of young Thai college women is also limited. Thai women are mainly agriculturists (Punyaratabundhu et al., 1996). This may explain why little research attention has been focused on college women who are believed to be in the healthiest age group (Pooncharoen, Shunharat, Wibulphonprasert, Juengsatiensap, & Sriratanaban, 2000). Lee and YuenLoke (2005) also indicate that young people are considered to be at a relatively healthy stage and receive less health interventions worldwide. Little health policy relevant to health promotion for Thai college women is observable.

Thai literature relevant to health behaviours among university students was reviewed by Trumikaboworn (2004). The author searched databases and other sources from 1989-2004 and found 33 items in English and 57 in Thai. The majority of the reported studies were quantitative and focused on correcting health risk behaviours rather than on promoting health. Trumikaboworn recommended that specific factors for promoting health should be studied instead of focusing on correcting health risk behaviours.

The two Government sectors that deal with population health and development are public health and education. Since 1999, there have been crucial movements in both healthcare reform and education reform in Thailand: the National Education Act in 1999 and the National Health Act in 2002. Both are to provide for people's development and well-being. However, only an estimated 14 % of the nation's health budget is provided for health promotion (National Health Security Office, Thailand, 2007), and still less strategy has been developed to initiate health-promotion programmes. In the case of education reform in the National Education Act, the aims are strongly placed around speeding up the country's economic recovery and competitiveness (Kaewdang, 1999). The first priority of integrating contents for basic education emphasises 'knowledge about oneself' and 'the relationship between oneself and society' (Kaewdang, 1999, p. 3), and implies the significance of achieving a sense of self in order to achieve well-being at both the

individual level and the larger society level. Still, it does not provide many practical strategies for implementation in order to contribute to the population's well-being. Despite the need to address wellness as a component of self-development, few researchers have addressed wellness with this specific population in combination with addressing other developmental characteristics – such as SOC and identity – that face college students.

In summary, little is known about the influence of SOC combined with sense of identity on an individual's engagement in HPLBs. More specifically, little is known about the SOC and self-construction concepts among young college women in the context of Northeastern Thailand. What is the level of HPLBs among these women? To what extent can measures of SOC and achieving a sense of self predict HPLBs among college women in the context of northeastern Thai culture? What kinds of descriptors or identities would young Thai college women report as motives for maintaining healthy behaviours? Little is known about young Thai women's motive of self-construction (sometimes about non-health issues) and the way it drives their self-initiated and subsequently self-sustained healthy (or unhealthy) behaviours.

Familiarity with the descriptors young Thai women use to describe themselves might enable facilitation of health-creating behaviours amongst this group by helping them establish or maintain appropriate self concepts. Adolescence is a timely period to form and consolidate healthy lifestyle behaviours, and a strong sense of self. College educated young women will become the leaders of the future. Through the maintenance of HPLBs, college educated young women could become positive role models for work-place peers, as well as family members and significant others as they progress through and graduate from higher education, enter the workforce, and establish new families.

PURPOSE OF THE RESEARCH

This study involves a threefold paradigmatic shift from many current approaches to research in health-related issues. First, a shift from a disease-based to a health-based perspective; second, a shift from explaining health related-behaviours by employing traditionally popular behaviourist and cognitivist models of behaviours to models that derive people's motivational roots from the construction of self; third, a shift from population-based health promotion to a gender-specific health

promotion. The purpose of this study is to investigate the positive aspects of sense of self that contribute to young Thai college women's engagement in HPLBs. Specific aims of the research are shown below.

AIMS OF THE RESEARCH

1. To identify the level of health-promoting lifestyle behaviours (HPLBs) among Thai college women in northeastern Thailand.
2. To gain more understanding of the relationship between SOC, identity status (identity achievement, identity foreclosure, identity moratorium, and identity diffusion) and HPLBs in this population.
3. To generate a dense conceptual explanation of the interplay between sense of self, identity formation, and HPLBs among college women in northeastern Thailand.

RESEARCH QUESTIONS

Observing the social phenomena and engaging in literature review, I asked 'What are the factors that can be used to promote healthy behaviours of Thai college women?' To answer this main research question, two questions were posed.

1. To what extent do sense of coherence, and identity status predict health-promoting lifestyle behaviours among Thai college women in northeastern Thailand?
2. What is the sense of self and identity formation among women who have positive health-promoting behaviours in a Thai cultural context?

These two questions led to a two-phase study utilising both quantitative and qualitative approaches. The purpose of the first phase of this study was to assess the relationships between SOC, identity formation (based on two characteristics of identity development: exploration of alternatives and commitment), and HPLBs. Although there were expectations that individual characteristics and cognitive factors might play an important role in encouraging college students to engage in HPLBs, dynamic cultural influences were also taken into account. This study, therefore, was not based on the belief that personal characteristics of health behaviours were static and stable in college-aged women, but rather that they were subjected to learning through constructed social discourses and social interactions. In addition, it was expected that the characteristics of the determinants of interest that predicted HPLBs might be impacted by culturally specific issues. Therefore, the second phase of the study was designed to explore the worldview of the

participants in depth. Löyttyniemi, Virtanen, and Rantalaiho (2004) assert the importance of taking subjectivity into account “which means taking seriously both the researcher’s own situated subjectivity and the particularity of those surveyed.” (p. 938). A mixed method design divided into two phases of inquiry was therefore legitimate to address the research questions.

CONCLUSION

As I am a nurse who has shifted my perspective from a bio-medical to a wellness focus, wellness literature has underpinned the presumptions which I brought into this research study. To achieve wellness, health-promoting lifestyle behaviours have to be created. I came to New Zealand with three key terms in mind: women’s health, health promotion, and wellness model. Searching for knowledge around these key terms during the first year’s course work, I found a gap in the existing knowledge about sense of coherence and individuals’ sense of self, related to health promotion. I was really excited and curious, and that was the beginning of this research inquiry.

The emphasis on wellness in terms of engaging in HPLBs promises a shift to live a life focused on well-being rather than struggling with health problems and becoming dependent on drugs, professionals and instruments in the medical arenas. The development of self-directed health-promoting behaviours among a targeted population would alleviate the workload of healthcare professionals and reduce cost and demand in the healthcare system. It is also important for healthcare professionals to provide healthcare by knowing that health is not merely a state of absence of disease.

Despite existing cognitivist and behaviourist theories for modifying the health-related behaviours proposed, commitment to healthy behaviours is still hard to develop among people in general. In Thailand, most health promotion theories have been imported from the Western context without assessing whether or not they are congruent with the Thai context, especially, Thais’ sense of self. Also, in northeastern Thailand which has been influenced by urbanisation and globalisation, the sense of self of young people in Udonthani – where the research took place – has been transformed by the impact of media and fashion from Western culture. The knowledge of women’s sense of self in the Thai context would provide insight

for healthcare providers and educators to create appropriate interventions to promote health and well-being for young Thai college women. There is evidence that some women can move themselves toward well-being, but some cannot. Education and socioeconomic aspects play crucial roles in these disparities. There is also evidence that people can stay well regardless of external determinants. Sense of self might relate to people's well-being or the engagement in healthy behaviours which entail wellness. Knowing people's sense of self in a Thai context would be useful for informing health-promoting practices and educating young Thai women in general and healthcare providers in particular.

THE THESIS LAYOUT

This thesis is divided into two parts. In Part I the background information for the research, the methodology and mixed method design, and design of Study A and its quantitative results are outlined. In Part II the design of Study B, the conceptualisation of The Mindful Self Model generated as the result of the qualitative part of the research, and the implications for health promotion in the Thai context are presented. Chapter 1 provides an introduction and justification for this research.

In Chapter 2 the gap in the existing literature is examined, and the limitations of bio-medical perspectives in dealing with health-related behaviours which lead to consideration of the wellness model are identified. The literature related to the three parameters of interest: health-promoting behaviours, sense of self and identity formation, and sense of coherence are then reviewed regarding their relationships and gaps in knowledge. This knowledge forms the theoretical framework of the research inquiry detailed at the end of this chapter. Note that the Thai cultural context was initially taken for granted as part of the world view of the researcher. The significance of the Thai cultural context to identity formation and health-related behaviours came to the fore in analysis of Part II data and is therefore presented in that section.

In Chapter 3 the paradigmatic bases for mixed methods research are explored and a rationale for the use of social constructionism as an epistemological stance for the research is provided. Mixed methods research design is reviewed and the

theoretical drive (Morse, 2003) for the mixed methods design is clarified. An overview of the two-part research design is provided.

Study A tests the relationships among health-promoting lifestyle behaviours, the four types of identity status, and sense of coherence in a sample of 350 college women in their final year of study. Chapter 4 provides details of the study design and the results of the relationships of these parameters. A brief discussion of the findings and limitations of Study A is also presented in this chapter. The limitations of the Western constructs of the three measurements in Study A to give advice for health promotion in the Thai context, supports the research question in Study B asking about the sense of self in the distinctive Thai cultural context.

Part II provides the course of the qualitative study of the sense of self and health-related behaviours of Thai college women in the context of northeastern Thailand. Chapter 5 presents the details of design of Study B and introduces the concept of The Mindful Self. A summary of the products of the inductive data analysis introduces the thesis mapping out the qualitative data into three main themes in the following three chapters. The further chapters explain the self formation in the Thai cultural context which creates the health-related behaviours – both positive and negative aspects.

Chapter 6, Common Cultural Background and Surrounding Influences, contains an explanation of the context that impacts on Thai college women's sense of self and therefore health behaviours. Chapter 7, Sense of Self and Identity Formation, outlines the particular sense of self functioning as a positive sense of self for this group of Thai college women. The paths of knowing self are also present as the factors that enable the participants to achieve a positive sense of self. A sense of non-attachment influenced by the Buddhism-based Thai culture is discussed. In Chapter 8, Health-Related Behaviours and Wellness Enactment, health-related behaviours are presented and positive and negative ones are compared as influenced by the participants' programmes of study as nurses or non-nurses which explicitly impact on their health knowledge and behaviours, especially regarding nutrition practice and exercise.

In the final chapter, Chapter 9 the significance of key aspects from Study A and Study B in the model of The Mindful Self for health promotion, nursing and nursing education implications are discussed. Limitations of the study and recommendations for future research are also described.

CHAPTER 2

LITERATURE REVIEW

The research questions were posed by observing the social phenomena and also by reviewing the existing literature related to the area of interest. The concept of health maintenance has been untenably based around medical practice and hospital-based care (Cowen, 1991). Economic status and social integration are factors that contextualise health and illness and they are widely recognised as “social determinants” of health (Ballantyne, 1999); however, lifestyle is reported to play an important part in determining health status and well-being (Pender, 1982). Some explanations for wellness have been placed around the salutogenic concept of sense of coherence (SOC). While many theories have been considered to be inadequate for behavioural modifications aimed at encouraging people to commit to healthy behaviours (Burton & Hudson, 2001; Crossley, 2001; Kearney & O’Sullivan, 2003), achieving a sense of self has been found to be a factor influencing well-being (Kang, 2000; Marigliani, 1997; Meeus, 1996; Rukin, 1997). Engaging in healthy lifestyle behaviours (HPLBs) is reported to underpin physical and psychosocial well-being (Walker et al., 1987). While SOC and sense of self have been considered with respect to their links to health-related behaviours in various settings, the gap of knowledge is the extent to which SOC and identity formation predict HPLBs among late adolescent females in the northeastern Thai context. This chapter, therefore, provides the pieces of the puzzle that are constructed to question the phenomena under study.

HEALTH-PROMOTING LIFESTYLE BEHAVIOURS

A number of theoretical models are used to direct current research on both health-promoting behaviours and medical adherence behaviours. For example, the theory of reasoned action or the theory of planned behaviour, based on the premise that humans are rational decision makers utilising information available to them, was proposed by Fishbein and Ajzen (1975). In this model, specific behaviour is determined by (1) beliefs, attitude toward the behaviour, and intention; and (2) motivation to comply with influential persons known as referents, subjective norms, and intention. The relative weights of subjective norms and the individual’s attitude

toward a behaviour based on its believed or known consequences combine to predict intention to perform a behaviour. The theory of reasoned action has been used in the study of health-related decision making.

The most common model used in health-related research since the 1970s is the health belief model (Becker, 1974). In the health belief model, adoption of a health-related behaviour can be explained by the individual's subjective perception of susceptibility to a condition, the severity of its consequences, and the benefits and costs of the health-related action with perceived barriers being the most influential factor. The cue to action that will be needed to prompt the individual to implement a behaviour becomes more intense with the lower perceived susceptibility. The model has been widely used to study patient behaviour in relation to preventive behaviours, and acute and chronic illnesses (Bastable, 2003).

Building on the health belief model and wellness perspectives, the health promotion model (HPM) (Pender, 1982), has gone beyond illness avoidance and explained behaviours that create health, self-actualization, and fulfillment. In addition to external cues to action, the seven cognitive/perceptual factors and a wellness-based definition of health have been linked to healthy lifestyle. The seven cognitive/perceptual factors included in HPM consist of importance of health: the value placed on health in relation to other personal life values; perceived control of health: the belief that health is self-determined, influenced by powerful others, and/or the result of chance or fate; perceived self-efficacy; definition of health; perceived health status: the self-evaluation of current health as a subjective state; perceived benefits of health-promoting behaviours; and perceived barriers to health-promoting behaviours. Modifying factors proposed in this model are: demographic characteristics; biologic characteristics; interpersonal influences (such as expectations of significant others and social norms); situational factors (such as health-promoting options available within the environment); and behavioural factors including prior experience with health actions (Pender et al., 1990). Pender's health-promotion model has been widely applied in nursing studies of health-promoting behaviours.

Pender (1982) constructed the Lifestyle and Health Habits Assessment (LHHA), by reviewing literature on wellness issues, as a checklist tool for positive health behaviours. It is a 100-item checklist arranged in 10 categories: general health practices, nutrition, physical/recreational activity, sleep, stress management, self-

actualisation, sense of purpose, relationships with others, environmental control, and use of the health care system. The Health-Promoting Lifestyle Profile (HPLP) (Walker et al., 1987), a 48-item checklist, obtained its initial form from the LHHA, and the 10 categories of the LHHA were reduced by factor analysis to six dimensions. The Health-Promoting Lifestyle Profile II (HPLP II), a 52-item checklist, was developed by the same authors for assessing the likelihood of engaging in health-promoting lifestyle behaviours. The HPLP II measures six dimensions of HPLBs, which include health responsibility, physical activity, nutritional practice, spiritual growth, interpersonal relations, and stress management. The spiritual growth subscale replaced the self-actualisation subscale which used to measure the individual's sense of purpose, personal development, self-awareness, and satisfaction. Engaging in the six dimensions of healthy lifestyle behaviours is reported to underpin physical and psychosocial well-being (Walker et al., 1987). The HPLP and the HPLP II have been used to study people's HPLBs in various settings.

Perceived health status was significantly predictive of total HPLP II, exercise, stress management, and spiritual growth among 151 USA university students. Women students were found to have better practices in nutrition, interpersonal relationships, health responsibility, and total HPLP II, compared to men (Larouche, 1998). Students who attended health-related education did not present any significant changes in their HPLBs when they completed a nursing programme in Canada (Riordan & Washburn, 1997).

Tongsong and Taitae (2003) developed a questionnaire from Pender's Health Promotion Model to study the health-promoting behaviours of high school students. They found that health promoting behaviours among 208 high school teenagers in grade 7-12 in a province in Central Thailand were at a moderate level. Grade and Perceived Benefits to action were positively associated with health-promoting behaviours. Perceived Barriers to action was negatively associated with health-promoting behaviours. Perceived Benefits and Perceived Barriers to action explained 23.5 % of the variance of health-promoting behaviours. Gillis and Perry (1991) found that level of well-being, exercise and stress management combined accounted for 58 % of the variance in adherence to a programme of physical exercise among mid-life women in Canada. Women in that study reported psychological well-being as an important outcome of exercise. However, it has

been reported that perceived benefits are not adequate to keep women exercising (Felton, Boyd, Bartoces, & Tavakoli, 2002).

Various factors beyond those proposed in the HPM have been tested for their association with HPLBs. Kagee and Dixon (2000) reported the relationships among two types of worldview, organismic and mechanistic worldviews, and health-promoting behaviours in a group of 259 undergraduate students in the USA. They reported that organismic thinkers were more likely to engage in health-promoting behaviours compared to mechanistic thinkers, and a slight indirect effect of gender that women were more likely to endorse an organismic worldview and more likely to engage in health-promoting behaviours than men were. No relationship was found between other socioeconomic factors (level of education, level of occupation, and marital status) and health-promoting behaviours.

Maslow's five levels of basic need satisfaction were investigated for their association with HPLBs in HPLP 11. Among 84 adults in the USA, Acton and Malathum (2000) found that self-actualisation, physical, and love/belonging need satisfaction accounted for 64 % of the variance in HPLBs. The authors concluded, "... persons who are more fulfilled and content with themselves and their lives, have physical need satisfaction, and have positive connections with others may be able to make better decisions regarding positive health-promoting self-care behaviours." (p. 796). By administering the HPLP scale and the Multidimensional Health Locus of Control scale to 34 Canadian baccalaureate nursing students, MacDonald, Laing, and Faulkner (1994) found that there were no prominent associations between the variables measured. Small relationships were found between stress management and internal health locus of control, and between interpersonal support and powerful others locus of control.

In general, physical activity and healthy nutritional habits have been paid a lot attention in wellness research. Felton and Parsons (1994) reported factors influencing physical activity in young women in the USA. They found that while race, personal control, and regular participation in organisations and groups were significantly related to physical activity in both groups of average-weight and overweight young women, physical activity among overweight women was also associated with interpersonal support. African American college women relative to white college women reported less exercise because of their lack of time and feeling bad (Felton et al., 2002), and also less interpersonal relations and proper

nutrition practice (Felton, Parsons, Misener, & Oldaker, 1997). It was reported that sometimes significant others like family and friends disapproved of women spending time being physically active (Felton et al., 2002).

In a study by Tashiro (2002), only 15 % of 546 Japanese college women reported themselves as being “healthy,” whereas 40% reported themselves as being “rather unhealthy” and “unhealthy.” Tashiro reported ten categories of health promoting lifestyle behaviours addressed by Japanese college women: commitment to college groups, positive mental health self-care, recreation, health assessment, health maintenance self-care, resting, health seeking, environmental health, eating/nutrition/diet, and physical exercise. In addition, the college women in the high health behaviour group found encouragement for healthy behaviours from “books and magazines,” “advice from family,” “information learned in peer groups,” and “lectures at the university.” The author also concluded that perceived health concern was negatively related to perceived health status and number of years in college. Even though the most common reason for not practising healthy behaviours was “time”, the low practising group more often chose “mental energy” and “personality” as perceived barriers to engaging in health-promoting lifestyle behaviours. This implies the need for more understanding of identity construction and specifically of positive personality factors that provide mental energy for the practice of healthy behaviours.

More recently, Lee and YuenLoke (2005) examined health-promoting behaviours of 247 university students in Hong Kong and found no gender differences in the dimensions of health responsibility, nutritional habits, spiritual growth, interpersonal relations, or stress management of HPLBs, but males scored higher than females in the dimension of physical exercise. Both genders scored quite low in the dimensions of health responsibility and physical activity. Implications were suggested around the issues of healthy environment and to support healthy choices for university students.

In Thailand, the HPLP II has not been widely used. Learned resourcefulness was found to correlate significantly with the total HPLP II among 80 Thai women with HIV (Boonpongmanee & Zauszniewski, 2003). Thai research into health-promoting behaviours among university students was reviewed by Trumikaboworn (2004). The author searched literature regarding health-promoting behaviours in Thai college students in various kinds of databases from 1989-2004 and found

thirty-three studies in English and fifty-seven studies in Thai. The results of the data analysis showed that college students engaged in physical activity at a low level due to their perceptions of, and attitude towards, exercise. Friends, and individual characteristics such as gender, perceived risk and perceived benefits were significant factors impacting on health behaviours. Low condom usage was the major health risk behaviour. Knowledge was not found to have a direct effect on health behaviours, but affected attitude toward health behaviours. Trumikaboworn remarks that the way that the health-promoting model and related models had been used in the Thai context was to emphasise correcting health risk behaviours and not to actually promote health. For examples, the Health Belief Model and the Theory of Reasoned Action (Fishbein & Ajzen, 1975) have been used to evaluate and design interventions for sexual behaviours and HIV/AIDS prevention in many studies (Baker, Rumakom, Sartsara, Rewthong, & McCauley, 2003; Buckingham, Moraros, Bird, Meister, & Webb, 2005; VanLandingham, Suprasert, Grandjean, & Sittitjai, 1995). The focus of this study was to explore factors influencing health-promoting behaviours in Thai college women.

SENSE OF SELF, IDENTITY, AND HEALTH-RELATED BEHAVIOURS

Identity or one's sense of self over time is accepted as an important component of well-being, and identity formation is described as a purposeful activity (Whaley & Ebbeck, 2002). One's sense of self is a product of social interactions as Burr (1995, p. 51) contended: "... our identity arises out of interactions with other people and is based on language ... our identity is constructed out of the discourses culturally available to us, and which we draw upon in our communications with other people." Therefore, it was asserted by Burton and Hudson (2001, p. 409) that "working from a self-construction perspective provides researchers and clinicians with the concept of identity salience, which can easily be used to identify and rank factors that are important for an individual's self-construction."

Burke and Reitzes (1991, p. 242) summarised the characteristics of identities as follows: first, identities are social products which are produced, maintained, and established through the process of naming or locating the self in social categories, interacting with others in terms of these categories. Second, identities are self-

meanings that are acquired in particular situations and are based on the similarities and differences of a role in relation to its counter-roles. Third, identities are symbolic, calling up in one person the same responses as are called up in others. Fourth, identities are reflexive. Persons can use their identities as reference points to judge the implications of their own behaviour as well as of other people's behaviours; this assessment is part of the reflected appraisals process. Finally, identities are sources of inspiration for action, particularly actions that result in the social affirmation of the identity. "The self becomes an active agent in interaction." (Burke & Reitzes, 1991, p. 242). Identities as active agents are conceptualised as cybernetic control systems.

Human beings act from their sense of self. The self as a collection of self-schemas is a concept proposed by Markus (1990) who states that "the self is a multidimensional, multifaceted set of structures that plays a critical role in organizing all aspects of behaviour." (p. 242). These structures are called *self-schemas*. Amongst a diverse array of representations about the self or the universe of self-representations, only some will become focal for each person and the targets of such intensive amplification are the self-schemas. The self-schemas will dominate consciousness and unconsciousness and are considered to be the "core" self (Markus,). The concept of sense of self or identity formation has been researched as having significant impact on health-related behaviours.

These concepts of sense of self have been used to study various kinds of health-related behaviours, for example prediction of repeated blood donation behaviour (Charng, Piliavin, & Callero, 1988); commitment and role performance in college students (Burke & Reitzes, 1981, 1991); the link to food choice (Bisogni, Connors, Devine, & Sobal, 2002); eating disorders (Hoskins, 2002); smoking (Lloyd, Lucas, & Fernbach, 1997); and exercise identity (Donnelly & Young, 1988; Whaley & Ebbeck, 2002). Achieving a sense of self or identity has also been proved to contribute to well-being (Kang, 2000; Meeus, 1996; Marigliani, 1997; Rukin, 1997). A range of measures of sense of self have been used to predict health-related behaviours. However, most studies linked to the identity formation of adolescents use a measurement based on Erikson's perspective, the Extended Version of the Objective Measure of Ego Identity Status (EOM-EIS) developed by Bennion and Adams (1986).

Based on Erikson's work (Erikson, 1959, 1968), Sheldon and Kasser (2001) defined identity strivings as the tasks in which the person seeks better self-understanding or self-knowledge, seeks to resolve role conflicts or confusions, or seeks greater autonomy and self-sufficiency. Maturity from an Eriksonian perspective begins from the late adolescent period where people begin to search for their own identities through various social roles. In this sense identity achievement is the primary step to mature adulthood.

According to Bennion and Adams (1986), the identity of late adolescence can be measured by the Extended Version of the Objective Measure of Ego Identity Status (EOM-EIS) tool in two distinct components; ideological identity and interpersonal identity. Drawing from Erikson's theory (Erikson, 1959, 1968), the term *ideological identity* is used to signify Erikson's construct of ego-identity, whereas the term *interpersonal identity* refers to Erikson's construct of self-identity. Ideological identity issues include occupation, religion, politics, and philosophical lifestyle. In contrast, interpersonal identity issues are composed of friendship, dating, sex roles, and recreation. Drawing from Marcia's (1966) work, the development of each type of identity can be measured in terms of achievement, moratorium, foreclosure, and diffusion which are defined along the dimensions of crisis and commitment, where crisis refers to the exploration of alternatives, and commitment refers to an investment in ideological and interpersonal issues.

As adolescents move into early adulthood, their identity statuses progress from identity diffusion (no crisis or commitment) and identity foreclosure (commitment without crisis) into identity moratorium (crisis without commitment) and identity achievement (crisis followed by commitment). In the sense of the EOM-EIS measurement, "identity-achieved individuals have gone through a period of exploration and have made identity-defining commitments." (Bergh, 2005, p. 1). Identity achievement refers to people who are characterised by emotional maturity, an ability to refuse to accept compliance to peer pressure, and psychological well-being. Healthy personality development is based on successful achievement of these tasks of ideological identity and interpersonal identity. Pastorino (1997, p. 1) provides the following definitions of exploration and commitment:

Exploration refers to a period of decision-making when previous choices, beliefs, and identifications are questioned by the individual and information of experiences related to alternatives are sought; commitment refers to the choice of relatively stable set of roles and ideals.

Archer (1989b) reviewed literature on identity formation and found that identity achievement and moratorium are more likely to be positively associated with desirable psychological characteristics such as autonomy, reflection, mature intimacy, self-esteem, post-conventional moral reasoning, cultural sophistication, and an internal locus of control. In contrast, identities of foreclosure and diffusion are more frequently associated with authoritarianism, pre-conventional and conventional moral reasoning, less self-directedness, an external locus of control, a preference for cognitive simplicity or disorganised cognitive complexity, and impulsivity.

Among 198 Western college students (Clancy & Dollinger, 1993), the four identity statuses were linked to five types of personality (neuroticism, extraversion, openness, agreeableness, and conscientiousness). While identity foreclosure was negatively correlated with openness to experience, identity achievement was found to involve low neuroticism (anxiety, hostility, depression, self-consciousness, impulsiveness, and vulnerability), and high conscientiousness. Moreover, identity achievers were found to be extraverted (warmth, gregariousness, assertiveness, activity, excitement seeking, and positive emotions). It is interesting that moratorium and diffusion identity were found to be positively correlated with neuroticism and negatively correlated with conscientiousness. Identity diffusion was also found to be correlated negatively with agreeableness. This knowledge confirms the merits of identity achievement for a healthy personality.

The EOM-EIS was constructed in the USA, and has been the only identity status measure used to explore cross-cultural differences between North-American and other contexts (Schwartz, Adamson, Ferrer-Wreder, Dillon, & Berman, 2006). While the EOM-EIS has been widely used in the various cultural contexts, and its structural integrity has been confirmed across ethnicity, such as among African-American, Caucasian, and Latino adolescents (Abraham, 1986; Forbes & Guarino, 2002); among a specific group of mentally retarded adolescents in Israel (Levy-Shiff, Kedem, & Sevilla, 1990); among female university students in Japan (Sugimura, 2001); among Turkish middle adolescents (Cakir & Aydin, 2005); late

adolescents in New Zealand (Kroger, 1990); and more recently among White American, Hispanic American, and Swedish adolescents (Schwartz et al., 2006); it has not been used with adolescents in the Thai context.

The measure has been used to predict health-related behaviours among adolescents in the USA, such as their initial substance use (Jones & Hartmann, 1988); death anxiety (Sterling & Van Horn, 1989); alcohol consumption (Bishop, Macy-Lewis, Schneklath, Puswella, & Struessel, 1997); and compulsory heterosexuality (Konik & Stewart, 2004). While HPLBs need exploration and commitment, to date, there is no study which focuses on the relationship between achievement of identity and HPLBs.

A study of the contributions of parent-adolescent relationship factors to the identity formation process in 174 students in the USA (Schultheiss & Blustein, 1994) found that greater levels of attitudinal dependence were associated with higher levels of ego identity commitment. Attitudinal dependence was associated with foreclosure status as well as identity achievement status. The extent of parental attachment was also a predictive variable in this study. High levels of attitudinal independence from both parents were associated with a tendency to avoid ego identity commitment, reflected in lower levels of foreclosure and achievement along with a greater level of diffusion. Attachment to one's parents in addition to a modest degree of conflictual independence from one's mother was associated with a greater tendency toward foreclosure and achievement identity along with a lesser degree of diffusion.

Identity development has been found to be gender different in a domain-specific manner. Pastorino (1997) in a study of 210 university students in the USA reported that men and women pay attention to exploration and commitment in different areas of ideological and interpersonal identity in the EOM-EIS measurement. This implies that gender-specific research is warranted for identity formation study. Similarly, Cella, DeWolfe, and Fitzgibbon (1987) suggested, on the basis of their study about ego identity status and decision-making style in US male and female late adolescents that "...study of both genders with the same measures and hypotheses is not recommended." (p. 1). Archer (1989a) also found that identity formation is subject to gender differences. Although Schwartz and Montgomery (2002) confirmed the consistency of identity structure across gender and levels of acculturation among 357 students at a culturally diverse university in the USA,

they suggested that identity interventions should emphasise gender and culture-related context.

The nature of problems of women's construction of sense of self has been researched. Sanford and Donovan (1984) reviewed six common problems related to women's self-esteem which included: (1) lacking knowledge of themselves and how they identify themselves; (2) minimising who they are and their importance; (3) perceiving themselves to be failure in most areas; (4) minimising the importance of things that they are good at; (5) experiencing events that have contributed to a new and lowered self-esteem which is named 'self-concept dislocation'; and (6) readjusting their own image of who they would like to be (Sanford & Donovan, 1984, p. 17). It is noted that "women who have a healthy sense of self will be healthier in a holistic way and will be able to better contribute to society as well as reap the benefits of good health" (Olshansky, 2000, p. 77).

SENSE OF COHERENCE AND WELL-BEING

There is evidence that in stressful life events, some people still stay well because of their strong sense of coherence (SOC) (Antonovsky, 1987). The salutogenic concept was developed to answer the question of what helps people stay well despite bad conditions. Antonovsky sought to explain successful coping with stressors in a study showing that 29% of an Israeli sample who had survived Nazi concentration camps were in good general physical and psychological health. SOC is defined as follows:

SOC is a global orientation—an enduring tendency to see the world as more or less comprehensible, manageable, and meaningful. The first component, comprehensibility, means the individuals experience events as structured, predictable, and explicable. The second, manageability, means that they have the resources to cope with the demands posed by changing events, and the third, meaningfulness, refers to perceiving these demands as challenges which are worth engaging with and investing energy to meet.

(Antonovsky, 1987, p. 19)

Comprehensibility, manageability, and meaningfulness are the three main components of SOC and the resources with which an individual may combat stress and resist illness.

Antonovsky (1987) constructed a measurement of SOC. The tool is composed of 29 items used for measuring the orientation to life of each participant. There are 11 items for measuring the dimension of comprehensibility, 10 items for manageability, and 8 items for meaningfulness. Having reviewed 26 Western studies, Antonovsky (1993) reported that undergraduates tend to have low SOC scores. The Cronbach alpha measure of internal consistency was reported between .85-.91 from those 26 Western studies. The Cronbach alpha was reported between .72-.86 from studies in the Thai context (Cederblad, Pruksachatkunakorn, Boripunkul, Intraprasert, & Hook, 2003; Chotikapong, 2006; Vanaleesin, 2002).

Antonovsky has suggested that many different cultural paths may result in similar levels of a SOC. This notion is confirmed in a study by Bowman (1997) who found that SOC was influenced by the different backgrounds of Native American families living in a rural reservation in Montana and Anglo American families living in North Dakota. The author suggests that differences between rural and urban environments may impact on levels of SOC and that there may be differing cultural paths in the development of SOC.

The measurement of SOC has been widely used in the Western context. SOC is related to both physical and emotional health. To date, most studies of SOC have been focused in relation to ill health. For example, in Sweden, middle-aged women reporting low SOC have lower HDL cholesterol and higher triglyceride levels, and report more clinical visits and medical symptoms than do women with higher SOC (Svartvik, Lidfeldt, Nerbrand, Samsioe, Schersten, & Nilsson, 2000). SOC is the strongest predictor of subjective health-related quality of life in HIV-infected patients of both genders (Cederfjall, Eklof, Lidman, & Wredling, 2001). In the study, the authors reported that participants with stronger SOC had lower rates of depression and anxiety, and reported higher levels of energy and positive well-being. For women with breast cancer, the stronger the SOC the more positive were the patients' emotional perceptions; perceived general health and mental well-being after surgery; and their perceived well-being before surgery was the strongest predictor of the patients' well-being postoperatively (Boman et al., 1999). The risk of coronary heart disease was studied in 4405 Finnish working men based on their occupation differences in an eight-year follow-up time. Poppius et al. (1999) found that high SOC had a salutogenic effect on promoting health in white-collar workers but not in blue-collar workers. It is more likely that the level of systolic blood pressure and smoking depend on occupation, while physical activity is strongly

associated with SOC. There is a high correlation between SOC and quality of life in a study on patients with coronary heart disease who survive cardiac arrest (Motzer, & Stewart, 1996). Recently, Surtees (2006) in the UK reported that SOC as a personal coping resource was specific to cancer mortality among 20,323 participants.

SOC as a factor promoting well-being has been observed to be gender different. Comparing the SOC scale in correlation with the Sixteen Personality Factor Questionnaire, Mlonzi and Strumpfer (1998), in South Africa, found high correlation between the two measurements, and females with high SOC had specific characteristics of Tough Poise and Independence. Lower SOC was also found to predict the low satisfaction of female patients with quality of care in a hospital in Sweden (Larsson, & Larsson, 1999). Even though the mean score of SOC was similar for male and female university students, a positive association between SOC and self-rated health was found only among female students (Von Bothmer & Fridlund, 2003). In the group of substance abusers in Norway, being a woman rating normally on the SOC scale and having a high degree of social integration in rehabilitation institutions were found as significant predictors of long-term survival (Andersen, & Berg, 2001). Women who have low SOC and have low decision latitude at work are associated with type 2 diabetes and insulin resistance regardless of the level of demand at work in Sweden (Agardh, Ahlbom, Andersson, Efendic, Grill, Hallqvist et al., 2003).

The level of SOC seems to affect women's health more than men's. A 4-year follow up study of 577 municipal male and female employees by Kivimaki, Feldt, Vahtera, and Nurmi (2000) in Finland, supported the stability of SOC over time in a normal working population in both sexes, but the prediction of SOC on health and sickness absence rates showed a prominent gender difference. SOC did not predict the sickness absence rate in men whereas low SOC predicted the sickness rate in women. They found no difference in the development of health between individuals with a high SOC and those with a moderate or low SOC and argued that at a general level SOC played a more pronounced role in women's than in men's health. No support was found for the proposed salutogenic function of SOC (Kivimaki et al., 2000). Even more interesting was the finding that SOC associated very strongly with psychological complaints and pathogenic factors of depression and anxiety. Based on a secondary review, Geyer (1997, p. 1771) commented that "very high negative correlations between SOC and depression/anxiety suggest that

the instruments used may assess the same phenomenon, but with inverse signs.” However, among patients with lumbar spinal stenosis, low SOC is an important correlate of depression (Sinikallio, Aalto, Airaksinen, Herno, Kröger, Savolainen, et al., 2006) as well as in people experiencing multiple trauma (Snekkevik, Anke, Stanghelle, & Fugl-Meyer, 2003). Sense of coherence and social support have been reported to be crucial moderators of the recovery among patients with major depression (Skärsäter, Langius, Agren, Häggström, & Dencker, 2005). SOC has been shown to predict variance in hope and depressive symptoms in a population of college students (Mascaro & Rosen, 2005); depression among separated women living with their children (Stewart & Cornell, 2003); and depression and burnout in a group of nursing staff (Tselebis et al., 2001). In general, SOC has been found to have moderating or mediating effects in the explanation of health (Eriksson, & Lindström, 2006).

In the Thai context, SOC has been used to predict sense of burden among 566 caregivers of people with schizophrenia. Education and income had direct positive effects on the SOC of the caregivers and indirect effect on caregiver burden (Pipatananond, 2002). In a study of SOC in a Thai sample, adults, parents and grandparents from 456 families had mean score of SOC of 143.38. Half of these adults were from north and half of them were from northeastern Thailand, both rural and urban areas (Cederblad et al., 2003). This average score was in the middle range compared to the normative data reported from 26 Western studies reviewed by Antonovsky (1993).

The relationship between SOC and health-promoting behaviours has been studied among healthy people and patients in some settings. In a study of 228 adult males and females in rural industrial sites in the USA, using the HPLP, SOC, and Perceived Health questionnaires, Johnsen (1992) found that strong SOC was present in individuals who engaged in health-promoting behaviours and perceived themselves as healthy; and that many participants saw work as a health-promoting behaviour. For white-collar working men, physical activity has been reported to depend strongly on SOC (Poppius et al., 1999). Among 120 colorectal cancer patients in Thailand, it was found that SOC and perceived benefits of HPLBs could predict 52 % of the variance in HPLBs (Suteerawut, 2001). More recently, SOC was found to have moderately positive relationship with psychosocial adaptation among high school students in northern Thailand (Chotikapong, 2006). In Hong Kong, Shiu (2001) found that public health nurses with high SOC were more likely

to maintain emotional well-being and positive affect while being interrupted in the face of work-family juggling and more likely to perceive tasks as progressing and to be within control. In Finland, in a study with 3,403 participants, those who engaged in regular physical exercise showed higher levels of SOC than those who did not (Hassmén, 2000). Among Canadian women ($n=6748$), SOC was shown to be a psychosocial factor that affected their income and health, but did not buffer the adverse effects of low income on health (Ing, 2003). It has been confirmed that SOC, although it does not alone explain overall health, seems to be a health-promoting resource (Eriksson & Lindström, 2006). Its contribution to engagement of adolescents in health-promoting behaviours has not been well confirmed.

It is accepted that healthy lifestyle behaviours are learned early in life, consolidated in adolescence, and then persist in adulthood (Perry, Griffin, & Murray, 1985). Thus the period of adolescence is the time to firmly develop core identity, values, and sense of self in order to develop a healthy personality (WHO, 2004). However, little is known about whether adolescents' identity formation and SOC are correlated to their HPLBs.

Kindig and Stoddart (2003) suggest that population health may be defined by focusing on the independent variables (the multiple determinants) or the dependent variables (health outcomes), but the more appropriate way to think about population health is to address both the definition and measurement of health outcomes and the roles of determinants. In this research I examined the roles of some socially constructed determinants that impact on health behaviours among late adolescent Thai college women. A theoretical framework for the research based on this literature review is presented in Figure 2.1. Sense of coherence and positive sense of self along with the commitment to engage in health-promoting lifestyle behaviours have been demonstrated to promote well-being (Boman et al., 1999; Kang, 2000; Pender, 1987; Rukin, 1997; Walker et al., 1987). Those relationships are represented by the solid arrows in the theoretical framework. The contribution of sense of coherence and sense of self to wellness via HPLBs among college women in northeastern Thailand is less clear – as represented by the dashed arrows in the framework. The impact of the cultural context is also questioned.

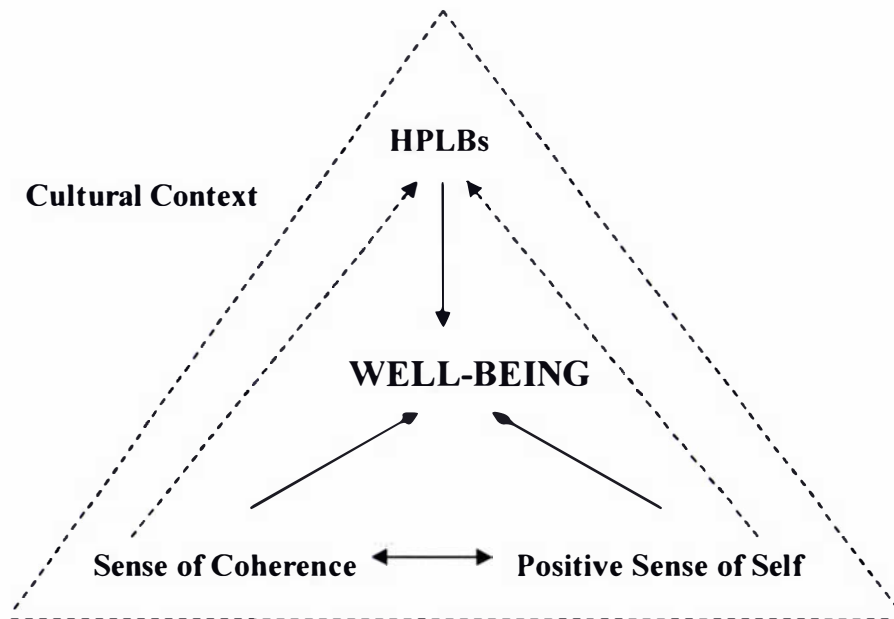


Figure 2.1 Theoretical framework of factors impacting on HPLBs

CONCLUSION

Although sense of coherence and sense of self have long been studied for their merits to contribute to people's well-being in various stages and settings, there is a gap of knowledge, especially in the Thai context, as to the extent to which these variables help healthy women commit to health-promoting lifestyle behaviours and how this is impacted by the cultural context. The bio-medical perspective with its emphasis on curing provides no means for promoting health. Shifting our perspective to the salutogenic standpoint may help complement health care knowledge. There is evidence that achieving a sense of self is necessary for well-being. However, little is known about how young Thai women form their perspective for their lives and the society they live in, especially, college women in whom society has invested, in terms of full formal education. This group of educated young Thai women is considered to be an important resource for social development. Learning of their self constructs in the Thai context by exploring the relationship between sense of self, SOC, and HPLBs in a cross-sectional survey, then exploring their sense of self and behaviours in-depth, would provide essential clues for nursing and nursing education.

The presumptions I brought to the conducting of this research were based on Western constructs that have been presented in this chapter and tested in the first phase of this research. As a result, readers will inevitably see literature that has not been presented in this chapter when reading through the results of the second phase of the research. This is because the themes that emerged from the qualitative study have raised some new issues for me to search for in literature for comparison and discussion. Another presumption brought to this study was that sense of self and health behaviours were the products of social interactions, so they were believed to be socially constructed. The next chapter provides the philosophical perspective underpinning the study and the sequential mixed method research design.

CHAPTER 3

CONSTRUCTING AN APPROPRIATE METHODOLOGY

The purpose of this research was to understand factors that could be used to promote young Thai college women's health-promoting lifestyle behaviours. A sequential mixed methods design was selected to enable firstly a deductive exploration of the relationships between measures of sense of coherence, identity status and health-promoting lifestyle behaviours in Thai college-aged women (Study A), followed by an inductive analysis of the impact of the Thai cultural context on the motivation of college-aged women to engage in health-promoting lifestyle behaviours (Study B).

In this sequential mixed methods study I used both cross-sectional research methods and qualitative in-depth interviews within a social constructionist lens of inquiry. In this chapter I explore the paradigmatic bases for mixed methods research and provide a rationale for the use of social constructionism as an epistemological stance for the research. Mixed methods research design is reviewed and the theoretical drive (Morse, 2003) for the mixed methods design is clarified. An overview of the two-part research design is provided. Details of methods utilised in Study A and Study B are described in Chapters 4 and 5 respectively. Ethical considerations pertaining to both parts of the research are discussed in this chapter.

PARADIGMATIC ASSUMPTIONS

A *paradigm* has been defined as the basic belief system that guides the researcher both in choices of method, and in ontologically and epistemologically fundamental ways (Guba & Lincoln, 1994). More recently, Morgan (2007) reviewed this understanding of paradigm, identifying it as one of three major versions of the concept of paradigm discussed by Kuhn (1970) and the most widespread version within social science research. In particular he criticised the prioritising by Guba and Lincoln of ontology and issues related to the nature of reality and truth, which Morgan viewed as imposing constraints on subsequent epistemological

assumptions about the nature of knowledge. Morgan identified four nested versions of the concept of paradigm: paradigms as worldviews; paradigms as epistemological stances; paradigms as shared beliefs in a research field; and paradigms as model examples. Morgan comments: “although paradigms as epistemological stances do draw attention to the deeper assumptions that researchers make, they tell us little more about substantive decisions such as what to study and how to do so” (p. 52).

All paradigms are human constructions. As Guba and Lincoln (1994, p. 108) comment:

They are all inventions of the human mind and hence subject to human error. No construction is or can be incontrovertibly right: advocates of any particular construction must rely on *persuasiveness* and *utility* rather than *proof* in arguing their position.

Greene and Caracelli (2003, p. 95) suggest that researchers should think about each paradigm “... as having its own coherent set of assumptions and stances but not intrinsically bound to a particular set of methods or techniques.” Thus a researcher could use mixed methods regardless of the paradigmatic perspective.

Greene and Caracelli (2003, p. 107) further suggest that inquiry decisions should be grounded primarily in the nature of the phenomena being investigated and the contexts in which the study is conducted. This approach is consistent with the work of Morgan (2007) who proposes a more pragmatic approach to epistemology and methodology in the social sciences.

The pragmatic approach ... would concentrate on methodology as an area that connects issues at the abstract level of epistemology and the mechanical level of methods.... A pragmatic approach would treat issues related to the research itself as the principal “line of action” that methodologists should study, with equal attention to both the epistemological and technical “warrants” that influence how we conduct our research” (p. 68).

Morgan (2007) also argued for attention to how the researchers’ worldviews influence the research that they do. In the following section justification for the use of a social constructionist lens for this study, consistent with the pragmatic approach proposed by Morgan is provided.

SOCIAL CONSTRUCTIONISM

Constructionism is defined by Crotty (1998, p. 42) as: “ ... the view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context.”

Crotty argues:

It is clearly not the case that individuals encounter phenomena in the world and make sense of them one by one. Instead we are all born into a world of meaning. We enter a social milieu in which a ‘system of intelligibility’ prevails. We inherit a ‘system of significant symbols’. For each of us, when we first see the world in meaningful fashion, we are inevitably viewing it through lenses bestowed by our culture. Our culture brings things into view for us and endows them with meaning and, by the same token, leads us to ignore other things.

(Crotty, 1998, p. 44)

In relation to health and illness, Lupton (1994, p. 11) suggests a constructionist approach does not “... call into question the reality of the disease or illness states or bodily experiences, it merely emphasizes that these states and experiences are known and interpreted via social activity and therefore should be examined using cultural and social analysis.” Health issues are social constructs (Lupton, 1994) and sense of self is socially constructed also (Berger & Luckmann, 1966). Social constructionism does not deny human agency; rather both the power of human agency and the impacts of the context on identity and behaviours have to be taken into account.

For social constructionists, meaning is not discovered but constructed (Crotty, 1998). Crotty’s claim is echoed by Minichiello, Madison et al. (1999, p. 396), when they state: “...people’s stories are social constructs, which are created and sustained through social interactions, at both the personal and macro level of society.” Chamberlain, Camic, and Yardley (2004, p.74) clearly articulate the position that underlies this study that the data are “a constructed account of experience, given for a specific purpose within a particular context: an account that may differ from occasion to occasion, and which is constructed to present this person in a particular light to this particular researcher.”

As a Thai researcher undertaking doctoral studies in a Western context, yet focusing on issues of importance to me in my home location, social constructionism has provided a useful interpretive lens for me as a researcher, helping me to see my own cultural context and the ongoing movement of the world in different ways and to engage in more critical thinking. Social constructionism guided the choice of the mixed methods design used in this research. At the outset, it provided an inside-out way of thinking for developing a plan of the study and helped me work with the research questions. Inside-out thinking means I was, in the first phase of asking the questions and doing the research, a person in the whirlpool of the phenomena, seeing things as an insider and looking for the explanation outside. Thus in Chapter 2 I reviewed the existing knowledge about sense of coherence and sense of self and identified the gap in knowledge as to the extent to which these variables help healthy women commit to health-promoting lifestyle behaviours. In Study A I used validated measures to test those relationships as outlined in Chapter 4. A social constructionist lens prompted me to enquire how these phenomena might be impacted by the cultural context. The use of the in-depth interviews in Study B enabled me to acquire a fuller understanding of the phenomena under study.

Using a social constructionist lens as I analysed the qualitative data, interpreting and understanding the phenomena under study, led to an outside-in viewpoint to be aware of the taken-for-granted nature of the context I had been in. My awareness had been raised and I had moved a little bit further to see the big picture of the whirlpool I had been in. As Gergen (1985) acknowledges, social constructionist accounts enable the researcher to escape the confines of the taken for granted.

These philosophical perspectives underpin the research design presented in the next section, and also provide the lens for data interpretation in the last chapter. In the following section I review mixed methods research design.

MIXED METHODS RESEARCH DESIGN

Mixed methods research has evolved as a third methodological movement over the past three decades, parallel to the ‘qualitative revolution’. This development, and the issues and designs in mixed methods research, were summarised by Tashakkori

and Teddlie in 1998 and further elaborated in an edited handbook of mixed methods in 2003. Mixed methods research design has been defined as follows:

A mixed methods study involves the collection or analysis of both quantitative and/or qualitative data in a single study in which the data are collected concurrently or sequentially, are given a priority, and involve the integration of the data at one or more stages in the process of research.

(Creswell, Clark, Gutmann, & Hanson, 2003, p. 212)

The term *mixed methods research design* is usually restricted to studies that include research strategies that are not normally included as part of the base design, but that increase the scope or comprehensiveness of the study (Morse, 2003). Sandelowski (2003, p. 328) suggests two purposes for the use of a mixed methods design, firstly to achieve a fuller understanding of a target phenomenon, and secondly verify one set of findings against the other. The purpose for using a mixed method design for this research was to achieve a fuller understanding of the phenomena under study. The process of refinement of quantitative constructs was not possible without the qualitative exploration of these concepts of sense of self and health-related behaviours from a cultural perspective.

Teddlie and Tashakkori (2003) concluded that there are three advantages when using a mixed methods design for research. First, it can provide answers to the research questions that the other methodologies cannot. Second, it provides stronger inferences. Finally, it provides the opportunity for presenting or merging a greater diversity of divergent views.

A number of typologies of mixed methods research designs have been developed. Such typologies help to legitimise the field and provide organisational structure, although it has been suggested that currently such typologies provide multiple competing organisational structures (Teddlie & Tashakkori, 2003). Typologies help researchers to understand the diversity of mixed method studies and make decisions about their own study, however as Maxwell and Loomis (2003) point out the actual diversity in mixed methods studies is far greater than any current typology can adequately encompass.

The two-part design of this study can be classified as a sequential mixed methods research design (Tashakkori & Teddlie, 2003).

This design involves one type of question (exploratory or confirmatory, QUAL or QUAN), two types of data (QUAL and QUAN) that are collected in sequence (with one being dependent on the other, e.g., selecting extreme cases) and analyzed accordingly, and one type of inference at the end ... The second strand of the study emerges as a response to or during the data analysis of the first strand. In other words, this design is mixed in its data collection and analysis phase only.

(Tashakkori & Teddlie, 2003, p. 687)

In sequential mixed method design, the second phase of the study is designed as a result of, or in response to, the findings of the first phase (Tashakkori & Teddlie, 2003). Based on the stage of integration, this design integrates research tasks in its data collection and analysis phase, while research questions are asked at first simultaneously for the two phases of research. Figure 3.1 illustrates the flow diagram of tasks in this kind of research design.

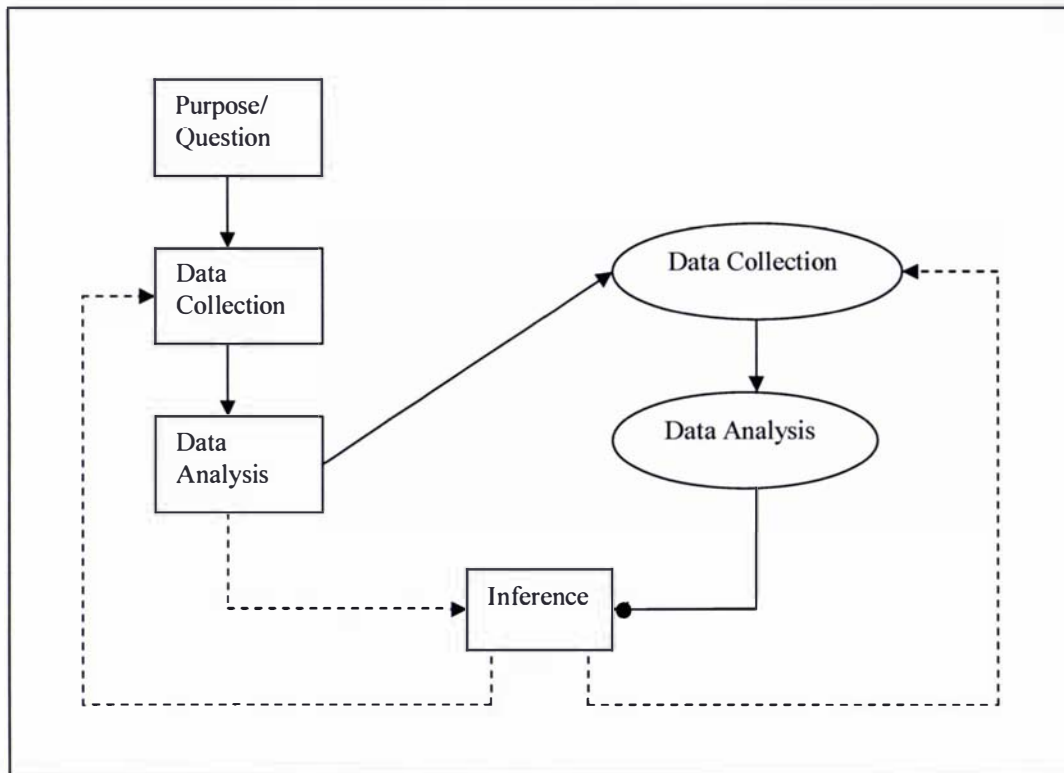


Figure 3.1 Diagram of sequential mixed method design
(Tashakkori & Teddlie, 2003, p. 688)

The questions in this study were exploratory. In Chapter 2 I demonstrated limited evidence in the literature for relationships between SOC, identity status and HPLBs; moreover I was curious as to the applicability of these Western constructs in the Thai context. The priority of approach (Cresswell, Clark et al., 2003), or as Morse (2003) terms it the “theoretical drive” of the research was therefore inductive.

If the purpose of the research is to describe or discover, to find meaning, or to explore, then the theoretical drive will be inductive. The method most commonly used will be qualitative.... Quantitative methods may also be used for exploratory purposes with an inductive theoretical drive (sometimes referred to as “fishing trips”) such as exploratory factor analysis or a survey. The direction of the researcher’s thinking when conducting a single study might not be continuously inductive – adductive thinking may be used to verify hunches or conjectures – but overall the major theoretical drive will be inductive. (p.193)

In the implementation of mixed methods research it is important to clearly identify the reasons for collecting both forms of data, and to understand the interrelationship between the quantitative and qualitative phases in data collection (Cresswell, Clark et al., 2003). In sequential mixed methods research designs with an inductive theoretical drive it is usually assumed that the qualitative strand will precede the quantitative strand (Cresswell, Clark et al., 2003; Morse, 2003). In this study the quantitative strand preceded the qualitative strand for two reasons. First, because little was known about levels of health-promoting lifestyle behaviours amongst college-aged women in Thailand; second, because the study had been designed to purposively select for qualitative interviews, participants who scored highly on their health-promoting behaviours. Study A therefore provided a supplemental strategy (Morse, 2003) in the research project. Quantitative supplemental strategies increase the scope and comprehensiveness of a qualitative study.

First, they may be used to identify notions, ideas, or concepts that are then incorporated into the main study. Second, they may provide different information or insights as to what is happening in the data as well as different explanations or ideas about what is going on – ideas that are subsequently verified within the data or used to guide subsequent interviews or the collection of additional information to verify emerging theory. Third, they may be used to reexamine a category in the main study from a different perspective.

(Morse, 2003, p. 192-193)

As previously outlined there were two studies in this research. Study A follows the conventions of quantitative research and Study B follows the conventions of qualitative research.

THE RESEARCH PROTOCOL

To achieve the three aims of the research, multistage sampling was applied to obtain the sample for this research (Schofield & Jamieson, 1999). All sampling methods utilised in this research were non-probability sampling. College women in their third year or fourth year of college study in northeastern Thailand were the population of the research.

Study A: A quantitative study design was applied to explore the extent to which SOC and identity statuses predict health-promoting lifestyle behaviours. Three instruments were used with 350 participants gained by quota sampling in four colleges in Udonthani Province. The three instruments were the Health-Promoting Lifestyle Behaviors Profile II (HPLP II), the Extended Version of the Objective Measure of Ego Identity Status (EOM-EIS), and the Sense of Coherence Questionnaire (SOC-29). Statistical analysis was used to test predictors for health-promoting lifestyle behaviours in this group of young college women. The scores from the HPLP II also enabled identification of participants with high scores who were willing to participate in Study B.

Study B: A qualitative approach was applied in which in-depth interviews with 25 participants were conducted: 11 participants were purposively sampled from Study A participants with the highest scores on the HPLPII and 14 students were convenience sampled from various faculties in Ratchapat University in Udonthani Province and Khon Kaen University. Data-driven thematic analysis was used to inductively analyse themes. The details of methods for each study are presented in Chapters 4 and 5 respectively.

ETHICAL CONSIDERATIONS

The Massey University Human Ethics Committee approved the mixed methods research (MUHEC: PN Protocol 03/128). Permission was obtained from the four colleges in Udonthani Province, to approach students during their free time in college to explain the research project and invite them to participate in answering the questionnaires or in interviews. An information sheet in Thai was handed out to interested student participants in each study (for details of the information sheet, see Appendix 6). Return of the questionnaire implied consent to participate in Study A; for Study B written consent to participate was obtained (for details, see Appendix 7). The participants had the right to refuse to join the study and to stop the tape-recording during the interviews at any time. Collected data were kept anonymous. Refreshments were provided to participants. Permission was not sought from Khon Kaen University to recruit additional students for in-depth interviews who had not been part of Study A. Rather, the students were approached in their free time in public places where college women go for their daily life activities, like libraries, cafeterias, public parks, joss houses, and temples.

Although I was known as a teacher in the nursing college, BCNU (on leave to undertake doctoral study), the nurse students realised that I, as the researcher, had no influence on their studies. Prior to all interviews, rapport was established and a non-judgmental and neutral position was maintained throughout the processes (Parsons, 1999). The participants were informed that recommendations concerning education policy and health promoting strategies for Thai women would arise from the study. Identifying the importance of participants' contribution to knowledge in this way was an altruistic appeal conveyed to participants (St John, 1999). And obviously, I informed them verbally and in the information sheet that "I am doing this research project as a doctoral student enrolled at Massey University." They would know that their cooperation would help me obtain a doctoral degree, but I had done my best to make the study useful for the Thai context by not conducting the research in New Zealand, in a Western context. They appreciated that.

Establishing rapport and credibility provided a safe environment in which they could freely share their experiences. Rapport was established in different situations. The strength (vigour) points were that: the researcher as a Thai woman approached the Thai women as participants; the communicative skill of both sides was capable of dealing with the necessary level of academic and abstract communication; the researcher, introduced as a nurse, was traditionally accepted in the society; the

participants in Study A were accessed from their peers trained as research assistants; and women have a nature of cooperation. These made gaining agreement to participate from these college women not a difficult issue in this study. Though establishing relationships as a major aspect of the field study was kept in my mind in all circumstances. This was performed by clearly explaining about the background and the aims of the research project, respecting the rights of the participants, and expressing good will of the intention to make use of the research to some extent to benefit society as well as reinforcing a feeling of a key informant whose data would be useful for understanding further knowledge about the studied social phenomena, and always responding from a non-judgmental position throughout participation. All participants' personal information was kept confidential.

MAKING INFERENCES FROM MIXED METHODS RESEARCH

The findings of both qualitative and quantitative data were integrated during the interpretation phase (Creswell, Clark et al., 2003). The quantitative results were used to assist or embellish the interpretation of qualitative findings to explore the phenomena under study. Inferences were made at the end stage of the research. "Inferences are integrated and internally consistent sets of statements about the phenomena, events, people, and/or constructs under study." (Tashakkori & Teddlie, 2003).

The inference quality of mixed methods research should include two important aspects. The first is *design quality*, which means the methodological rigour of the mixed methods research, and the second is the *interpretive rigour*, which means the accuracy or authenticity of the conclusions. The term *inference transferability* is used for both the quantitative research term *external validity* and the qualitative research term *transferability* (Teddlie & Tashakkori, 2003). Accordingly, it is suggested that:

... inference transferability is relative. That is, no research inference in social and behavioral sciences is fully transferable to *all* (or even most) settings, populations (of entities, people, texts, etc.), or time periods. On the other hand, we believe that any inference has *some* degree of transferability to other settings, populations or times.

(Teddlie & Tashakkori, 2003, p. 42)

This means that not all inferences from this research can be transferred to other settings, a future period of time, or other populations. Nevertheless, the inferences would be useful for implementation in the area of health promotion and nursing education. Future research is always needed to continue the tasks of social development.

CONCLUSION

In this chapter I have provided an overview and justification of decision making around the selection and design of research methodology in this study. This sequential mixed methods study utilised both cross-sectional research methods and qualitative in-depth interviews within a social constructionist lens of inquiry. The chapter included an exploration of the paradigmatic bases for mixed methods research and provided a rationale for the use of social constructionism as an epistemological lens for the research. Mixed methods research design was reviewed and the priority or theoretical drive for the mixed methods design was clarified. An overview of the two-part research design was provided including sampling, ethical issues and the basis for making inferences from the study. In the chapter that follows the design, methods and results of Study A are detailed.

CHAPTER 4

STUDY A: DESIGN, METHODS, AND RESULTS

Study A seeks to determine: (a) the degree to which Thai college women say that they engage in health-promoting lifestyle behaviours (HPLBs), (b) the degree to which sense of coherence (SOC) and identity statuses are related to the rate of their engagement in HPLBs, and (c) if significantly related, the extent to which SOC and identity statuses predict HPLBs. Sense of coherence, identity status, and health-promoting lifestyle behaviours were the core variables of interest in Study A, therefore the next section provides details of the three instruments used to measure these variables in the study. This will be followed by details of the pilot study conducted to evaluate the wording and assess the internal consistency of these instruments. Participant selection for Study A, data collection, analysis and results are presented, followed by limitations and a brief discussion of the study.

STUDY A: PREDICTION OF HEALTH-PROMOTING LIFESTYLE BEHAVIOURS

The questionnaire used in this study consisted of three standardised instruments and six demographic questions. Details of the three instruments are as follows.

INSTRUMENTS

The instruments used in Study A were the Health-Promoting Lifestyle Behaviors Profile II (HPLP II) (Walker et al., 1987), the Extended Version of the Objective Measure of Ego Identity Status (EOM-EIS) (Bennion & Adams, 1986), and the Sense of Coherence questionnaire (Antonovsky, 1987). Details are as follows:

The Health-Promoting Lifestyle Profile II (HPLP II)

The HPLP II assesses the rate at which respondents assert that they engage in HPLBs (For details, see Appendix 8). The HPLP II is a 52-item instrument that yields six dimensions as subscales of HPLBs, which include spiritual growth (9 items), health responsibility (9 items), physical activity (8 items), nutrition (9

items), interpersonal relations (9 items), and stress management (8 items). The format of the scale for all items is scored on a 4-point Likert scale: 1 = *never*, 2 = *sometimes*, 3 = *often*, and 4 = *routinely*. The term *routinely* is used because it suggests a regular pattern of behavior characteristic of life-style (Walker et al., 1987). The mean score of the total HPLPII as the frequency of engaging in HPLBs was obtained by dividing the total score of the individual by 52. The mean scores of its six subscales were obtained by dividing the total score of the individual in the dimensions of spiritual growth, health responsibility, physical activity, nutrition, interpersonal relations, and stress management by 9, 9, 8, 9, 9, and 8, respectively. The total mean score of the HPLP II was used as the dependent variable in the regression analysis. Mean scores for the six subscales are reported to describe the degree to which participants said that they engaged in various health-promoting behaviours.

The Sense of Coherence Questionnaire (SOC Questionnaire)

The Sense of Coherence Questionnaire developed by Antonovsky (1987) is composed of 29 items used for measuring orientation to life across three dimensions: comprehensibility (11 items), manageability (10 items), and meaningfulness (8 items) (For details, see Appendix 9). A 7-point Likert scale is used. The participants were asked to identify the response which best expressed their feeling. For analysis, 13 items were reverse scored so that a higher total score indicated a stronger level of SOC in all instances. According to Antonovsky's suggestion, the three aspects of SOC are to be treated as a whole and not analysed separately. The participants' scores represent their overall level of SOC. The total score from the SOC-29 was assessed for use as an independent variable to predict total HPLP II in the regression analysis.

The Extended Version of the Objective Measure of Ego Identity Status (EOM-EIS)

The EOM-EIS developed by Bennion and Adams (1986) is an identity instrument designed to measure ego identity status across two domains: ideological (occupation, politics, religion, and philosophical lifestyle); and interpersonal (friendship, dating, sex roles, and recreation) on four types of identity (achievement, moratorium, foreclosure, and diffusion) yielding 8 subscores with each subscore measured by 8 items. Thus, the scale includes a total of 64 items, 16 items for each identity status. Participants respond to questions on a 6-point Likert scale (from 6 = *strongly agree* to 1 = *strongly disagree*) (For details, see Appendix 10). The four

types of identity status included in the instrument are (a) identity achievement (commitment to a choice based on exploration of alternatives); (b) identity moratorium (currently exploring choices but not yet committed); (c) identity foreclosure (committed based on little or no exploration of alternatives; and (d) identity diffusion (lack of exploration and commitment). The subscores for each identity status were assessed for use as independent variables to predict total HPLP II in the regression analysis.

All instruments were modified for the study population initially by literal translation into Thai by the researcher. To ensure language consistency, the instruments were back translated into English by a linguistics expert who was a native Thai speaker and had not seen the original version. The back translated copy was compared with the original English version by the investigators to identify language incongruities (Ma'aitah, Haddad, & Umlauf, 1999). The Thai translation was adjusted with corrective retranslation prior to utilisation. A pilot study was conducted to assess internal consistency or reliability of the three instruments and evaluate their applicability for this group of Thai college women.

THE PILOT STUDY

A pilot study was conducted before Study A took place. The Thai versions of all instruments were used with a group of college women who speak Thai as their native language.

AIMS

The aims of the pilot study were to assess the reliability of the three instruments (HPLPII, EOM-EIS, and SOC) used in Study A and to identify any further changes which may be required in the wording of these instruments.

THE PILOT PARTICIPANTS AND PROCESS

Fifty-six female senior students studying at Boromarajonani College of Nursing, Udonthani, were invited to participate in the pilot study. Information sheets were handed out to all participants before the questionnaire was administered. Open discussion of the items was allowed during the administration of these instruments to ensure shared understanding. Wording was adjusted in the instruments following this pilot. Language modifications were suggested from the pilot participants for

items 13, 15, 31, 45, and 48 for the HPLP II and for items 2, 4, 13, and 32 for the EOM-EIS. No language change was suggested from the pilot participants for the SOC questionnaire.

RELIABILITY

The Cronbach alpha was used as a measure of internal consistency with each instrument (For details of all Cronbach alphas, see Appendix 1). The Cronbach alpha recorded for the Thai version of the instruments was .86 for the total scale of the HPLP II, and ranged from .50 to .76 for its six subscales. The Cronbach alpha for the total score of SOC was .84. The Cronbach alpha for the EOM-EIS was .79 for the total score, and ranged from .42 to .81 for its eight domains of the ideological and the interpersonal identity. These scores compared with the Cronbach alphas ranging from .79 to .94 for the HPLP II, from .85 to .91 for the SOC questionnaire, and from .58-.75 for the EOM-EIS which were reported when constructed in English by native English speakers (Antonovsky, 1993; Bennion & Adams, 1986; Walker et al., 1987). The Cronbach alpha levels of the three instruments in this study indicated good internal consistency and were acceptable.

In the case of the EOM-EIS, the lowest Cronbach alpha in this study was found in the domain of interpersonal identity moratorium (.42). The reason for this low level of reliability is not known, however, modification of language and further investigation of the content validity may be warranted. As noted by Schwartz et al. (2006), language and cultural issues may affect mean scores obtained in cross-cultural and cross-ethnic groups.

STUDY A

PARTICIPANTS

The sample for Study A was obtained by using quota sampling. Quota sampling is defined as “a non-probability sampling strategy in which various strata are identified by the researcher who ensures that these strata are proportionately represented within the sample to improve its representativeness.” (Gray, 2004, p. 404). According to Tabachnick and Fidell (1996, p. 132), for multiple regression the sample should be $n > 50 + 8m$ (where m = number of independent variables; there were nine independent variables in this study, sense of coherence and the eight domains of identity statuses, so it targeted up to 122 participants). There are four colleges representing the undergraduate study level in Udonthani Province.

The quota sampling method was applied in this study because participants had to represent late adolescent college women who were the population of interest. The formula of sample size which targeted approximately 122 participants was applied for each college. The criteria for inclusion of the participants were:

1. Thai college women studying in colleges in Udonthani Province in the academic year 2003-2004.
2. Participants were senior students (year three or year four) at the time.
3. They were willing to participate in the study.

Three hundred and fifty participants were obtained from the four colleges in Udonthani Province. The sample size exceeded that needed to conduct the multiple regression analysis for the population which is suggested to be ≥ 122 ($n > 50 + 8m$ where m = number of independent variables). The sample size was not very large or very small. This could avoid type I error which occurs when the correlation between aspects does not actually exist but statistical correlations are found (Peat, Mellis, Williams, & Xuan, 2002). In sum, Study A gained 100 participants (actual total population) from third and fourth year student nurses from Boromarajonani College of Nursing, 120 senior students from Ratchapat University (total population was 1,270), 108 senior students from the Technology Ratchathani Institute (total population was 180), and 22 senior students (total population was 24) from the College of Physical Education.

DATA COLLECTION

Four senior students from Ratchapat University, two from Technology Ratchathani Institute, and one from Boromarajonani College of Nursing were hired as research assistants. They were trained to explain the aims of the study while handing out the information sheet to interested students (for details of the information sheet, see Appendix 6). They were also trained to explain the meaning of each question in the instruments where necessary, and collect the questionnaires from those participants in this study. The hired research assistants read the information sheet and understood the ethical issues involved. Questionnaires were collected anonymously.

Information sheets and questionnaires were handed out to participants. Participants were allowed to take the questionnaires home to complete and return them to the research assistants from each institute on an appointed date. In this sense, the participants would have a choice of times, dates, and venues for completion of the

questionnaires. Completion of questionnaires implied consent. They were informed that they had the right to decline to participate or answer any particular questions, or withdraw from the study by not handing in the questionnaires.

DATA ANALYSIS

Data were analyzed using SPSS Version 10.0 for Windows. Cases in which responses to more than 3 of the items on each instrument were missing were eliminated from the sample. When three or fewer item responses were missing, sample median values were substituted prior to analysis to maximise sample size (Walker, Kerr, Pender, & Sechrist, 1990). These made up to a total of 350 participants after some questionnaires were separately cut out because of their incompleteness. However, only eleven participants (nine from Technology Ratchathani Institute and two from the College of Physical Education), 3.05 % of all initial participants (361), were cut out.

The three instruments yield scores on ordinal scales. The nature of an ordinal scale is that: 1) data categories are mutually exclusive, 2) data categories have some logical order, and 3) data categories are scaled according to the amount of the particular characteristic they possess (Hinkle, Wiersma, & Jurs, 1979, p. 7). According to Hinkle et al., correlations were assessed using Spearman's rho correlations for two variables both of which are measured on ordinal scales. The correlations were run first to determine which variables met the criteria for inclusion into the regression analysis as independent variables. At a minimum, any variable entered had to be significantly correlated with the dependent variable.

Hierarchical multiple regression was used to address how well a set of scores from the SOC and the EOM-EIS questionnaires were able to predict the rate of engagement in HPLBs using the score from the HPLP II. Multiple regression can provide information about the model as a whole (overall scales), and the relative contribution of each of the variables or subscales (Pallant, 2001). The purpose of a regression analysis is to estimate the response variable y (the HPLP II) for a specific value of the independent variable x (SOC and four identity statuses or eight domains in identity statuses) (Freund & Wilson, 1997). In sum, predictions are shown in Figure 4.1.

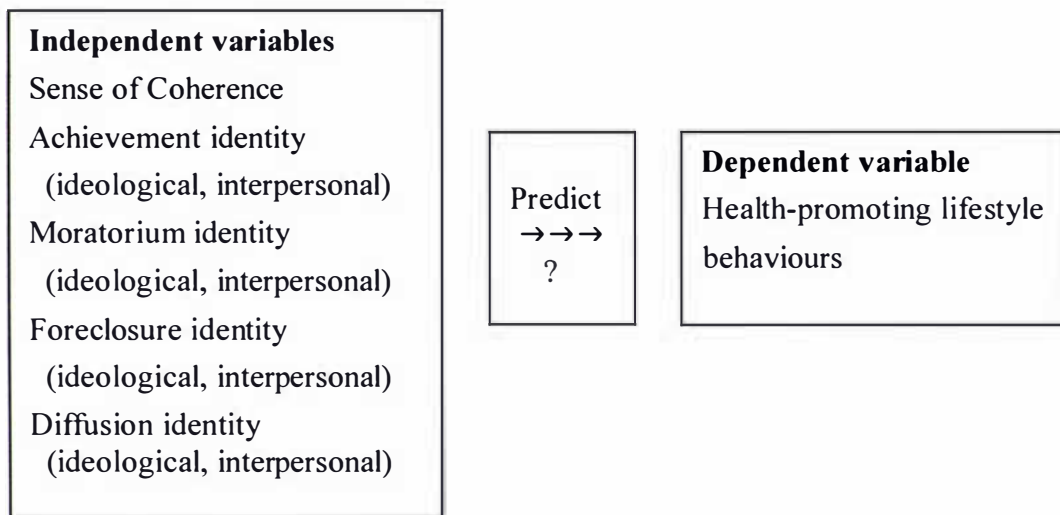


Figure 4.1 The prediction diagram for Variables in Study A

The strength of the relationship between variables provided an understanding of the aspects that had an impact on HPLBs among Thai college women, and answered the question as to which characteristic of the independent variables could predict the HPLP II and its subscales. Demographic data were analysed by using descriptive statistics. The results are as follows.

DEMOGRAPHIC DATA

All participants were females studying in their third or fourth year in four colleges in Udonthani Province in the Academic Year 2003-2004. Their ages were between 19-25 years old, average age was 21.5 years old. From the 350 participants completing the questionnaire, almost half of them (159 cases, 45.4 %) were student nurses from Boromarajonani College of Nursing Udonthani and Technology Ratchathani Institute. The rest were non-nurse students studying in other programmes in Technology Ratchathani Institute, Ratchapat University and College of Physical Education (see Appendix 2). Most of the participants, 98.5 %, had their hometowns in various provinces in Northeastern Thailand, and only 1.5% were from the Central region of Thailand. Their family income was between 500 – 400,000 Bahts per month, with the average family's income being 13,791 Bahts per month. The number of siblings in their families (including the participants) was 3 per family and ranged from 1-12.

DESCRIPTIVE STATISTICS OF THE VARIABLES

The mean of frequency of engagement in the six dimensions of HPLBs reached 2.65 for total HPLP II, and ranged from a low of 2.25 for the physical activity subscale to a high of 3.04 for the spiritual growth subscale. Means for the other instruments were 126.21 for SOC, and 64.70, 55.65, 46.51, 52.18 for the four types of identity status (achievement, moratorium, foreclosure, and diffusion, respectively). Means and standard deviations for each measure are reported in Table 4.1.

Table 4.1 The range of scores, mean scores and standard deviations for HPLP II and its subscales, sense of coherence, and total scores of each identity status, and ideological and interpersonal identity domains

	n	Possible Range of Score	Actual Range of Score	Mean	Std. Deviation
Dependent variable:					
Total HPLP II (52 items)	350	1-4	1.71-3.58	2.65	.32
Health Responsibility (9 items)	350	1-4	1.33-4.00	2.44	.51
Physical Activity (8 items)	350	1-4	1.13-3.88	2.25	.51
Nutritional Habits (9 items)	350	1-4	1.22-3.78	2.66	.39
Spiritual Growth (9 items)	350	1-4	1.56-4.00	3.04	.43
Interpersonal Relation (9 items)	348	1-4	1.67-4.00	3.01	.43
Stress Management (8 items)	350	1-4	1.63-3.88	2.75	.39
Independent variable:					
Sense of Coherence (total score)	350	29-203	76-192	126.21	17.66
Identity Achievement					
Total (16 items)	347	16-96	38-94	64.70	8.58
Ideological (8 items)	347	8-48	18-48	33.06	5.05
Interpersonal (8 items)	350	8-48	13-47	31.71	5.22
Identity Moratorium					
Total (16 items)	348	16-96	29-88	55.65	8.51
Ideological (8 items)	348	8-48	15-44	28.34	4.80
Interpersonal	349	8-48	11-47	30.47	5.10
Identity Foreclosure					
Total (16 items)	345	16-96	16-83	46.51	12.12
Ideological (8 items)	347	8-48	8-42	24.25	6.32
Interpersonal (8 items)	348	8-48	8-43	22.27	6.99
Identity Diffusion					
Total (16 items)	342	16-96	25-82	52.18	9.33
Ideological (8 items)	347	8-48	11-43	27.04	5.59
Interpersonal (8 items)	345	8-48	10-40	25.18	5.27

CHECKING ASSUMPTIONS FOR MULTIPLE REGRESSION ANALYSIS

Assumptions were checked to ensure that assumptions of the multiple regressions had not been violated. First of all, all variables had to show normal distributions. Then, correlations were run between the independent variables and the dependent variables to check the assumptions underlying the use of multiple regression. The first was to determine whether or not all independent variables showed at least some relationships with the dependent variables. The second was to ensure that the correlations between the independent variables entered into multiple regression were not too high or expressed correlation coefficients of less than .7 (Tabachnick & Fidell, 1996).

The Spearman's Rho Correlations

Table 4.2 presents the Spearman's rho correlation of the dependent variables and the five independent variables. The relationship (correlation) of each of the potential independent variables (SOC, identity achievement, identity moratorium, identity foreclosure, and identity diffusion) with the dependent variable (total HPLP II), and the correlations of these potential independent variables with each other are presented in the correlation matrix. The Spearman's rho correlation coefficients (ρ) express the direction and strength of the association between each pair of variables. The correlation coefficients less than .3 are determined to be weakly correlated. A significant correlation was deemed a minimum requirement for inclusion of that variable as an independent variable in the regression analysis to follow.

Table 4.2 The Spearman's rho correlation coefficients for HPLP II, SOC, and the four types of identity

	(2)	(3)	(4)	(5)	(6)
(1) Health-Promoting Behaviours (total HPLP II)	.320**	.406**	.232**	.106*	-.073
(2) Sense of Coherence (SOC)	-	.143**	-.100	-.127*	-.310**
(3) Identity Achievement (Ach)		-	.430**	.109*	.021
(4) Identity Moratorium (Mor)			-	.288**	.432**
(5) Identity Foreclosure (Fore)				-	.387**
(6) Identity Diffusion (Dif)					-

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

As can be seen in Table 4.2, SOC was moderately correlated with HPLP II, as was Identity Achievement ($\rho = .320$ and $.406$ respectively). Weak but significantly positive correlations were also found between identity moratorium and HPLP II, and between identity foreclosure and HPLP II ($\rho = .232$ and $.106$ respectively). These four variables (SOC, identity achievement, identity moratorium, and identity foreclosure) were then entered as independent variables into the multiple regression analysis shown in Table 4.4. Identity diffusion did not meet the minimum requirement to be included as an independent variable in the regression analysis.

It is interesting that SOC showed significantly negative correlations with identity foreclosure, and identity diffusion ($\rho = -.127$, and $-.310$, respectively). Negative correlation, however non-significant, was found between identity diffusion and total HPLP II ($\rho = -.064$). A range of correlation coefficients (ρ) from $-.310$ to $.432$ indicated that the independent variables were not highly intercorrelated or redundant. Although multiple regression analysis will be best when each independent variable is uncorrelated with other independent variables, a bivariate correlation of less than $.7$ of each pair of independent variables is acceptable (Tabachnick & Fidell, 1996). An intercorrelation of $.7$ or above among independent variables would have been determined to violate the assumptions of multiple regression. No such intercorrelation was found.

Table 4.3 The Spearman's rho correlation coefficients for the eight dimensions of ideological identity and interpersonal identity and HPLP II

	(2)	(3)	(4)	(5)	(6)	(7)	(8)	HPLP II
Ideological:								
(1) Achievement	.151**	-.098	-.075	-	.253**	-.003	-.011	.320**
(2) Moratorium	-	.389**	.432**	.271**	-	.312**	.419**	.101
(3) Foreclosure		-	.331**	.135*	.230**	-	.414**	.066
(4) Diffusion			-	.143**	.309**	.155**	-	-.070
Interpersonal:								
(5) Achievement				-	.540**	.209**	.001	.371**
(6) Moratorium					-	.190**	.275**	.236**
(7) Foreclosure						-	.307**	.126*
(8) Diffusion							-	-.032

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

In Table 4.3, achievement identity in both the ideological and interpersonal domains were moderately correlated with HPLBs ($\rho = .320$ and $.371$, respectively). Interpersonal moratorium identity and interpersonal foreclosure identity were also significantly correlated to HPLP II ($\rho = .236$ and $.126$, respectively). Sense of coherence and these four subscales of identity status correlated to total HPLP II were entered as independent variables in the multiple regression analysis shown in Table 4.5. Identity diffusion in both domains, ideological and interpersonal, was weakly associated with HPLBs ($\rho = -.070$ and $-.032$, respectively).

Splitting the EOM-EIS scores into ideological identity (composed of dimensions of occupation, politics, religion, and philosophical lifestyle) and interpersonal identity (composed of dimensions of friendship, dating, sex roles, and recreation) were also assessed for absence of multicollinearity among these eight dimensions of identity. All correlation coefficients were less than $.7$, thus the assumption of absence of multicollinearity among independent variables was not violated (Tabachnick & Fidell, 1996). However, in comparison to the original construction of the EOM-EIS developed by Bennion and Adams (1986), identity achievement and identity moratorium (both ideological and interpersonal identity) should show negative correlations to each other with correlation coefficients between $-.11$ to $-.41$, and negative correlations between identity achievement and identity moratorium, identity foreclosure, and identity diffusion were also observable. In contrast, the results from this study revealed positive correlations among these variables with correlation coefficients ranging from $.135$ to $.540$. This might be the effect of culture differences or some complexity of the sentences used in the Thai version of the EOM-EIS that made unclear overlapping among issues in the instrument. Bennion and Adams (1986) reported that identity achievement was significantly negatively related or unrelated with all other status subscales. Therefore, more research using the EOM-EIS and modification of the instrument to test for its discriminant validity in the Thai context may be needed.

In summary, assumptions of data structure were assessed and found to be satisfied for multiple linear regression (Hough, 1999). These may be summarized as follows:

1. Normal Distributions and linearity: All variables showed normal distributions and the Normal Probability Plot of the regression standardised residuals displayed no major deviations from normality (see Appendix 3).

2. Correlations: Only those variables which were statistically correlated with the dependent variables were entered as independent variables in the regression analysis.
3. Multicollinearity: All variables entered as independent variables were found to be correlated with one another below the threshold of .7 (Table 4.3). Hence, all variables were retained according to Tabachnick and Fidell (1996).
4. Outliers: Since multiple regression is sensitive to outliers (very high or very low scores), checking for extreme scores was done. The results of checking for outliers of all variables are shown in the standardised residual plot or scatter plot in Appendix 4. Tabachnick and Fidell (1996) define outliers as cases that have a standardised residual displayed in the scatter plot of more than 3.3 or less than -3.3. A few outliers were evident in the data of this study. However, it is not uncommon to find a few outlying residuals with large samples (Pallant, 2001). Accordingly, it was not necessary to take any action.

RESULTS FROM MULTIPLE REGRESSION

Hierarchical multiple regression was used to determine the ability of the subscores of the EOM-EIS to predict HPLBs while controlling for SOC. The relationships between the SOC score, and subscores of the EOM-EIS and HPLP II were assessed. Any variable found to be significantly correlated with HPLP II and its subscales was retained for inclusion as an independent variable in this analysis. The total SOC score was entered as an independent variable in the first step of this model, and all remaining independent variables in the second step. The model as a whole (step 2) was analysed to determine the degree to which SOC and each of the subscales of EOM-EIS predicted HPLP II or its subscales when SOC was controlled. The assertion that SOC plays a central role in mediating the effects of various illness situations and contributes to health-promoting behaviours and well-being (Antonovsky, 1987; Boman et al., 1999; Cederfjall et al., 2001; Svartvik et al., 2000) provided the rationale for the order of entry of the blocks of variables.

In Table 4.4, Model 1 referred to the first block of predictor variable that was entered (SOC), while Model 2 included the first block variable (SOC) and the remaining independent variables entered in both blocks (SOC, identity achievement, identity moratorium, identity foreclosure). After SOC, the variable in

Block 1, had been entered, the model explained 11.5 % of the variance in total HPLP II score (.115 x 100) ($p < .0005$). After Block 2 (Identity Achievement, Moratorium, and Foreclosure) had also been included, the overall model significantly explained 26.7 % (.267 x 100) ($p < .0005$) of the variance in the HPLP II. Identity achievement and identity moratorium had explained an additional 15.2 % of the variance in the HPLP II, when the effects of SOC were statistically controlled for ($p < .0005$).

Table 4.4 Hierarchical regression analysis predicting health-promoting lifestyle behaviours with sense of coherence, identity achievement, identity moratorium, and identity foreclosure

Model ^a	Cumulative R^2	R^2 Change	Sig. F Change	Beta	Sig.T
1 Sense of Coherence	.115 ^b	.115	<.0005	.339	<.005
2 Sense of Coherence				.316	<.005
Identity	.267 ^c	.152	<.0005		
Achievement				.294	<.005
Moratorium				.113	.046
Foreclosure				.093	.061

a. Dependent Variables: HPLP II, All significant correlated variables entered.

b. Adjusted $R^2 = .113$

c. Adjusted $R^2 = .258$

Note: Adjusted R square could be chosen instead of R Square when a small sample is involved because the value of R square may be an overestimation of the true value in the population. The Adjusted R square statistic will correct this value to provide a better estimate of the true population value (Pallant, 2001). The sample size in this study exceeded that needed to conduct the multiple regression analysis for the population which is suggested to be ≥ 122 , according to the solution $n > 50 + 8m$ (Tabachnick & Fidell, 1996, p. 132). However, Adjusted R square values are provided for readers to consider.

The beta values represent the size and direction of the unique contribution of each variable, when the overlapping effects of all other variables are statistically removed. Three of the four predictor variables made statistically significant contributions ($p < .05$) to this prediction. In order of importance they are: SOC (beta=.339, $p < .005$), identity achievement (beta=.294, $p < .005$), and identity moratorium (beta=.113, $p = .046$). This decision was made on the basis of the significance of the t -value (Sig.T) of the beta values. Identity foreclosure was not found to make a unique contribution to this prediction.

Table 4.5 Hierarchical regression analysis predicting health-promoting lifestyle behaviours with sense of coherence and ideological and interpersonal identity achievement

Model ^a	Cumulative R^2	R^2 Change	Sig. F Change	Beta	Sig.T
1 Sense of Coherence	.115 ^b	.115	<.0005	.339	<.005
2 Sense of Coherence Identity	.254 ^c	.139	<.0005	.301	<.005
- Ideological: Achievement				.152	.004
Moratorium				.040	.484
- Interpersonal: Achievement				.217	<.005
Moratorium				.078	.217

a. Dependent Variables: HPLP, All significant correlated variables entered.

b. Adjusted $R^2 = .113$

c. Adjusted $R^2 = .244$

In Table 4.5, after significantly independent variables from Table 4.4 were entered into regression analysis, SOC and identity achievement in both domains (ideological identity achievement beta=.152, $p=.004$, and interpersonal identity achievement beta=.217, $p<.005$) significantly predicted the variance in HPLP II after the effect of SOC was statistically controlled for.

Standard multiple regression was performed to reversely predict SOC and identity achievement from the six dimensions of HPLBs. Spiritual growth and health responsibility were the significant predictors for SOC ($R^2 = .142$, beta= .217 and .143, $p= .005$ and .027. respectively). Interpersonal relations and spiritual growth were the significant predictors for identity achievement ($R^2 = .178$, beta= .176 and .154, $p= .005$ and .041, respectively) (Table 4.6 and 4.7).

Table 4.6 Standard multiple regression analysis predicting sense of coherence with the six dimensions of HPLBs

Model ^a	Cumulative R ²	R ² Change	Sig. F Change	Beta	Sig.T
	.142 ^b	.142	<.0005		
Health responsibility				.143	.027
Physical activity				-.037	.530
Nutritional habits				-.017	.782
Spiritual growth				.217	.005
Interpersonal relations				.015	.816
Stress management				.106	.114

a. Dependent Variables: SOC, All significant correlated variables entered.

b. Adjusted R² = .127

Table 4.7 Standard multiple regression analysis predicting identity achievement with the six dimensions of HPLBs

Model ^a	Cumulative R ²	R ² Change	Sig. F Change	Beta	Sig.T
	.178 ^b	.178	<.0005		
Health responsibility				.095	.133
Physical activity				.065	.266
Nutritional habits				.006	.916
Spiritual growth				.154	.041
Interpersonal relations				.176	.005
Stress management				.061	.361

a. Dependent Variables: SOC, All significant correlated variables entered.

b. Adjusted R² = .163

Accordingly, reciprocal relations between SOC and spiritual growth and health responsibility, and between identity achievement and interpersonal relations and spiritual growth were theoretically indicated – which is interesting.

ANALYSES BASED ON MAJOR

Since nearly half of the participants were student nurses, it was decided to analyse the data further to determine if the major of study had any effect on the prediction of HPLP II. The participants were divided into two groups, nurse ($n= 159$) and non-nurse ($n= 191$). Dummy Variables were created for nurse participants = 1, and non-nurse participants = 0. Running multiple regressions showed no significant additional prediction of HPLBs after loading SOC in Block 1 and three types of identity in Block 2. The major programme of study (nurse or non-nurse) explained only 1.4 % of the variance in the HPLP II (beta=.120, $p=.025$) without significance,

but significantly explained 4.9 % of the variance in SOC ($\beta=.222$, $p<.005$). There was a significant difference in total mean scores of HPLP II between nurse and non-nurse participants in this study (2.69, $SD=.33$ and 2.61, $SD=.30$, $p=.025$, respectively). There was also a significant difference in the mean score of SOC between nurse and non-nurse participants (130.54, $SD=17.70$, and 122.68, $SD=16.84$, $p<.0005$, respectively).

The interesting thing was that the nursing programme of study explained significantly an additional 3.2 % of the variance in SOC after the effects of the six dimensions of HPLBs were statistically controlled for ($p=.000$). Spiritual growth was the significant predictor for SOC ($R^2 = .142$, Adjusted $R^2 = .127$, $\beta= .217$, $p=.005$) and when adding the programme of the study in Block 2, the overall model increased the power of prediction ($R^2 = .174$, Adjusted $R^2 = .157$, $\beta= .192$, Sig.T < .005). Despite this, the programme of study of the participants showed no significant effect in prediction of HPLBs. The analyses based on major here were follow-up questions after the researcher had left the field. These analyses consequently led to coding names of participants as nurse (N), and non-nurse (NN) in study B.

DISCUSSION OF STUDY A

The mean score of the total HPLP II in this group of Thai college women was 2.65. This level of engagement in HPLBs compared to 2.30 among university students in Hong Kong (Lee & YuenLoke, 2005), 2.72 among US college students and 2.56 among Japanese college students (Hawks, Madanat, Merrill, Goudy, & Miyagawa, 2002). A similar trend in HPLP II scores with the lowest mean in physical activity and the highest mean in spiritual growth and interpersonal relations was also reported in other studies (Felton, Parsons, et al., 1997; Lee & YuenLoke, 2005; Ma'aitah, Haddad, & Umlauf, 1999). These findings were also consistent with results from a cross-cultural study of HPLBs which showed the highest mean in interpersonal relations and spiritual growth among Japanese and American college students (Hawks et al., 2002); university students in Hong Kong (Lee & YuenLoke, 2005); and among nursing students in Canada (MacDonald et al., 1994). The low score in physical activity is not unexpected as Eastern or Asian people often show the lowest score in the exercise dimension (Hawks et al, 2002). Physical activity or exercise among this group of women is usually performed through their daily

activities like household chores and walking to places because it is not a tradition in Eastern cultures to exercise in a gym.

The high average scores of HPLBs were found in items 12, 13, 18, 19 of the HPLP II. They are aspects of saying: I believe that my life has purpose (mean=3.45 ± .69); I maintain meaningful and fulfilling relationships with others (mean=3.35 ± .66); I look forward to the future (mean=3.54 ± .65); and I spend time with close friends (mean=3.26 ± .75). These aspects are in spiritual growth and interpersonal relations dimensions of HPLBs, which are characteristics of people with strong SOC. The low average scores of HPLBs are found in items 4 and 41 of the HPLP II. They are aspects of saying: I follow a planned exercise programme (mean=1.98 ± .72); and I practise relaxation or meditation for 15-20 minutes daily (mean=1.83 ± .78). These activities of healthy behaviours are time consuming and require greater effort and motivation, and also more empowerment from one's social network. As noted by Eyler and colleagues (2002), women need social support for their physical activity as reported from 91 studies from diverse racial and ethnic groups.

The mean score of SOC in this group of Thai college women was 126.2. This was congruent with that of undergraduates in the United States whose mean score was 129.5. Student nurses in this study had a mean score of SOC similar to that of a group of public health nurses in Hong Kong whose mean score of SOC was 135.75 ($SD = 12.27$, mean age = 39), found in a study by Shiu (2001). Undergraduates have generally been found to score on the low side compared to the normative data for the SOC (Antonovsky, 1993) – whereas Thai adults who were parents or grandparents scored in the middle range (143.4) compared to the normative data (Cederblad et al., 2003). Again, considering the highest reported range of SOC which belongs to Swedish adults with high-risk childhood and religious people (Antonovsky, 1993), it seems that strong SOC develops over time with tough life experiences and deep spirituality. This might explain why adolescents usually score on the lower end of SOC.

In this study, college women with strong SOC might be less likely to have diffusion identity and more likely to have achievement identity. Achieving a sense of identity in both the ideological and interpersonal domains resulted in a significant contribution to the prediction of HPLP II. There were moderately positive associations between SOC and spiritual growth; and between identity achievement and interpersonal relations. The dimensions of interpersonal relations

which showed significantly positive association with identity achievement and in turn with HPLBs should be factors considered by health care professionals in dealing with adolescents' health. This is congruent with a study done by Thongpriwan and McElmurry (2006) who found that mental health, intimacy, interpersonal relationships with family members and friends, and body image were the discussion and query issues which revealed the most concern among Thai adolescents participating in the internet forum. In contrast, research to date on Thai adolescents' health, which emphasizes sexuality and risky behaviours, has not paid attention in these issues which are really adolescents' interests and in need of support.

The contribution of SOC and identity statuses of identity achievement and moratorium in predicting mean levels of HPLBs was modest. The results of this study indicate that SOC could predict only 12 % of variances of HPLBs. The low prediction power might be due to the fact that SOC is the characteristic of coping with the complex stressors in the course of living (Antonovsky, 1993). This is consistent with the interpretation by Cederblad et al. (2003, p. 587) that the three components of SOC are: "(1) ability to clarify and structure stressors, (2) to flexibly mobilize coping mechanism, (3) approaching a problem situation as a challenge to be met." The authors continue to claim that these components "...will be valuable assets to constructive dealing with regular life-stressors regardless of cultural differences." It seems that SOC has more to do with coping with stress than with promoting engagement in HPLBs. However, these components of SOC may contribute to spiritual growth and identity achievement which are parts of the assets of HPLBs in terms of exploration and commitment.

When SOC and identity achievement and identity moratorium were combined, the overall prediction increased to 27% of the variances in HPLBs (Table 4.4). It seems that the independent variables designed to predict HPLBs here are still not sufficiently powerful to predict healthy behaviours among healthy women. Even though the prediction power of SOC and identity formation onto HPLBs was not so high, the associations between SOC and spiritual growth and health responsibility, and between identity achievement and interpersonal relations and spiritual growth were interesting and reasonable. The eight components in the EOM-EIS which are occupation, politics, religion, philosophical lifestyle, friendship, dating, sex roles, and recreation, although determined as important to be explored during adolescence, exclude health-related issues. This might explain why the prediction

power of the EOM-EIS for HPLBs was not high. However, the results imply that exploration and commitment statuses of identity achievement are important factors in predicting HPLBs for college women in the context of this study. It makes sense that exploration and commitment, which are prominent characteristics of identity achievement, would be the important factors for engaging in HPLBs. Commitment has been claimed to be a significant component in the revised Health-Promoting Model (Pender, 1996, p. 67).

To ask about the extent to which SOC could predict HPLBs among women in this study is justifiable because SOC was originally constructed from the world view of a group of women. However, SOC legitimises the characteristics of Western white menopausal women who had gone through and survived tough life experiences in the concentration camps of the Second World War (Lindström & Eriksson, 2006). While Eriksonian developmental theory is useful, it is based on the individualistic, androcentric, and Euro-American tradition (Gergen, 1991). To take account of the cultural impact on identity and behaviours, Paris and Epting (2004, p. 10) confirmed that “the power of a social constructionist framework is that it allows us to see meaning-making as a collaborative process that is necessarily situated in and informed by a larger cultural, socio-political, and historical contexts.” All results from Study A seem to leave out the cultural construction which influences sense of self and ways of practice in the real world. The inadequacy of the survey outcomes to inform practice implications led to the in-depth qualitative study in the second phase.

LIMITATIONS OF STUDY A

1. All samples were drawn from non-probability sampling. As sampling units were selected by non-random methods, there was no assurance that every subject had a chance to be included. Therefore, results in samples may be less representative and also generalising the data to the population or other group of women may be limited (Schofield & Jamieson, 1999).
2. The findings of this part of the study are cross-sectional in nature, therefore, the results do not allow for precise causal inferences.
3. The data were collected by self-report instruments. Consequently, there was no assurance of accuracy and they could be biased because subjects might answer in the way that they judged to be the more desirable response

pattern. However, Bennion and Adams (1986) assessed the responses for the social desirability scale and the self-report responses to the EOM-EIS subscales in a sample of 106 college students and no significant correlation was found.

4. The three instruments contained some long and complicated sentences. Filling them out took time and needed concentration. Moreover, they are all constructed from the Western context. A different cultural background could make filling them ambiguous. For example, dating and sex roles are areas which are not much in the thinking of adolescents in the Thai context. Details of nutrition in the HPLP II such as drinking milk, or eating dairy products are not habitual for Thai people.
5. The three instruments were translated from the English language; therefore, incomplete meaning related to translation may have occurred.

Despite these limitations, the findings identify some useful factors for predicting health-promoting behaviours among Thai college women.

CONCLUSION

Overall, Study A provided a general picture and initial examination of the levels of the three parameters, HPLBs, SOC, and identity statuses, and their associations in a sample of late adolescent Thai college women. Compared to normative data from various studies, their HPLP II scores were in line with those of college women and students from other parts of the world, all engaged in health-promoting behaviours at a medium level. Like their counterparts, their level of engagement was found to be the lowest in the physical activity dimension and highest in the spiritual growth and interpersonal relations dimensions. Their SOC scores were on the low side, similarly to those found in other college students. Health-promoting lifestyle behaviours were significantly positively correlated with the commitment statuses of achievement, with the exploration status of moratorium, and with SOC. While SOC has been shown to be a crucial characteristic for people to combat stressful events, it may be also proved to be a useful base for predicting healthy behaviours and lessening identity diffusion. Identity achievement both in the ideological and interpersonal dimensions played a role in predicting HPLBs. Also, the exploration component of identity moratorium showed a contribution to the prediction of HPLBs. Interpersonal relations and spiritual growth are crucial in helping college

women develop identity achievement and their sense of coherence. In addition, the nurse participants in this study showed significantly higher scores in SOC and HPLP II than did the non-nurse participants.

Part one of this thesis has provided the background to the study, its rationale, methodology, and its mixed methods design for the collection and analysis of the data, both the quantitative and qualitative parts. The results from Study A, the quantitative part of the research, have provided a basic understanding of the relationships among SOC, Identity Achievement, and HPLBs. Sense of Coherence seems to contribute to Thai college women's achievement of a sense of self and their level of engagement in healthy behaviours. A purposeful life towards a positive future amidst meaningful relationships with others, in turn, plays a role in predicting identity achievement and sense of coherence.

However, all instruments used in Study A are Western in context. Research in this area of self-development linking to HPLBs in Thai college women has not been done in depth. Thus, I expected that there may be a unique sense of self among college women who engage well in HPLBs in the Thai context. To understand these factors that help Thai women create a healthy self, in-depth interviews were done with the HPLP II high-scorer nurse participants compared to the non-nurse, non-scored participants. The themes which emerged would show influences of Thai society in transition and various aspects of Thai sense of self.

The assumption that the free will of individuals enables them to choose their health-related behaviours and lifestyle (which is believed to be a primary determinant of health) (Piper & Brown, 1998), is not the assumption of social constructionism (Burr, 1995). Understanding the sense of self and self-formation of individuals in a specific social context plays an important role.

Part Two of this thesis focuses on the design of Study B and the analysis of the qualitative data that results in the conceptualisation of the Mindful Self Model in Chapter 5. This is followed by three chapters that explain the three main themes – The Common Cultural Background and Surrounding Influences as the context of self, The Mindful Self as a functional knowing self, and wellness enactment or health-related behaviours as the products of self-development. These three main themes are the key components of the model conceptualised.

PART II

CHAPTER 5

STUDY B:

DESIGN, METHODS AND RESULTS

After gaining more understanding from Study A of the relationships between SOC, identity statuses and HPLBs of Thai college women, Study B, an interpretive qualitative study, was conducted to uncover the perceptions and worldviews of Thai college women with respect to health-promoting lifestyle behaviours and their sense of self. The aim of Study B was to generate a dense conceptual explanation of the interplay between identity formation and health-promoting lifestyle behaviours among Thai college women. The following sections outline the design and methods for this study, providing details as to the rationale for participant selection, methods of data collection and data analysis and establishing trustworthiness of the research. Themes, sub-themes, and components from the inductive data analysis are summarised to frame the research findings that are presented in Chapters 6 to 8.

STUDY B: AN INTERPRETIVE QUALITATIVE STUDY

An interpretive qualitative study is an attempt to understand and explain human and social reality. In it, one looks for “culturally derived and historically situated interpretations of the social life-world” (Crotty, p. 67). Qualitative inquiry is not detached; rather it is value-bounded by the perspective of the researcher (Gray, 2004).

Study B involved in-depth interviews with 25 participants: 11 participants were purposively sampled from the student nurse participants in Study A with the highest scores on the HPLPII and a further 14 students were convenience sampled from various faculties in Ratchapat University in Udonthani Province and Khon Kaen University. Data-driven thematic analysis was used to inductively analyse themes (Boyatzis, 1998).

PARTICIPANTS

In qualitative research purposive sampling is used to select information-rich cases (Llewellyn, Sullivan, & Minichiello, 1999). In this study, I anticipated that students who had scored highly on the HPLBII would be 'information rich' and could represent a picture of 'healthy women' in the Thai context. Thus student nurse participants from Study A who had obtained high scores on the HPLP II were purposively recruited. Eleven student nurse participants agreed to participate in Study B (HPLP II range=2.77 to 3.44 cf. mean=2.65); two participants who had higher scores on the HPLP II (3.48 & 3.58) were unable to be recruited as they had graduated and left Boromarajonani College before the in-depth interviews took place.

A further 14 students (two student nurses and six students from various faculties at Khon Kaen university; and six students from various faculties at Ratchapat University) were recruited using convenience sampling. I approached these participants in various faculties in KKU and Ratchapat University during their free time in places like libraries, the cafeteria, and places in general around the two institutes. The criteria for selection were that they were senior female college students and were willing to participate after receiving information about the research. The scores on the HPLP II for these 14 students were not known.

It was helpful to have the latter group of students, as knowledge of the HPLP II scores of all participants may have led to a Hawthorne effect (Polit & Hungler, 1999). That is, my analysis of their interviews may have been influenced by my knowledge of their scores and therefore obscured the effect of other factors or behaviours in the distinctive context. At the time the in-depth interviews took place I considered these 25 students to be a relatively homogeneous group of Thai adolescent educated women. However I was aware that student nurses would have been cognitively constructed in health-related education. It was important therefore to interview students from other programmes.

Separation of the 25 students into 'nurse' and 'non-nurse' participants for comparison occurred during later phases of qualitative data analysis, once it was known (following further in-depth data analysis of study A data) that the programme of study had some impact on their SOC. A numbering system with letters 'N' or 'NN' representing the participants and identifying the transcript was used to provide an anonymous reference point and audit trail for the qualitative data

in Study B. The student nurse participants were code named from N1 to N13; and the students from other programmes were code named from NN1 to NN12.

DATA COLLECTION: IN-DEPTH INTERVIEWS

In-depth interviews help the researcher obtain from the participants' stories "a subjective interpretation and evaluation of the events as they inform the phenomena under investigation." (Minichiello, Madison, Hays, Courtney, & St John, 1999, p. 396). While the results from Study A had provided some initial clues regarding the determinants predicting HPLBs in this group of senior college women, the in-depth interviews were not guided or structured directly from the results of Study A. Rather, the participants and I engaged in an extensive non-structured conversation in order to reveal the participants' subjective experiences about their sense of self and health-related behaviours in Thai culture. As suggested by Minichiello, Madison et al. (1999, p. 397):

An essential feature of in-depth interviews is that they are conversations that are informal in style and engaging intellectually. They are an invitation to recall, reveal and construct aspects of subjective experiences and interpretations and to make that discussion coherent and meaningful.

After establishing rapport with participants, I asked them to tell me about their beliefs and experiences about health, and then questioned from their answers in general. The questions and language used were not planned in advance; rather the interviews flowed in a conversational manner.

Appropriate questions or relevant answers emerge through a dialogue which occurs between the interviewer and the interviewees, and it is through this informal process that relevant and meaningful issues are generated.

(Minichiello, Madison et al., 1999, p. 397)

I listened analytically and by following the questioning techniques of funnelling, story telling and probing described by Minichiello, Madison et al. (1999, p. 399), could engage the participants in disclosing information. The focus of the in-depth interviews in Study B was the participants' descriptions of their health-related behaviours and their ways of thinking about health. Their sense of self was implicitly revealed in the dialogues, which I had to make sense of and interpret through the analysis processes.

The interviews in Thai language with each participant ranged from 45 to 100 minutes. Interviews were audio-taped and each interview was transcribed verbatim

in Thai. A brief summary of each interview was done to outline what the data showed, and to provide some directions for the interviews that followed. The in-depth interviews were conducted until a sense of data saturation was achieved. When further data collection and preliminary analysis in the field are contributing nothing new – that means the data is saturated (Joffe & Yardley, 2004).

All transcripts from in-depth interviews were subsequently translated into English by the researcher and a hired translator with several years' experience in bilingual translation. Some words in Thai and Pāli-Sanskrit language were retained in transcripts because they have been used among Thai for particular meaning, and are not easily translated with equivalent meaning in English. The glossary at the beginning of the thesis gives a short explanation of words.

DATA ANALYSIS: THEMATIC ANALYSIS

In this study I chose to use thematic analysis as a method of data analysis. In contrast to grounded theory method wherein data collection and data analysis are inter-related and simultaneous along the research process, it is more common to thematic analysis to collect all the data before analysing it (Chamberlain, Camic, & Yardley, 2004). In this study, thematic analysis was undertaken after all data had been collected. The data-driven thematic analysis was mostly based upon Boyatzis's (1998) protocol while theme and sub-theme analyses were added by following the suggestion from Joffe and Yardley (2004) and Chamberlain, Camic, and Yardley (2004).

Boyatzis (1998, p. 9) defines thematic analysis as “a process for encoding qualitative information. The encoding requires an explicit ‘code.’ This may be a list of themes; a complex model with themes, indicators, and qualifications that are causally related; or something in between these two forms.” He explains that a theme is a pattern found in the data which describes and organizes the phenomena observed or interprets aspects of the phenomena. In thematic analysis, themes may be expressed at manifest and latent levels: that is, they may be directly observed or are implicitly referred to (Boyatzis, 1998). Thematic analyses draw on both levels of theme. Even though the focus is on the manifest theme, it is crucial to understand the latent meaning of the manifest themes expressed in the data, which requires interpretation (Joffe & Yardley, 2004, p. 57).

The data analysis process involved the inductive development of themes. Using themes as they appear in the raw data as the starting point in code development is the strength and power of the data-driven approach (Boyatzis, 1998). However “... no theme can be entirely inductive or data driven, since the researcher’s knowledge and preconceptions will inevitably influence the identification of themes.” (Joffe & Yardley, 2004, p. 58). Coding needs to be determined by the purpose of the study as well as “the principles that underpin the research, and the specific questions one seeks to answer” (Joffe & Yardley, 2004, p. 59), rather than from a purely inductive approach. For the thematic analysis for this part of the study I used inductive analysis within the scope of the proposed framework: women’s wellness, health-promoting lifestyle behaviours, sense of self and identity formation in the Thai context. Times, spaces, and key concepts explored had to be taken into account.

I found it was essential here to clarify terms used regarding qualitative data analysis in this study. For Boyatzis (1998), the terms *theme* and *code* are used interchangeably. In this study, the term *coding* is used as an action as Joffe and Yardley (2004, p. 63) stated that “coding involves noting patterns in the data and labeling these patterns to allow distinctions to be drawn and research questions to be answered.” The term ‘codes’ is used as noun, as the product of the first level of coding for generating initial codes: open coding. The higher products of data analysis and coding would be themes and sub-themes.

Open coding

In thematic analysis, codes are initially derived from a small initial sub-set of data and later applied to the whole data set subsequently (Chamberlain, Camic, & Yardley, 2004). Initially I undertook open coding with the transcripts of nine participants (N1, N3, N5, N7, N9, NN1, NN3, NN5, and NN9). These transcripts were selected because the participants provided a long time for the in-depth interviews so the transcripts were rich in information. Examples of open coding are shown in Table 5.1.

Table 5.1 Open Coding

Excerpt from Data	Open Coding
<p>...I will die someday. Before I die I have to do something and look for a lot of experiences so I would die in peace and not worry. It's just a plan. It doesn't mean that I am dying just from seeing people dying but they had a lot of things to do and they weren't happy.</p>	<p>think about death and will do things and look for a lot experiences before dying, Dying-sensibility, dying-consciousness, Value life experiences, Look to the future, Seeing people and pondering and reflecting to self</p>
<p>I lived with my grandmother and she likes to read Dharma book then told me about it. My father likes to use Dharma as his lesson. I would <i>tam jai pen klang</i> when doing something because it might not be like what I thought and expected. <i>Tam jai pen klang</i> is when I have expectation for what I do but didn't get what I expected to get, to be <i>Oo-baehk-khaa</i> or to abandon the feelings when I did not get what I was hoping for. Sometime when you don't get things your way then be impartial about it, ... look at the good and the bad. Always weigh them both so you will see it clearly. Some situations there might be more of the bad outcomes or sometimes the good one.</p>	<p>being neutral, <i>tam jai pen klang</i>¹, and prepare mind for the unexpected events, and be impartial (<i>Oo-baehk-khaa</i>) when things do not go as expected, Learning Dharma and Buddhism principle, Abandon one's feelings and expectations</p> <p>Look at both sides of things</p>
<p>I like to be neutral or impartial about friends because I might be mad at them but they're still my friends and one day we might have to rely on one another. To be less stubborn (<i>Tithi</i>) and talk to them even when I'm still mad at them. Isn't it better to be a giver? That's what I think. ...I have to look at the overall situation too. Some situation might be better if I speak first and do not wait for him and be uncomfortable. Sometimes I am wrong and he won't talk to me and I am uncomfortable. Why do I have to think about something that made me uncomfortable? I would be uncomfortable if I didn't talk to him and that would harm my mental health because I wouldn't be confident when I do things.</p>	<p>Maintaining interpersonal relations Collectivistic view with people and future-oriented, one day we might have to rely on one another Abandon stubbornness or <i>la tithi</i></p> <p>Giving forgiveness in relationships Look at the overall situation Reconciliation in relationships is better Contradictions ruin mental health, and self-confidence</p>

¹ The reader will, from now on, experience some of Pāli-Sanskrit words and Thai words (present in italics) commonly used in Thai culture to convey concepts, the meaning of which are not easily communicated in English.

A mind map was created to answer the questions that I asked while reading the first set of transcripts. The questions were the what, why, and how pertaining to health issues of the participants as shown in Figure 5.1.

Questions used for linking codes into a mind mapping creation:
Health for this group of Thai college women:

- What does health mean for the participants?
- Why do they take care of their health?
- How do they take care of their health?

Figure 5.1 Questions used to assist the process of making sense of the data.

I answered these questions in a mind map (Figure 5.2), and realised that I could answer some of the what and why questions at this stage, but not the how questions. This led me to return to read and re-read transcripts, and create a table of initial codes. As suggested by Boyatzis (1998), this stage was to write, rewrite, or construct a set of statements that were found in common or not in common characteristics among participants. This set of preliminary themes is a code.

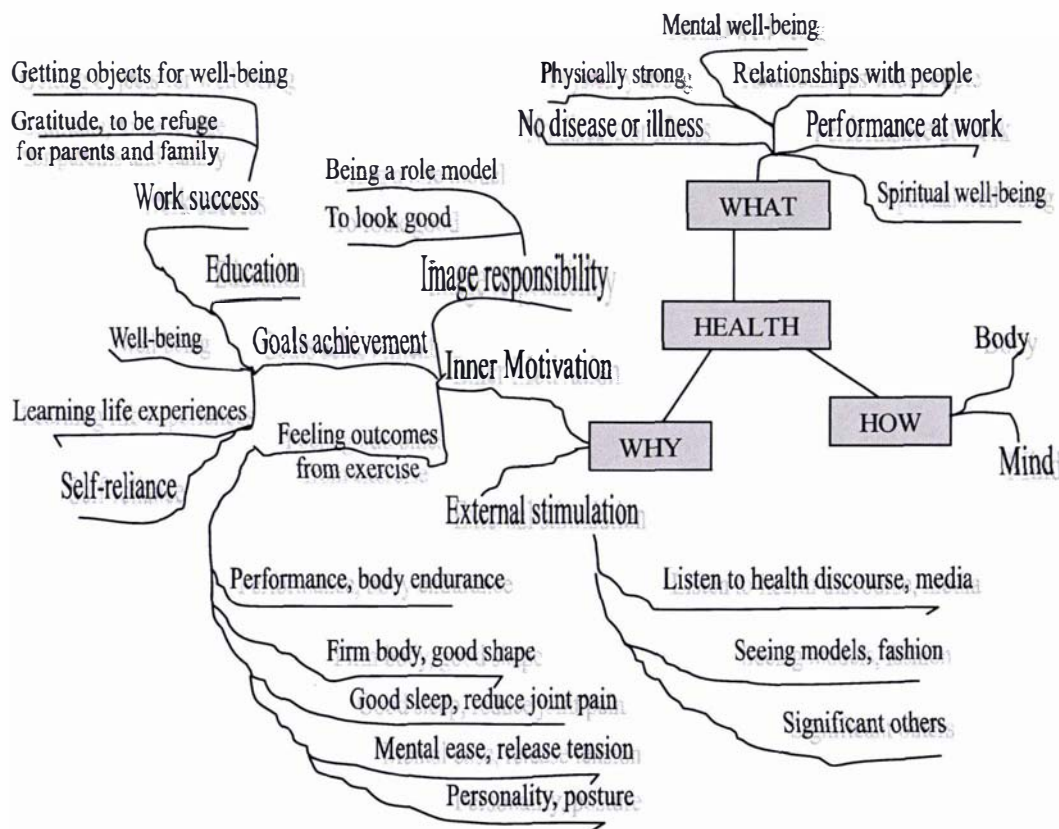


Figure 5.2 The initial mind map for making sense of the data

Developing themes and sub-themes

The raw information should be reduced first by reading each transcript and creating an outline of paraphrased items or a synopsis (Boyatzis, 1998). An example of generating a synopsis is shown in Table 5.2. After a synopsis for each transcript was completed, the higher level of coding was undertaken by “taking chunks of text and labeling them as falling into certain categories, in a way that allows for later retrieval and analysis of the data.” (Joffe & Yardley, 2004, p. 59). These synopses of transcripts were useful for comparison. Rereading all the transcripts expanded the table of initial codes (Table 5.3) and the table was useful for revising and linking codes while developing themes and sub-themes.

Reading and re-reading the transcripts, while translating them into English contributed to a more extensive list of codes. After obtaining some potential themes while living with the data, I created separate files for each potential theme comprising pieces of transcripts from many participants who talked about the common theme name of the file. For example, the file named ‘gratitude to parents’ comprised five excerpts at first (the excerpts expressed gratitude to parents at a manifest level), and expanded into fifteen excerpts of gratitude expression (expressed at a latent level).

The important strategies were that as coding progressed, categories were refined by splitting, splicing and linking codes (Joffe & Yardley, 2004). Splitting occurs when the researcher decides that “... two or more sub-categories within a code are so distinct that two entirely new, separate codes need to be created by splitting the original coding category [and it is important to be aware that] it will be impossible to incorporate all codes into the final analysis.” (Joffe & Yardley, 2004, p. 61). Therefore, splicing or fusing codes and linking codes to generate more powerful categories for a coherent analysis are the crucial steps for data analysis. At this stage, some initial themes became sub-themes when more explicit and powerful categories were set as a theme for a coherent analysis. The tasks were to return to the raw information and reread, and listen, while attempting to determine the presence or absence of each of the preliminary themes. To perform this task, editing, rewriting, or reconstructing each statement of the preliminary themes into a revised theme was done. The revised themes would (a) maximise the characteristics that were found to be in common or not in common among participants; (b) facilitate coding; and (c) minimise exclusions (Boyatzis, 1998). These ongoing processes are illustrated in Figure 5.3.

Table 5.2 Synopsis Comparison

Synopsis from NN1, KKU, June 19, 2004	Synopsis from NN2, KKU, June 18, 2004
<p>-healthy body without illness and not pertaining to beauty, eating well, five groups food, no alcohol, but don't think much about health</p> <p>-Interpersonal relationship, club activities overwhelms other aspect of health, no free time for exercise and better do something else, do anything as long as I am happy. talking with people, Happy thing is connectedness to others, helping others, to meet people, be their consultant, help to reduce their burdens, and help them think.</p> <p>-Perceived self as healthy so no essential points to be aware, no one to go exercise with, no fun, strange if going alone</p> <p>-consult with someone I trust, get to let it out by talking when I am tense.</p> <p>-Senior-junior hierarchy determines behaviours</p> <p>-Effects from friends, like teasing all the time that I am fat then I would try to improve.</p> <p>-Job concern, and appearance, healthy body and not easily ill, do it for myself. Job selection and health</p> <p>-Trust is important in raising style</p> <p>-Meditation, able to think more in order. One essential for me is to always think before I speak or do anything, to calm my mind so I will understand what I am going to read.</p> <p>-work experiences in student activities clubs and internship, It would be easy to adjust at work, value experiential learning</p> <p>-Interaction with people and mental health, often think about others' words</p> <p>-Social isolation makes unhappy mind</p> <p>-I think that I took a very little care of myself (take a bath, hair wash, just that)</p> <p>-Spiritual, Mental refuge, KKU's joss-house, a place for mental refuge. I felt like he could help me and I felt better when I let out my problem by telling him, there's someone that is listening to me and help me there., pay respect to the image of Buddha at home and always pay respect at the shrine, pay respect to our ancestors., It's more like a mental support., asked for blessing for me and everyone in my family. I think that he would help good person and I am a good person so he would help me, ... believe in Karma, would do good deeds and I won't do the things that I think are bad, this should be good and maybe for others too. It might be good for society and friends. I felt good, would do only good things for the society</p> <p>-Thai women nowadays, elephant's hind legs,</p> <p>-I believed in faith and I think that the best things are always prepared for me and they will suit me.</p> <p>-Life is oneself and eventually I have to control my fate and make my own decision</p>	<p>-To live well, eat well, don't get sick, and no harried illnesses, To choose healthy food, five groups of food, and also exercise, foods can be used as a medicine, eat healthy foods then we will be fine and won't get sick. ... have been changed a lot. I read one book and I was interested ever since. Macrobiotics, Thai people call Chiwa-Jit food. Use natural therapy from food, don't like to take medicine, I am coughing with a cold. They say that orange juice will help to speed up the healing process. I would make it, used to read about the vegetables juice and herb juice that is good, have to make it without adding any sugar and drink it right a way after you make it fresh, ... Food choices concern, order food without monosodium glutamate, order mixed vegetables, buy more fruits for dessert, constipation, eat fruits and vegetables every day, concerned about the cleanness.</p> <p>-health concern, To be happy you got to have good healthy body and mind, Body and mind go together</p> <p>-have to take care of yourself, who else will?</p> <p>-Cheerful, let go of things, to be flexible. Find its good points, comfort myself and won't put too much pressure on myself. At least I know what I did wrong and next time it should be better</p> <p>-Happiness is the happy mind, catch up with my emotion, be in a good mood.</p> <p>-Buddhism, taught me that things would not be as I desire or hope or expect. don't worry too much about it and try to relax. It's impossible to be like this or like as I think. catch up with my consciousness I would pull my (neutral) mind back to myself.</p> <p>-Exercise, play badminton, Jogging in the evening</p> <p>-Joss-House: kind of mental support and mental refuge, made me feel good, happy to have a hope.</p> <p>-Reconciliation in intimacy relationship is important for mental health</p> <p>-Eat on time, Parents as role model to eat when it's time even when I am not hungry. They said that breakfast is important so I always eat my breakfast.</p> <p>-Calm mind is the best, meditation, By calming my mind and not thinking about anything because we are confused all day long so let your mind calm and rest some. but when you really concentrate on doing something then it's like a meditation too.</p> <p>-Exploration health information, searching from the Internet too but mostly from reading., would change method if I can't do it. I might not get the same result like the book says. For example, to use moist tamarind to scrub my face but I was allergic to it so I stopped. Real trying experience</p> <p>-Anxious about other people's feeling</p> <p>-Contented with self developmental changing, feel hurt but find other thing to replace it. I'm not so good with English but I am pretty good with Japanese.</p>

Table 5.3 Generating the initial codes

Initial Codes
Being a role model
Seeing others as role models
Encounter with death issue
Gratitude
To parents, to be refuge for parents when they are getting old, Strong sense connected to parents
To parents and expand to others
Interpersonal relations
Interpersonal sensitivity
Dependent on friends or not to cling on friends
Feel the whole society affects each other, A sense of connectedness to others
One is another's environment
Helping people and do good for society
Do no harm to others
Buddhism
To be neutral, To become stoic, <i>Upekkha</i> , Abandon one's attaching feeling, <i>Bplohng-Dtohk</i>
Four Noble Truths
Do good deeds, receive good, karma, and the Five Precepts, make merits
The Middle Path, <i>Tang Saii Klang</i>
Meditation, mindful, concentrate, Self-conscious
Feel about supreme being and power
Self-reliance, self-value
Self-reflection, self-talk, introspections
Value experiential learning
Awareness of the ongoing of becoming
Being authentic self
Won't do if it's not myself
Connected with one's feeling
Competency
I try to...
It's impossible to...
Exercise, nutrition and energy concern
Thinking before eating
Feel merits from exercise both physically and mentally
Exercise is waste of time, sweaty and sticky
Manageability, and be frugal and prudent
Explore and compare choices
Autonomous and parenting style
Health meaning beyond body and illness
Mental well-being
Spiritual well-being
Environment
Interpersonal relations
Health is strong body without diseases
Clear and coherent life's goal related with health and well-being vs do anything that's happy
Have to look good because of
Boy friend
Work success
Self-confidence

Expanded and Re-arranged While Linked and Labeled

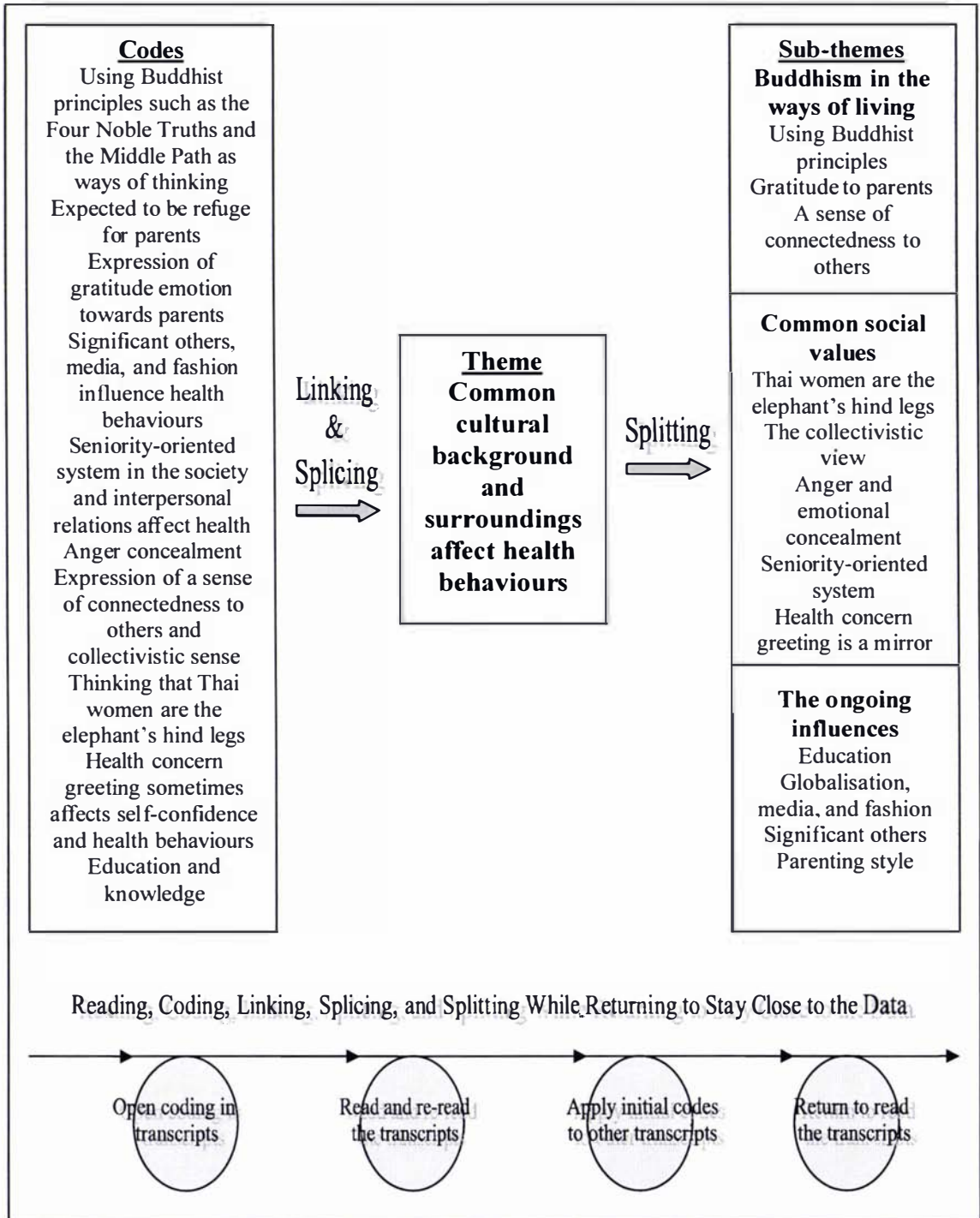


Figure 5.3

The Ongoing Activities to Condense Codes into Themes and Split them into Sub-themes

Unlike content analysis used for quantitative data where exclusive coding creates clear cut codes from the data, in qualitative thematic analysis it is accepted that codes may overlap on occasion (Joffe & Yardley, 2004). For example the code 'meditation' was overlapped as a common cultural background influenced by Buddhism and also a way of wellness enactment as well as a theme that created a mindful self in the self-development process of this group of Thai college women.

Indeed, Joffe and Yardley (2004, p. 62) comment that "although the coding will be influenced by similar subjective processes on every occasion, consistent coding by the researcher at least indicates that the distinctions made between codes are clear in the researcher's mind." The consistency of judgment helps protect against, or lessens, the contamination of projection. The desirable levels of consistency of agreement on the themes in the code can be achieved by applying the code to another set of transcripts. (Boyatzis, 1998; Joffe & Yardley, 2004). Applying a reliable code to the remaining raw information and to the entire sample is a cross-check. Coding the rest of the raw information means to apply a reliable code to the entire sample (Boyatzis, 1998).

Moving from coding to interpretation

Interpreting results is the last step of the data-driven approach of thematic analysis. The analysis began when all of the data had been categorised. For this step, Joffe and Yardley (2004) give explicit practical guidelines to explore the nuances of the high frequency themes in depth. And to remember that "a point that is only mentioned once, by one person, can still have great empirical relevance and conceptual importance ... [and that] ... numbers do not tell the whole story." (Joffe & Yardley, 2004, p. 67).

At this stage, themes and sub-themes had been linked and split by asking myself the questions presented in Figure 5.4. A reflective journal was kept to reflect the interactions with the data and some reflexivity was conducted orally with my supervisors. An example of a reflective journal is shown in Figure 5.5.

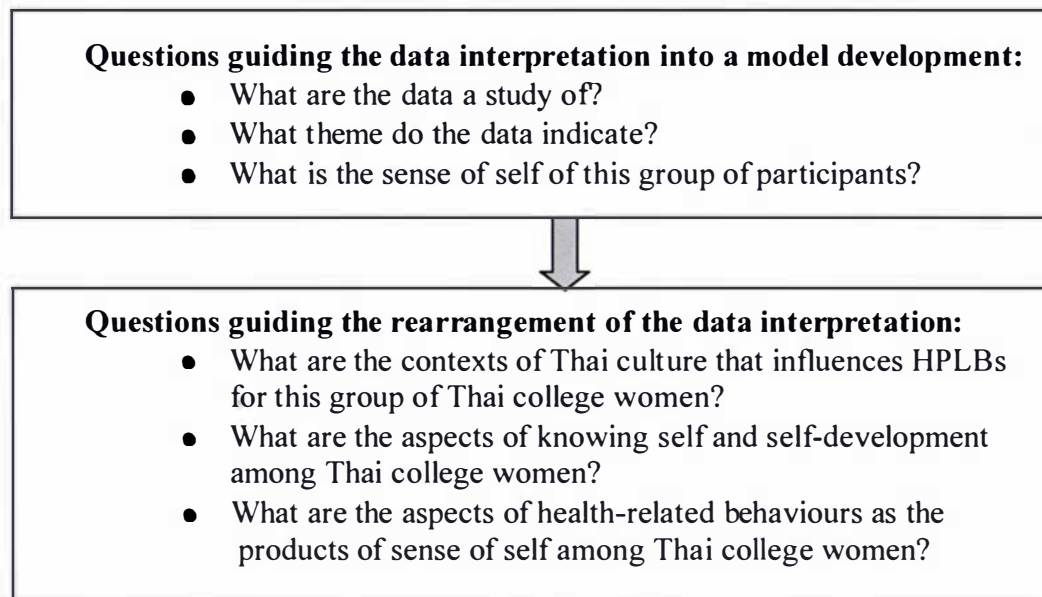


Figure 5.4 Questions guiding data analysis and interpretation

When I read through the qualitative data firstly I felt that a strong sense of gratitude towards their parents was shown in many transcripts, for example one participant (N9, 30 July 2004) said "mostly my parents. I love them a lot and do everything for them. I would never leave them and let them die together alone. I will keep on taking care of them forever." This seemed to be an essential motivation among this group of women.

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One aspect of the sense of self was their cultural self constructed in the Thai context. Living with the data, I conceived other components of sense of self that encourage the healthy women to engage in HPLBs that emerged from the qualitative data, and the compound sense of mindful self seemed to be overlapped to function in a healthy person.

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Figure 5.5 Reflective journals on the sense of gratitude towards parents.

The qualitative in-depth interviews revealed the sense of self of Thai college women in the Thai cultural context that even I had taken for granted before conducting this study. At first, I conceptualised their sense of mindful self that functioned to encourage them to take care of themselves without attending much to the context. Discussion with my supervisors opened my eyes to see that, actually, it was the sense of self in a particular context, and not the entire self that functioned. Professor Julie Boddy, with her Western context background, pointed out some

Eastern ways of thinking which I did not notice. Doctor Khanitta Nuntaboot, with her experiences of qualitative research with Thai people, pointed out issues in the Thai context which I had overlooked. Both of them have lifted me, a certain level, from the taken-for-granted in my own context.

The writing process was eventually interwoven into the sub-theme generating process after I had conceptualised the three main themes of the college women's *sense of self* and their *health-related behaviours in the Thai context*. Data analysis does not have to be finalised before starting the writing process, rather writing is part of the process of data analysis and is not separate from thinking and interpretation in qualitative research (Miles & Huberman, 1994; Sandelowski, 2003). Similarly, Atkinson (1991, p. 164) said:

The analytic induction of categories, themes and relationships; the explication of meaning; and the understanding of action may all proceed via the writing itself....The 'writing up' of the qualitative study is not merely a major and lengthy task; it is intrinsic to the 'analysis,' the 'theory' and the 'findings.'

The three main themes which emerged from the qualitative data are the context, the sense of mindful self, and the health-related behaviours. Table 5.4 summarises the concept of the Mindful Self as product of the inductive data analysis, the main themes and sub-themes that frame the data chapters that follow. The concept of the Mindful Self comprises three main themes, which are dynamic. It describes: (a) the cultural background and the surrounding ongoing influences which impact on the development of Thai women's sense of self and their health-related behaviours, (b) the sense of self and identity formation in the Thai context, and (c) the health-related behaviours which stem from the compound self that function more or less appropriately. They are the results of interactions between the self and its context. Even though apparent overlaps do occur, it is not repetition but addressing a different emphasis of the meaning of each theme, sub-theme, component, and coding.

Table 5.4 The Mindful Self: Themes, Sub-themes, and Components

	Themes	Focus	Sub-themes	Components
The Mindful Self	Common Cultural Background and Surrounding Influences	The context in Thai culture that influences HPLBs for Thai college women	Buddhism as a strong root in Thai culture	<ul style="list-style-type: none"> -Four Noble Truths principle -The Middle Path -Meditation, Accumulate merits -Keep morality and do good deeds -Gratitude to parents -Gratitude to others creates a sense of connectedness
			Common social values	<ul style="list-style-type: none"> -Women are elephant’s hind legs -The expanded family and collectivistic view -Anger concealment -Seniority-oriented system -Health concern greeting
			The ongoing influences	<ul style="list-style-type: none"> -Globalisation, media and fashion -The influence of education -Significant others
	Sense of Self and Self-Formation	The aspects of knowing self and self-development in the Thai Context	The Mindful Self	<ul style="list-style-type: none"> -The Cultural Self -The Autonomous Self -The Connected Self -The Authentic Self -The Sensible Self -The Competent Self
			The paths to knowing self	<ul style="list-style-type: none"> -Encounter with death issue -Interpersonal relations -Experiential learning and exploration
			A sense of non-attachment	<ul style="list-style-type: none"> -Non-attachment self-narrative
	Health-Related Behaviours and Wellness Enactment	The products pertaining to sense of self and HPLBs	Health motivation	<ul style="list-style-type: none"> -The gratitude motive -The positive health motivation -The negative health motivation -The motivation of attractiveness for intimacy -Anticipating graduation -To be a role model
			Health-comprehension	<ul style="list-style-type: none"> -Meaning given to health -Health and coherence life goals -Health manageability -Active cognitive monitoring
			Health competency	<ul style="list-style-type: none"> -Believing in self-capacity -Basic personal care -Searching for health information -Routine exercise creates well-being -Food and energy concerns -Interpersonal relations maintenance -Spiritual growth in Thai ways

The positive or negative consequences of self-formation in the Thai context and its health-related behaviours are discussed. I organise the three main themes in the three following chapters: the cultural context in Chapter 6, the mindful self formation in Chapter 7, and the wellness enactment and health-related behaviours in Chapter 8. Themes, sub-themes, and their components are grouped and divided during the writing process. More literature was searched to compare, support, and discuss from time to time. That is why the reader will see new literature discussed beyond the literature reviewed in Chapter 2.

ESTABLISHING RESEARCH TRUSTWORTHINESS

Credibility in this research was established by triangulation of methods which helped explain the predictors and the context of Thai culture encouraging Thai college women to engage in health-promoting lifestyle behaviours. Credibility was also established by prolonged engagement in the field during Study B. The qualitative data, their analysis, and the conceptualisation of the model were obtained by a systematic thematic analysis, while the theoretical predictors from the quantitative research were used to direct discussion and comparison for the main concepts of sense of self issues. All methods were undertaken under supervision from my supervisors who potentially reflected, challenged, and shaped my process of inquiry and also my verbal reflectivity encounter with them during the whole process.

Verification and trustworthiness were assessed by extensively reviewing the data (Whaley & Ebbeck, 2002). Additional verification procedures include keeping a journal during the course of the research, and clarifying researcher bias before and during the study with supervisors. Transferability, dependability, and confirmability were related to my reflective journal along the whole process. A diary record of any ideas, comments, and inquiry reflected in the whole process of the research was kept and discussed with my supervisors. A clear audit trail has been outlined in this chapter for the reader. The context relevant to the study presented in Chapter 6 is also an indicator for any future research transferability if a similar context will be considered.

CONCLUSION

For Study B of the research I gained qualitative data from in-depth interviews with twenty-five nurse and non-nurse participants. Qualitative thematic analysis yielded a model conceptualised from the emerged themes, sub-themes and their components related to the participants' narratives. Establishing research trustworthiness in terms of its credibility, transferability, dependability, and confirmability was undertaken by the design of mixed methods as method triangulation, by prolonged engagement in the field, and by keeping a reflective journal and diary records for discussion with research supervisors. The next chapter provides the cultural background and context of Thai culture that have impacted on the Thai college women's sense of self and health-related behaviours.

CHAPTER 6

COMMON CULTURAL BACKGROUND AND SURROUNDING INFLUENCES

This chapter outlines the cultural background of Buddhist-based traditions, common social values, and the surrounding ongoing influences which impact on the self formation and health-related behaviours of Thai college women. The self and behaviours are constructed amidst the social interactions with their significant others, and the ongoing surrounding influences in the Thai cultural context. This chapter therefore provides a general portrait of Thai college women in their context. Figure 6.1 summarises the factors in the Thai context that impact on sense of self and health behaviours of Thai college women. These factors affect people’s mindset, health behaviours, and well-being. The participants in this study are enculturated by Buddhism and yet in a culture in transition because of the impact of modernity and urbanisation.

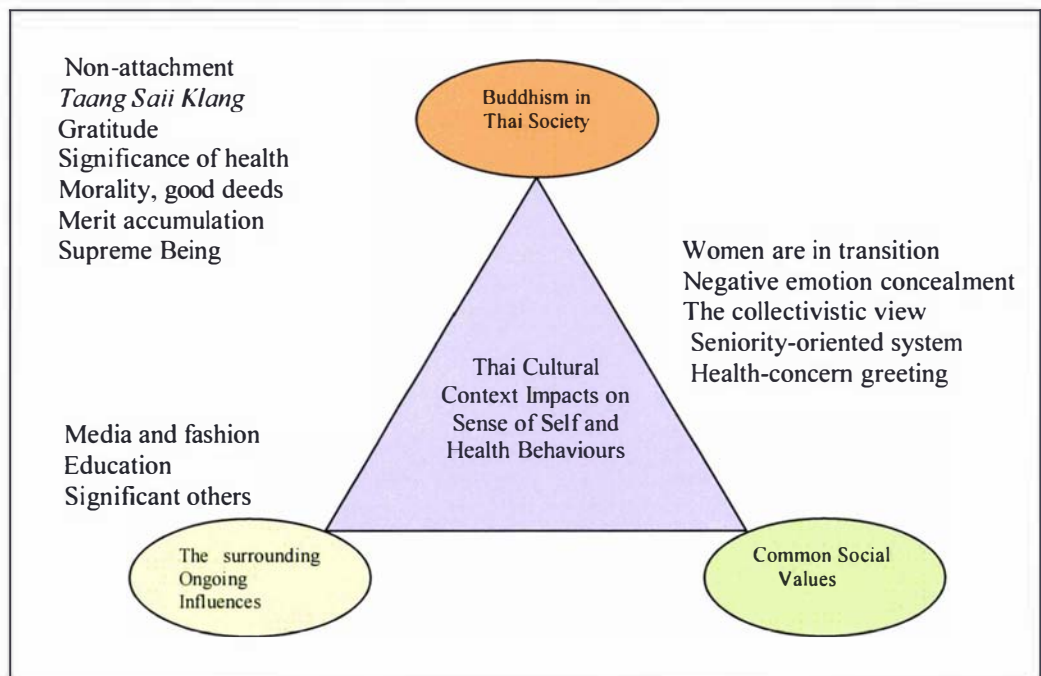


Figure 6.1 Summary of the context and surrounding influences that impact on sense of self and health-related behaviours in Thai society

BUDDHISM AS A STRONG ROOT IN THAI CULTURE

Many participants mentioned the impact of Buddhism on their lives and ways of thinking. Out of the estimated 65 million people in Thailand, about 95 % are Buddhists. Theravāda² Buddhism was established as Thailand's dominant religion. Therefore, Buddhism has been the main driving force in Thai cultural development, people's sense of self, beliefs, and way of life through the centuries.

Generally, Buddhists are invited to study deeply in all phenomena from the self to the universe and not required to believe anything. This understanding is illustrated by one participant who also implicitly conveys her beliefs in *karma*, the law of cause and effect, and Buddhist teachings to keep one's self and mind neutral:

Buddhism does not force what you should believe in. It would be to do good things and receive good things in return and bad things when you did something bad. ...With Buddhism there's no forcing to believe; I used to study Buddhism since 7th grade that taught me to *Tam Dee* (do good deeds), sharing, and keep *klaang-klaang* (lit. 'the middle') or to be neutral about things. (N5, 22 June 2004)

Buddhists believe that one should never cause harm to any living thing. Buddhist philosophy emphasises compassion and peaceful co-existence. The concept of *karma* plays an important role in people's ways of living. One's volitional acts are believed to be the causes of effects (*karma*) in the chain of conditioned consequences (Chan, Ho, & Chow, 2001).

Although Buddhism is a religion which reacts against caste and dogma regarding sacrifice and rituals of Brahmanism (a religion that originated in India), the concepts of karma and rebirth in Brahmanism have had a great influence on Thai Buddhists' beliefs. While adherents in Brahmanism tend to believe that all present events are the consequences of the old karma, Buddhists, in fact, decline to attach to all extreme views. Brahmanism impacts on the way of thinking of many people especially lay people and women who have no opportunity to be ordained or to study deeply in Buddhist principles. As a result, a mixture of ways of living and beliefs between Buddhism and Brahmanism can be seen in Thai society, for example, regarding the sacrifice of food or meat at worship shrines.

² Theravāda Buddhism developed in India during the century subsequent to the death of the Buddha, and for many centuries has been the predominant religion of Sri Lanka, Cambodia, Laos, Myanmar, Thailand, and southwest of China (Wikipedia Website, 2006).

During field work for in-depth interviews when I went to places around Khon Kaen University (KKU) to talk with the university students, and at the KKU's joss house I observed that many students came to worship the shrine, as a supreme being, as a mental refuge, and as a reality co-creator. One student came with a pig's head and told me that:

I've asked him, *Chaow Phoa Mor Din Daeng* (the KKU's Joss House) for good grades and I've received what I wanted. ...I would sacrifice a pig's head and wait until the incense that I light up is burned off and then take the pig's head back to eat at the dormitory. (NN11, 20 June 2004)

The word *chaow phoa* means the spirit guardian (male), and *Mor Din Daeng* is a local name for Khon Kaen University. However, not everyone made a vow with a sacrifice. Some just came to worship for their mental refuge. Like NN12, who came along to the shrine with NN11, and said that:

Mostly, it would be positive results and I would get what I asked him to bless me with but I didn't ask him to give me a grade or promise that I would sacrifice a pig's head. I don't know. I don't think that I have to do that much. Just worship and feel good...O.K. just that. I have a level of confidence which is more than my friends'. Mostly, I would come and make a wish but not sacrifice. (NN12, 20 June 2004)

Most of the student nurse participants believed that good health and good fortune began from themselves and their own conduct, even though they still needed to make a wish with their Supreme Being:

I can ask for anything from him, like to be accepted in college. [Who is him?] The Buddha, an image of Buddha and nowhere specific. I would pay respect and ask for me to be accepted in college, and also, to have a happy life and good health for my family and myself. ...It has to do with me too. ...Maybe because I asked for good health before I would do anything. I would ask him to grant me good health first. ...It should start with myself first by exercise first then good health will follow. (N13, 21 June 2004)

To understand the impact of Buddhism on Thais' way of thinking and well-being, some of the core concepts in Buddhism should be studied.

THE THREE CHARACTERISTICS OF BUDDHISM AND THE FOUR NOBLE TRUTHS

In general, Thais would learn the teaching of the Four Noble Truths in Buddhism when they attend secondary school or receive these principles from the elderly in their family, parents or grandparents. This teaching has influenced their ways of confronting life events.

...There're Four Noble Truths in Buddhism and I have to follow them, my father would tell me. I got to think when I was alone by myself. Think about what my father said. ... I lived with my grandmother and she liked to read Dharma book and then told me about it. (N3, 27 July 2004)

Canonical Buddhism has been conveyed in terms of the Four Noble Truths:

And what ... is the Noble Truth of Suffering? ... In short, the five aggregates of grasping are suffering... And what... is the Noble Truth of the Origin of Suffering? It is that craving which gives rise to rebirth (lit. 'causing again-becoming'), bound up with pleasure and lust, finding fresh delight now here, now there: that is to say sensual craving, craving for existence, and craving for non-existence ... And what ... is the Noble Truth of the Cessation of Suffering? It is the complete fading-away and extinction of this craving, ... , detachment from it.. And what... is the Noble Truth of the Way of Practice Leading to the Cessation of Suffering? It is just this Noble Eightfold Path, namely: Right View, Right Thought, Right Speech, Right Action, Right Livelihood, Right Effort, Right Mindfulness, Right Concentration...

(Pasadika, 2002, p. 149)

The knowledge and practices of Buddhism are derived from knowing the Dependent Origination (Macy, 1984) which can be explained in terms of the Three Characteristics proposing that all composite things (matter or mind, that is everything excluding Nirvana) are: (1) impermanent (*anicca*), (2) of suffering and unsatisfactory nature (*dukkha*), and (3) without self-entity or empty (*anatta*). The impermanence of everything (*anicca*) refers to the ceaseless change of all matter and energy (Kahn, 1985). While only the materialistic parts of things have been claimed to be impermanent by sciences, *anicca* or impermanence has been claimed in the mental world by the Buddha as well. Things are all composed of subatomic particles that appear and vanish in fractions of time. This implies that nothing is solid or endures; even if it is matter, feeling, or self. Suffering is caused by grasping for pleasure and repelling displeasure – that is the Second Noble Truth. *Dukkha* is a corollary of *anicca* meaning that things are changing every moment, thus they are unsatisfactory by nature. Everything is just of dependent co-arising, that is, both material and mental entities change continually according to causes and conditions. To see 'suffering' is to see the interdependent nature of reality. The word *anatta* means emptiness, but it does not mean nothingness (Macy, 1984).

For Buddhists, each mind in each self is a means to meditate and obtain this kind of truth in order to avoid “a state of distorted perceptions and fantasies, acting inappropriately with reference to our own true nature and the reality of the immediate situation, and consequently creating stupid and useless suffering.” (Tart, 1990, p. 81). A notion that should be held in the conscious mind is that there is no-self (*anatman*), and that “the ‘I,’ the ego, in the sense that we exist as separate entities, is actually a fiction.” (Macy, 1984, p. 117) The sense of no-self could be reflective of a healthy mind, which will be discussed later in Chapter 7. Definitely, it is not a teaching for people to lack control. The sense of self and the sense of non-self have to be understood in balance.

None of the participants explicitly talked about these principles of the Three Characteristics, however all Buddhists would be embedded at some level regarding the notion of the impermanence of all things. This kind of thought was implicitly expressed in terms of *Bplohg-Dtohk*, or *Ploay-wang*, or *Oo-baehk-khaa* presented for the detached feeling from, or being stoic with, things, self, and feelings – this is the basic emotion of non-self embedded in Thais’ cultural self. For example, they said:

Pretend that if it’s about beauty and I really want to be very beautiful but when I read Dharma Books....It means I was born to be like this so I have to accept my condition. That means *Bplohg-Dtohk*. (NN5, 2 July 2004)

Listen to music and warn myself that if I think too much then I might sooner get old. I have to let things be (*Ploay-Wang*), and I will feel better. (N3, 27 July 2004)

My father told me to be indifferent when I did not get what I was hoping for. Sometimes when you don’t get things your way, then to be *upekkhā* (*oo-baehk-khaa*, pronunciation in Thai), to *La* it (to let it go). (= equanimity, impartiality, indifference) (N3, 27 July 2004)

Generally, Thais would keep in mind these principles, and would not attach much importance to expectations and kinds of thoughts. However, when the principle is misused the sense of lack of control might be adopted. This principle of Buddhism impacts on their sense of non-attachment. The important practice to end suffering is the Noble Eightfold Path of Buddha which is, in summary, a practical description to follow the Buddha’s Middle Path.

THE MIDDLE PATH

The Middle Path Methodology has been conveyed to Thais as *Taang Saii Klang*, and adopted as a psychological survival strategy. This cultural knowledge conveyed from Buddhism could be seen as a psychological survival strategy, as seen in the case of Thai college women when they confronted difficult mental events. A participant narrated about keeping *taang sai klang*:

There was a time that I argued with my boyfriend and that made me feel no appetite. I would not like to do anything, would not like to eat, to study,...to do anything, even to take a bath. I did only sleep, laid down and did nothing, thought of nothing, wanted nothing and my health was ruined. I would think why did he not call me to reconcile with me. It was like the world would be broken that day. Health got bad. But like I said to you before, to become stoic and *Bplohng-Dtohk*, think and conduct life in *Taang Saii Klang*. I have to think it through and conceive it myself. But there was a time that I could not solve or think it through. I did not eat for three days, and my father supported me and touched my head warmly and asked me who my boyfriend was, because dad and mom have never hurt me this much, never hit or said bad things to me, and told me that my boyfriend was not the one who raised me to grow up, and that I still have dad and mom to support me. I thought it's true, then I could cope with it, started to eat, and decided (*Tam Jai*) to agree with my parents.

But for a while I would feel depressed again and I would ask my parents not to go to work and stay with me when I was sad and did not want to stay alone, but they would tell me that I have to be able to stay alone because one day they would pass away and I had to stay on my own. I thought it's true. I have to be able to stay on my own. My mother took me to the temple and I heard the monks teach about *Taang Saii Klang* (the Middle Path) to the audience and that pointed to my mind. Don't be too tense or too loose, try to be in *Taang Saii Klang*. I listened to him and thought, but to practise the principle depends on us. I think if we do not attach too much with anything, or expect things to be what we want, this or that, like thinking that my boyfriend has to take care of me all the time or something like that, don't attach to that thinking. He loves me and honors me and that's O.K.

Sometimes, I was already annoyed, and then got to think umm... why I had to be annoyed with that little thing, so let it go. ...Tenseness with study is normal and I can ask friends about it, but another stress is about my boyfriend, but I would think that it's normal for a guy to behave like a suitor with other women. I would feel stress, but when I think through I would *Bplohng-Dtohk* (become stoic with life). By *Bplohng*, I mean..., like Buddhism says about *Taang Saii Klang*..., like if we stay in *Taang Saii Klang* we would survive mentally, don't think too much or don't be depressed with things or put self to the inferior side too much. Walk straight and then there is no harm, nothing, and then we can stay alive, won't feel like nearly die or lonely, or this and that, so don't think too much. That's it. (NN9, 30 June 2004)

Learning about *Taang Saii Klang* is to see things as they really are. It is not to learn helplessness or to let your self down. For NN9, she learnt that:

Taang Saii Klang means not to be too tense or too loose, and can apply to every aspect in life, like study, if you are late and keep thinking tensely with why, why me, and then stress all day, or let too loose with the feeling or withdraw and let your self down, or get mad with little things. We had better do our best with our duty, now is studying and seeking knowledge. I think *Taang Saii Klang* can be applied with every aspect in life. I used to read Dharma but not much. (NN9, 30 June 2004)

In other words, they would say *Tam Jai pen Klang*, which means to be neutral about things, the mind, and the self. The Middle Path Methodology might be a quality that could buffer an overstriving manner in every aspect of life. As illustrated by many participants, for example, one said:

I would *Tam Jai Pen Klang* (being neutral) when doing something because it might not be like what I thought and expected. (N3, 27 July 2004)

The Middle Path is a position of neither/nor as Lax (1996, p. 197) defines it as “a position of seeing the delusion of the extremes.”

MORALITY AND GOOD DEEDS IN BUDDHISM

One of the strong commitments which have long been embedded in the minds of Thai people is to *tam dee* which means to do good deeds. As they said that:

...to always *Tam Dee* as if salt will always taste salty. (N6, 22 June 2004)

I would *Tam Dee* (do good deeds) and I won't do the things that I think are bad. I do believe [Karma]. (NN1, 19 June 2004)

The morality teaching in Buddhism impacts on Thais' worldview, they thought:

What I wanted is simple things that are worthwhile for me that is doing things that are not against my feelings and not troubling anyone. (N2, 18 June 2004)

You have to pay respect when you approach people, *khan-ti* (be patient), and learn how to talk to people. (N3, 27 June 2004)

Thai people are taught that the distinction between what is good or bad is simple. In Buddhism, it hinges on the intention or motivation which originates an action. It is said that the deed which is motivated by greed/attachment, hatred/ill will, or delusion/stupidity is malevolent. Greed, hatred and delusion are called the Three Evil Roots that create all bad Karma, which leads to all kinds of suffering in association with the Principle of Cause and Effect.

Thai people are always taught “do good deeds, receive good.” Generally, they are taught to be mindful with self and others regarding their deeds. The ten good deeds or The Ten Meritorious Deeds (*bun*), which guide people to gain a peaceful life and develop knowledge and understanding in their lives are as follows:

1. Charity (*Dāna*)
2. Morality / Taking Precepts (*Sila*)
3. Mental cultivation / Meditation (*Samadhi*)
4. Reverence or respect
5. Services in helping others
6. Transference of merits
7. Rejoicing in the merits of others
8. Preaching and teaching Dharma
9. Listening to the Dharma
10. Straightening one's own views (Alan Khoo Website, 2006)

These are all meaningful ways of living which are described by Thai college women in this study.

I think it (*tam bun*, or giving or making merits) has meaning. It gave me peace of mind and moralism. ...When it is a Buddhist day of worship there will be a sermon. We listen and try to use it with our daily life. (N6, 22 June 2004)

Because of the strong influence of Brahmanism most Thais believe in reincarnation, that each person will be born again and again until one reaches the state of emptiness if they accumulate merits, and purify the mind in each rebirth. In fact, people still have such a perspective of accumulation of meritorious deeds for their physical rebirth in the next life. A woman told me about accumulating merits for the next life:

Mostly I made the merits for the future, for the next life. Like offering food for monks now so I can get food in my next life that is to have food merit waiting for me in my next life. I believe like this, since I was a child and have listened to the sermon since then. (N8, 9 August 2004)

Even though physical rebirth is not claimed in Buddhist doctrine, it may be that this practice is implicitly tolerated within Buddhism so that less spiritually advanced people will not go astray. The belief of accumulation of merits can be seen in most participants.

Participants also report the immediate good feeling (*Sabaii Jai*) as a reaction after doing a merit. It is a practice in Thai culture for mental well-being as they usually report the feeling of *Sabaii Jai*, or feeling good in making merits by offering food for monks.

Normally, I would not go to temple, but I would go occasionally when I'm back home because my parents like to make merits or when we go to visit our grandmothers in another province then we would go to temple. We would sometimes go to give alms to monks or give food for monks when it's our birthday. Sometimes it's my friend's birthday so we will go along together to give food to monks. ...Because we are Buddhists so we should make merits. (*Tam-Bunn*), and after making merits, there is effect with my mind, like I would feel *Sabaii-Jai*. (NN3, 18 June 2004)

I would go to make merit and offer food to monks. I felt better and it seemed like everything is destined to happen and for them to meet me. I felt that when I make merit then it's for both good and bad things. Like the matter of good and bad destiny. ...I think that it's from listening to Dharma and sermon. He said that everyone has this life and next life and the good or bad things that you will meet this life are from the past life. Like the things that oppressed me then I would give the merit to them and make bad luck less. Something I would think and let loose some because I think that it's the result from the past life. ...I think it's for the present and future too. I felt that I would get good things in return when I did good things. Like doing well with my friends then I would get good things in return. And even if that didn't happen; I still felt good about it. (N8, 9 August 2004)

Only a small percentage of Thai Buddhists embrace the monastic life. Generally, women are not permitted to be ordained, but only permitted to be nuns who are Buddhist practitioners with fewer precepts to follow than monks. The Buddha offers to lay followers the Five Precepts.

I try to follow *sila* (Five Precepts) of Buddhism, but sometimes I cannot follow them all, like telling a lie to keep myself safe or to make an excuse but not to be reasonable. But it's just a kidding with friends not a big matter. (NN6, 29 June 2004)

In general, the Five Precepts (refrain from killing; from stealing; from lying, slandering, gossiping, and spreading rumours; from sexual misconduct; and from taking intoxicants) are the well known standard for morality in Thai society.

Meditation was another activity in normal life which the participants mentioned. For Thais, in meditation practice, their mind moments and behaviours are pondered. Like one said:

I would sit and meditate when I am alone on Buddhist day of worship. ...To meditate is not just sitting cross-legged like what I am doing now. It's to sit and ponder on things that you did. To figure out if it's right or suitable, if not then don't do it any more. When things happened then you should think and make it better and don't let it happen again. ...Let bygones be bygones. (N3, 27 July 2004)

A prominent practice to ponder deeply on the way things really are for a Buddhist is called *Vipassana Meditation*, and it will be called *meditation* for short. The essential practices of meditation are to be mindful, to be aware of all the bodily sensations, and to observe them with equanimity, even if they are positive or

negative ones without attachment, grasping them or fleeing from them, loving or hating them, because there is nothing to grasp or flee from (Fontana, 1987):

When we become able to take the reflective position of insight meditation in relation to our thoughts, feelings, and sensations, we are developing a state of equanimity. When we do not take this observing position, we become attached. We are immersed or captured by the contents of our interconnected mind moments.

(Lax, 1996, p. 205)

The word 'Equanimity' is a state of mind named '*Upekkhā*' (is also said to be impartiality or indifference). However, it is noted that:

... many spiritual teachers and gurus preach a detachment that appears suspiciously akin to sublime indifference, as if one should or could remain aloof from the sufferings of others. In dependent co-arising, such indifference is impossible; we participate in the existence of all beings and in the world we co-create with them. Dharma detachment is from ego, not from the world.

(Macy, 1984, p. 119)

Rather, one's spiritual growth should be headed to the Four Abodes of the Buddha, namely, the four *Brahmavihāras*: *mettā*, *karunā*, *muditā*, and *upekkhā*, which refer to loving-kindness, compassion, joy in the joy of others (altruistic joy), and equanimity (neutrality, poise) (Macy, 1984). It helps people keep a peaceful mind when things do not go in the way they want them to be, and at the same time, to have a desire to help other people, like when N3 who indicated the psychological strategy of '*Tam Jai pen Klang*' also said:

...I would like to help others to make them feel better... (N3, 27 July 2004)

These are the two general outcomes from learning Buddhism and practising meditation, being neutral about self and things or learn to move to the non-attachment stage and having loving-kindness and compassion. Meditation is a general wellness practice among this group of healthy women that will be discussed again in Chapter 8.

However, this does not mean that every participant uses Buddhist principles. Some This would put Buddhism aside as a taken-for-granted and do not make an exploration of it, especially, when their parents have not led them to take on Buddhist principles.

Each year if school does not send us to the temple, then I would never go. My parents are like that too. The one that's not my parents then it has to be monks; I would be respectful when I see one. It's what I have seen for a long time. Not believing but not be disrespectful. I would respect. Everyone accepted and believed in Buddhism, even my grandparents. Since I was born my grandparents would teach me about Buddhism and took me to offer food for monks. I was taught and raised that way. But about how much faith I have in it, I don't look much in religion. Right now I still don't have a job or anything so I'm mostly thinking about these things. When I am gratified with these things then I would be thinking of religion. My grandparents are going to temple now that they are getting older and they hadn't gone before. Do one stage at a time with age, life, and the situation that I am in. Just put religion aside. (N9, 30 July 2004)

SIGNIFICANCE OF HEALTH IN BUDDHISM

The significance of health is also explicitly taught in Buddhism. Ethics and health are cultivated in Buddhist practice. Thais are taught that '*arogya parama labbhā*' which means 'non-diseased-ness is the greatest treasure'. The value of health in terms of *arogya*, or 'non-diseased-ness' in Thai, would be said in a phrase *Mai Mi Roak Pai Khai Jeb* (meaning no diseases, harms, fevers, and pains), and was expressed by most of the participants, for example, they said that:

Health is to live well, eat well, don't get sick, and *Mai Mi Roak Pai Khai Jeb*. (NN2, 18 June 2004)

In Buddhist-based culture, a healthy body and mind are significant. This is well depicted by Pasadika (2002) that:

...a prominent feature of the Buddhist doctrine is the teaching that birth as a human being, vis-à-vis myriads of the other forms of life, is exceedingly difficult to obtain. For this reason human existence, oneself being fortunate enough to be endowed with it, should not be squandered or intentionally shortened. The longer one's life-span is, the more opportunity one has at disposal to study and practice according to the Buddha's teaching, to cultivate one's mind and become mature so as to get nearer one's goal of final emancipation from all suffering (Pasadika, 2002, p. 155).

This reflects a general ideas about health for Thais. However, wellness practice is likely to be derived from the meanings given to health beyond the stage of non-diseased-ness. Knowledge of health in more detail has given the student nurse participants a meaning of health in a more expanded and integrated manner, and obviously encourages them to engage in more healthy choices in everyday life as will be illustrated later in this chapter.

GRATITUDE AS A GRAND ROOT OF WELLNESS FOR SELF AND SOCIETY

The moral effects of gratitude on health-promoting behaviours were expressed by most of the participants in this study. In this section I will firstly provide readers with general knowledge of the historical background of gratitude emotion embedded in Thai culture by Buddhism, and it will be followed by details of participants' transcripts expressing their sense of gratitude in many ways.

Understanding gratitude in Buddhism

The Pāli word for gratitude, *Kataññū*, literally means “knowing what was done.” The recurring theme of having benefited from what others have done makes gratitude a central component in the narration of Theravāda Buddhism. According to Berkwitz (2003), gratitude emotions can be cultural products instilled by historical narratives to accomplish a variety of ethical ends. Gratitude is an emotion predicted on one's relationship to another and involves making ethical judgments about what one owes to another or others who have rendered service or help to oneself. “As an emotional response prefigured by historical narratives, gratitude is thereby implicated in efforts to transform Buddhist devotees into virtuous persons who recognize and act on their ascribed status as beneficiaries of the past.” (Berkwitz, 2003, p. 588).

To cultivate grateful dispositions in readers and listeners, the historical narratives of the Buddha³ give rise to feelings of dependence on past actors via at least two prominent themes. The first theme pertains to the struggles and sacrifices endured by the bodhisattva (a state of a person before Buddhahood) on his way to attaining Buddhahood. The second theme pertains to the resolutions of the living Buddha to teach and leave relics for other beings to venerate.

³ A Buddha is considered to be a person who discovers the true nature of reality through years of study, investigation of the various religious practices of his time, and meditation. This transformational discovery is called "enlightenment". Any person who has, without the instruction of others, become awakened to the principles of the Dharma, is called a Buddha (Wikipedia Website, 2006).

Gratitude seen in the composed Buddhist histories is to orient the emotional lives of devotees toward the past and to give rise to moral communities in the present, in other words “narratives that ‘record’ the past were also seen to *re-create* the present” (Berkwitz, 2003, p. 582). In so doing, emotions of gratitude have been taken to be social products and cultural constructs rather than taking emotions as passive and natural characteristics of one’s individuality as described in modern Western culture (Berkwitz, 2003).

In Theravāda Buddhism histories, numerous examples of virtuous persons displaying gratitude for the past, cause the readers and listeners to internalise gratitude, the moral obligation to respect one’s benefactor and acknowledge one’s status as a beneficiary. These remarks emphasise a general expectation that “virtuous persons acknowledge those who have helped them to become virtuous.” (Berkwitz, 2003, p. 595).

Importantly, this recognition of one’s dependence on others has not led Theravāda Buddhists to devalue self-effort and moral responsibility. Instead it signals a vision of a moral community wherein one stands to benefit from what others have done and feels obligated to respect one’s benefactors and to try to reciprocate by displaying one’s gratitude in the form of offerings.

(Berkwitz, 2003, p. 597)

These narratives make ethical demands on the Buddhist devotees such that the beneficiaries of the selfless acts of the Buddha feel obliged to do something for him in return. This obligation is usually manifested in the form of making offerings, or *pūjā*, to the relics of the Buddha (Berkwitz, 2003), and to monks who are the Buddhist devotees as well. This practice could be illustrated in a participant’s saying that:

...when I am alone on Buddhist day of worship. I would do everything like arrange flowers to pay respect in front of the image of the Buddha which makes me feel good. I got used to doing this with my father since I was a child. (N3, 27 July 2004)

This is called *katavedī*, which means to offer reciprocal kindness to one’s benefactors. In Thai culture, they say “*Kataññū katavedī* is the symbolic behaviour of a virtuous person.” In addition, grateful feeling is conveyed to children in the family by the discourse that says “parents are the greatest monks at home.”

Gratitude Expressions in Thai College Women

Gratitude triggers many kinds of healthy behaviours from physical to spiritual. The research participants want to be physically strong to work and earn money to take care of parents, and also the memory and expressions of gratitude promote their health, both mentally and spiritually. The opportunity to be educated is often a trigger for gratitude emotion and then gratitude acts as a health promotion booster. Gratitude is a potential factor that encourages young Thai college women to engage in healthy lifestyle behaviours, even in a frugal manner in some cases.

The concept of repayment for their parents' goodness is a belief held by most Thai Buddhists (Choowattanapakorn, 1999). Since their secondary school years, Thai children would be taught that there are three kinds of sons or daughters, which are *abhijāta-putta* (or another term is *atijāta-putta*) (superior-born son), *amujāta-putta* (like-born son), and *avajāta-putta* (inferior-born son), in terms of their virtue for self, parents, family and society. For example, N10 said her motivation was:

... to be refuge for our parents to take care of them and make them feel comfort when they are getting old. We want to be *abhijāta-putta* (superior-born son), which means the daughter or son who make the better things for the family and parents, not to be *avajāta-putta* (inferior-born son). (N10, 26 May 2004)

This value of being *abhijāta-putta* (superior-born son), and *kataññū katavedī* (grateful and offer reciprocal kindness to parents) is a kind of commitment among Thais. Culturally, children have a sense of obligation to care for their parents, and do not leave their parents alone. An expression was given by a participant below:

Mostly (I do for) my parents. I love them a lot and do everything for them. ... I would never leave them and let them die together alone. I will keep on taking care of them forever. (N9, 30 July 2004)

Children are expected to take care of, and repay, their parents for having borne and nurtured them. This sense of obligation is very strong, especially regarding their relationship with their mothers. This can be seen in Mulder's statements:

Your mother loves you more than anybody else. She has given birth to you: you have grown up because of sucking her blood. She has been feeding you and caring for you. She knows what is best for you. You should return her love, be thankful to her, respect her, yet in all your life you will never be able to repay her for the overflowing goodness she has done for you. Never, never forget to return the goodness that she has to you; be grateful and fulfil your filial obligation (Mulder, cited in Choowattanapakorn, 1999, p. 97).

Most Thais would refuse to let their parents move into an institute for aged care, of which there are currently only 18 places countrywide, and might get negative criticism from the community in which they live if they failed to provide care for their parents. Although Thai women now have equal access to education and work outside in the workforce, they are still expected to be the caregivers for elderly parents (Choowattanapakorn, 1999). The value of gratitude was reported in Thailand in a study done by Kespichayawattana (1999) who found that for Thais, to take care of frail elderly parents was perceived as earning valuable merits. The concept of *Katanyu Katavedi* was explored into three dimensions: “a) *bun khun* of parents: total benefits that parents have bestowed upon children; b) *katanyu*: the sense of gratitude towards parents; and c) *katavedi*: the obligatory action in paying back to parents. She reported that the cultural contextual factors which underlined gratitude value and this kind of social practice were: 1) hierarchical relationships between parents and child; 2) social value of obligation to parents; and 3) religious teaching. Her participants reported that the positive consequences of caregiving to parents were: happiness, sense of self-pride, recognition of praise from others, warmth, attaining of merit, and feeling of being lucky. Yet, there were also negative consequences of caregiving situations. They were: frustration with other family members, burden, deterioration of the caregiver’s health, petty conflict with the care receiver, physical strain, stress, feeling of guilt, and social isolation.

Generally, most of the participants were from middle class socioeconomic families, so their parents had to work hard in order to support their children’s higher education. Also, education and the culture itself urge young educated Thai women to feel grateful for their opportunity to be educated. For example, some participants said that:

I would think of them [my parents] first before doing anything because I am the youngest and I am the only one who goes to college. All my siblings only finished 6th grade. ... because we were poor. My siblings wanted to go to college but my parents wouldn’t let them because there was no money. I was the last one so they let me. Therefore, I think of my parents first before doing anything. (N6, 22 June 2004)

And while I was attending college I would miss my parents a lot and I realised that I probably couldn’t make it without them. (N3, 27 July 2004)

Gratitude emotion was expressed from a spiritual aspect like when they made merit and made a wish for their parents’ happiness as a routine ritual. The strong bonding between them and their parents was seen when N6 narrated that:

It felt good to *tam bunn* (make merit), offer food to monks, and to pour water for making merit. ... It felt like I am giving merit to the dead. ... The dead could be our relatives. ... Do it (pouring water through my hand, *gruoad-nam*) during a sermon. After that we sprinkle it (water) at a plant. At the time you have to take off your shoes then pray *uppamahoti arnayoung*, which mean happiness for living parents. Someone told me to do it when pouring water to make merit. I remembered. Nice.... there is a belief that this will affect our parents and the person that we gave merit to.... I don't actually see it but I can feel it. I did it because I want the person that I loved to be happy.... I become happy. (N6, 22 June 2004)

Instead of spending time having fun activities with friends, some college women thought that was useless. Gratitude emotion triggers the idea that they were better to do the activities that help save their parents money, such as spending free time to go exercising or jogging, or eating nutritious food in a frugal manner with fewer close friends. Concern about financial support from parents made them consider about spending time and money in useful ways, like N2 said that:

To cut down on expenses because right now my mother supports my younger brother and me. She doesn't have much money or huge income. Going out with friends, then the expenses would increase... That would increase my expenses but I realise that my mother is the one giving me money. I did it (exercise) and it made me happy and to kill time because some week, meaning Monday to Friday, was to kill time. The time for exercise is at 5 o'clock, for example if I would just only eat dinner and do nothing that is a day wasted. I really have free time but I had to manage it so I would have free time for reading textbooks. That is I don't like to go out to have fun like my friends, but would go out for milk sometimes when I pass by. ... I know the value of money and know that it's hard to have stuff and would not like to waste anything. To keep on managing my life well, outside factor is my parents because they want to see the success of their children. ... Any activity that I do would be at home where I help my mother take care of the chicken farm. (N2, 18 June 2004)

In Thai culture, the value of gratitude triggers a sense of connectedness to others also. The collectivistic view has been embedded in Thais' way of thinking in a way of implicit gratitude emotion and a sense of connectedness to others.

... We grow up because of the fostering from our parents, the buttress from our cousins and friendly talk from our neighbours, so why can't we give them polite talk and good relations, right? (N10, 26 May 2004)

Helping one another because of being together [in family]. One person is another one's environment and so on. (N1, 17 June 2004)

I would do the things that made me happy. [happy means]... Maybe to meet people, be their consultant, help to reduce their burdens, and help them think. (NN1, 19 June 2004)

It felt good with team work because with myself then I might not think of all the issues like looking at one side of the coin. You can see all of the issues when everyone is helping. ... I would try to work with friends when working in-group by sharing and reading together. That's trying to help out one another. (N8, 9 August 2004)

In contrast to individualism in the Western context, Thais would help one another in their family from generations to generations. This might be because there is no social security system to support the elderly. It is also a duty for the older siblings to support the younger siblings in the family to be educated.

...when I almost graduate he told me that he is about to retire and my younger brother is only in the 3rd grade so he won't have money for school. When I have graduated then I have to take care of my younger brother and parents that is what my father is hoping for. He told me that I have the responsibility of taking care of my brother and see that he's also graduated.... because I am the oldest and I am a refuge for my parents that is what they hope for. (N3, 27 July 2004)

The narrative background of Buddhism influences Thai women to have a sense of connectedness to family and others and create a collectivistic view in Thai society. This would be a core strength aspect which could be used to promote healthy behaviours. This is also a strong root embedded in Thai culture, and which is also mixed with individualistic view by modernisation in the transition period.

COMMON THAI SOCIAL VALUES

Buddhism has been the root of cultural expression in Thailand. Thai culture and Buddhism are intricately woven, difficult to separate. The roles of women used to be said as like the elephants' hind legs in Thai patriarchal society, and also by the religion, women are not permitted to be ordained. So, women have been kept behind men even when they are educated, but education has made young Thai women think more actively. Other common social values affecting the way of their lives are that they live mostly in an expanded family and conduct their lives in a collectivistic view of thinking. They value the manner of emotional concealment especially negative emotions, and are sensitive in a hierarchical tradition in the society, the seniority-oriented system. All common social values, even just a health-concern greeting, express a connection with others in the way they live, but also affect their health behaviours and psychological well-being from individual to collective levels.

THAI WOMEN ARE THE ELEPHANT'S HIND LEGS

During in-depth interviews I asked the participants about how they thought of Thai women's roles nowadays because they had studied more than in the past and the society had been in transition. Many of them still thought that Thai women were believed as the elephants' hind legs and had not much of a role in society.

...Not many roles, it's been adjusting but not much because of the old belief about they are the elephant's hind legs. Men would do most of decision making and women might not think of it that far. ...I believe that just half because some women are capable but in reality they could not make many decisions. ...I think they could be role model because women were always home in the old days, but now women started to have more roles, more educated, and new ideas that could develop the society. So women have taken more roles and helped a lot, only if that you have good ideas. I think that women should not think of just making their life just fun each day, but rather to go all out. (NN1, 19 June 2004)

The roles of women even for the capable ones were believed to stay behind men and to keep men as leaders in public. There was a tradition that 'women had to keep their brain, ability, and decision behind men's', and that seemed to be a polite manner:

Some situations you might be able to lead in some matters. But if it's men's thing then women shouldn't cut in front of him or interfere because it's like this for a long time. Men have their things and it's not our place to cut or jump in front of them. ...Something that a man has to do. For example, when we sat next to one another and he became quiet because he couldn't answer the teacher's question, then you shouldn't interfere by answering for him. It would be an intrusion because he's a guy and might be better to see if you could help. (to blurt it out) would disgrace him because a guy has some thing that shouldn't be interfered with. (N5, 22 June 2004)

Despite obtaining more education, Thai women still believe that they are the elephants' hind legs; they might be accepted more in communication and decision making, but it has to be in a polite manner:

My idea is that I might be able to help men. I still think women are the elephant's hind legs but more like the ones that reinforce the guy and might join in the decision-making. For example, in the meeting, the student president is a man and my friend was arguing with him and another friend would tell her that she should not argue with him here and should talk to him alone later because it's like she is disgracing him. To talk first and decide what is best before meeting, to protect his image as the president because he is the chief and he's a man. I would warn my friend sometimes. ...By looking at the expression then we think that it's not right and women is suitable as the elephant's hind legs anyway. ...Women might give suggestions about the line of thoughts for the thing that he might not look at it the same way as us. It's better to talk and see how much yielding he will give us. ...To look at the last issue and the final decision, because there are two ways of thinking. He should be able to choose the best one. Maybe moderation in all things might be the best way. He should choose the best answer. ...The best solution is that both sides accepted it. (NN1, 19 June 2004)

So, there was a clear distinction between men's and women's roles in the society. Women have to remember all the time that "you are a woman." This would be an orientation from family level.

Maybe from my parents because sometimes I would hit my younger brother on his head and my mother would tell me not to do it because he's a guy. I would argue that he's younger than me but she would still say that don't do anything like that because he is still considered a guy like my father. Or like I sat on a chair while my father was on the floor watching television then my mother would tell me not to sit higher than him and to come sit on the floor. (N5, 22 June 2004)

My mother would tell me about things. And then there's my father who kept telling me things. I believe in a man because my father is a guy that always has right thought, so I believe in him. (NN1, 19 June 2004)

This social narrative has determined the way Thai women place their gender roles in the family and the society; for example when N13 talked about her roles if she would get married in the future:

I would be bossy while we both are at home but out in society I have to honour him, let him be a leader or something, and trust his decisions. (N13, 21 June 2004)

Thai society is in transition because of globalisation and the advancement of technology. Being a Thai woman in transition and being educated have made Thai college women think and behave differently from the old days:

Nowadays, Thai female adolescents dare to express themselves more than in the past. (N11, 26 May 2004)

They dress up and actively express themselves in the society, but also realise about the traditional teaching and therefore adjust themselves to the situation. For example, a woman said that:

I would do the things that I like and feel good about it. My friend would ask me why did I have to put on make-up and I told them that why I should look pale face. I want to be cheerful and I know that wearing make-up makes me look good. ... But you have to see if it's suitable because overly dressed women are not nice in Thai society ... meaning that when others looked at you, even when you're a new trend woman, you still have to look at many things in many ways too. Depends on the group that you are going to. Like going to grandmother's house, she doesn't like flashy type dressing with slits here and there. What type of a woman are you?, ...from what she's been taught then she would think like this. It would be in the frame of Thai woman that I was taught by my mother. But there would be some kind of fashion too when going into society. ...like going to a discotheque, then I would go with my own style of dressing. (N3, 27 July 2004)

Fashion and dressing are essential concerns for Thai women of college age. It might be because they face a lot of people and become more concerned about their looks, however, they still think about how they have been taught to be Thai. As N3 claimed:

Thai culture women are Thai women that were trained to have nice manners and courteousness, and also on how to dress, act in front of elders and in society. "Fashion" and "teenager" are words from foreign country, which is obvious, but I won't forget the words "Thai women". I won't forget that it's just a colour that I put on so I can look good, that's all. Because they've used Thai tradition long before, even worked for my parents, so why do I have to throw away our Thai tradition? I would use other fashion too so I won't be outdated even if I don't like it. ...to integrate to make it better. I don't want them to say that I am out of date or too ancient because of being Thai. I think that it's beautiful but something might need to be updated and used in today's Thai society. To have some fashion when going out to society because you can't wear an old fashion blouse to a party. (N3, 27 July 2004)

Thai women have been in transition because they have had the opportunity to be educated and the role to bring financial support to their family, and these changes have affected their thinking. To be the elephants' hind legs means women have to stay home and be supported by men, but less so for modern educated women with knowledge and specific skills:

...we are a new kind of women and I see myself like that. ...New kind means that Thai society sees women as being elephant's hind legs. But not anymore because we have to walk alongside one another and whoever is going to be with me has to accept it. We are spending our life together so we have to help one another like raising a child we have to do it together. (N3, 27 July 2004)

It depends if we can bring out the leader role from the saying that a woman is like an elephant's hind legs. ...In fact, women have many elements of the leader. Some women are more enduring and can do some things with more aspects than men. But the feeling of many environments that will always make women to be disadvantaged against men so they will not dare to show it. ...I think like that sometimes because I can't choose to be born male or female but what I have is mostly the abilities to do things. Some might think that it's an aggressive habit, maybe but this is what I think. ...In my mind they are equal. At the same time I am a woman so I accept that women will always have disadvantage like strength. But with the mind and idea, everyone is the same with the difference in training. (N1, 17 June 2004)

The participants feel that being a Thai woman, society expects them to uphold Thai women's roles; when I asked N1 how she felt about the society's expectation of women, she replied:

Very much, that is Thai men can express themselves while women have to be patient and endure things. (N1, 17 June 2004)

For Thai tradition in the past, men were supposed to give their seats to women, children, the elderly, and the pregnant. In transition with active women in society, the tradition of giving seats to women might seem out of date.

... But when he did it for real then I don't know how others think with giving up seat for a woman because it's not necessary for him to do that. Nowadays, no one needs to give a seat for woman because we pay the same bus fee and a woman can stand on her own. (N5, 22 June 2004)

This traditional thinking provides a picture about what ideas have influenced Thai women and their behaviours. However, socio-economic factors and education may influence gender roles in Thai society. Most of the voices from this group of participants reflected much more in terms of '*kalatesa*' than oppressed status of women. *Kalatesa* in Thai literally means time and place. It refers to suitability, balance, politeness, and appropriateness regarding one's behaviours according to the context in which it occurs. "It is Thai sensitivity to context-expressed as *kalatesa*, knowing how time, locations and relationships intersect to create appropriate context-that allows for the flow of multiple gender identities." (Van Esterik, 2000, p. 37).

NEGATIVE EMOTION CONCEALMENT

Normally, Thais would believe that an emotionally and physically stable environment should be preserved for social harmony which is best maintained by avoiding any unnecessary conflicts in their contacts with others; even sometimes when they are angry with others.

I don't like to talk to anyone when I am angry because they would see that I am not in a good mood and the words will be like cursing and tone of voice will sound like I am not happy. Silent for a while, and then I would be back smiling and telling people that if I say anything to them it wouldn't be good for others and might make them angry at me. I would count to ten and go back talking normally with friends and would forget about the things that made me angry. It's like this, when I was angry I would sigh and tell myself that I'd better not. Just stop. Most of the time. (I would talk) normally, and won't tell her that I was angry. I would just go in and say hello or something like that and won't bring up the subject of my anger. To go in cheerfully and talk about new stuffs. I would just leave when I got angry while we were teasing and had something hurt one another. I would leave, sneak away, and they wouldn't know that I was angry, and then go back to say hello again later. I think that my surrounding friends and things are important so I don't want to trouble them or make them uncomfortable. ...I should be patient when talking to others. (N5, 22 June 2004)

Anger should be kept inside because it's evil and dominates everything. It would affect your mental health when you talk while you're angry because you might say something that you wish you wouldn't when you are calm. (N3, 27 June 2004)

The mindful self plays an important role to maintain self-consciousness in good relationship with others. When I asked whether the emotion concealment might ruin her mental health, the participant, N5, continued that:

Right, it's true that it's my own health, but I can take care of it. As for mental health, I would take care of it by telling myself that I am angry right now. (N5, 22 June 2004)

The Thai feeling of *kreng-jai* (to be considerate), which means an extreme reluctance to disturb others' personal equilibrium by direct confrontation has been embedded in the culture to preserve their individual inner freedom. In general, Thais will do their best to avoid personal conflict. Outward expressions of anger are not acceptable and are thought of as dangerous to social harmony. They are also regarded as being signs of immaturity, ignorance, and crudity. It is not usual to express strong feeling of dismay, despair, displeasure, disapproval, or enthusiasm in public. Accordingly, a person who appears to be serenely indifferent, or *wang choei* (Thai words for *upekkhā*) is accepted for having this venerable characteristic (The National Identity Office of the Prime Minister, 1991). This value of emotional concealment has been conveyed in families, for example, N5 said that:

Part of it was my own thinking. Like with my family, I would be angry with my mother but won't show it or act out to get what I would get it. ...I wouldn't slam the door when I got angry or anything. I can't do that so I won't act out when I get angry because I would be forbidden to do so. ...I did it at old time, I would stomp my feet when walking and my mother told me to stop doing it while complaining about my behaviour. I thought about what I did and I knew that I shouldn't have done it. That's how it was. (N5, 22 June 2004)

This tradition may help maintain well-being for the society, but participants also have to learn about assertion properly in order to maintain personal well-being.

SENIORITY-ORIENTED SYSTEM

A hierarchical tradition is a characteristic of Thai society in which people take up differently ranked social positions. Social relationships are mainly marked by their age and seniority which imply superiority and inferiority. In terms of Buddhist-based beliefs, older people are usually given high status and require respect, care, and obedience from the younger generations. From early stages of life, children are taught to respect older people and those of higher status, particularly parents, elders, older relatives, Buddhist monks, and teachers (Choowattanapakorn, 1999).

A contrast to Western culture is the way people participate with each other while keeping in mind 'who is who', by using the most common ranking, age or seniority in the place of encounter. It is a norm of expression of respectful gesture to the one who is older. To express brotherhood to each other, the pronouns are unique like: *pīi*, *nong*, *loong*, *paa*, *naa*, *aa* which mean older sister/brother, younger

sister/brother, uncle, or aunt. This kind of mindset stems from participation in family. Respect for elders is taught very early in children's development, normally, by the time children walk, they are aware of their position in the family hierarchy. The distinction of seniority applies not only between children and parents but also between siblings of different ages:

Pretend that there's problem (in family) then if it's like you are younger and you overreact, you have to always think that you should have done like this because you are *nong* (younger) or *pui* (older). (NN1, 19 June 2004)

The same delineation of roles is also applied to the society outside the family, especially when attending undergraduate education, the seniority system will be introduced to the freshmen in the very first week. This value seems to remain deeply ingrained throughout life. This gives some explanations for the reluctance of younger Thais to oppose or confront a senior during their study or subsequent careers in the workplace. However, the cultural social order entails harmony and well-being to some extent. People are willing to help each other with this brotherhood expression. In other words, this tradition also determines well-being and success for Thai people. This tradition is also applied in college life by using seniority-oriented system where younger classmen (*nong*) have to pay respect to older classmen (*pui*); the older ones are expected to support the younger ones and live together in the way of reciprocal kindness through their college years:

So they will be respectful. It might be a part that we will use with our job like to be respectful to your boss. To be respectful and know your upper and lower classmen so they could help out sometimes. The upper classmen (*pui*) have experience and can give you books and advice that are beneficial. To be respectful and courteous even if he or she is only one year older. It should start from small point in the university that will lead to the bigger part in the society. I think that it should be still like this here in Thai society because it's a good thing. I would pay respect all the time and didn't feel anything even if she is only one year older or someone even younger than my age but come into the faculty before me, I will pay respect without feeling anything. (NN1: 19 June 2004)

When I asked NN1 whether she pays respect to their age, experience, their support, or her own gratitude, she replied:

Many things all together because with me and this friend who was in her 2nd year that time we were very close when we met the first year and she helped me with everything. She didn't just help her assigned younger classmen (by ID number assigned) but she helps other younger classmen (*nong*) too. And all younger classmen could consult or seek help from every upper one. It's better this way and the upper classmen would be friendlier and see us as being respectful and not hard-headed. (NN1: 19 June 2004)

Some who did not care about the seniority system would be viewed differently and might not be accepted in social relations:

A few of the freshmen might not participate in the activities because they thought they were here to only study. Some upper classmen might boycott them but they don't care. They might pass it but they might not be happy inside. They might think that they should participate in the activities when they look back now. Some friends could help finding a job so I think this has something to do with it. But there were some that live alone. I feel nonchalant with them. They chose it themselves with their idea and if they think that this is best for their life then I won't interfere. (NN1: 19 June 2004)

The seniority system conveys the feeling of attachment. Once they get to know each other they become close like siblings and always help one other. Thai's sincere consideration for others is known as *nam-jai* which means 'water of the heart' is a characteristic encompassing spontaneous warmth and compassion that allows individuals to help, or make sacrifices for, friends and also to extend hospitality to strangers. The expression and practice of *nam-jai* maintain wellness and cultivate gratitude emotion among people. This could be seen when NN1 commented that:

I still think of the upper classmen and always help each other. Not just the assigned one but I was close with others too. Greetings when we walk pass by. They sometimes brought me some snacks when they went out. I would think about the old days like studied together and was tutored by this upper classman. I still see her even after she graduated and I still respect her because of the feeling of being younger. With some of them, I feel that we are sisters. I would think why she would really help me this much even when she doesn't know who I am? She would help me with tutoring and anything. Maybe because I am really close with this one but she's already graduated. She is not the assigned upper classmen but studied in the same department, but I could talk about anything and it's not like I only received things from her but we also shared things and helped each other. With school like when she didn't go to class then I would take notes to her and tell her that there will be a test. Make tutorial for each other. (NN1: 19 June 2004)

To have friend as an affiliate can assure you that they can help you. But I am more close to my older friends (*pii*)... In the evening, I would bring her stuff and sit with her. (N7, 5 August 2004)

In this climate not only ability would determine your success and well-being, because of the significance of the connections that people are conscious of. When you have a goal in mind then you should have connection sensitivity between self and others to gain many aspects in your everyday life. This is Thai tradition that might affect sense of control. The example of this climate could be seen when N3 said that:

He (my father) got to this point by being patient and even gave respect to someone who's younger if it's necessary. (N3, 27 June 2004)

HEALTH-CONCERN GREETING

It is normal on the level of acquaintanceship, when Thai usually make a remark intended as a gesture of friendship by greeting people how 'thin' or 'fat' he or she has become. Thai usually show their concern for others' health by remarking on his or her looks (The National Identity Office of the Prime Minister, 1991). However, this kind of greeting has an impact on female teenagers.

Self-confidence is gone and got more tense. Like going home before, I would not go out because friends at my village used to see me skinny. Going back home everyone would ask so I just stayed home. It's not good. I tried to eat less but can't do it because I was at that age where food is a necessity. Always craving and feeling happy every time I eat. Used to think what is the big deal about eating then I would eat. But when I got heavier and people ask about it, I would lose my confidence and when my clothes felt different when I wear them. So I started to exercise with my friends. (N6, 22 June 2004)

THE ONGOING SURROUNDING INFLUENCES

MEDIA, FASHIONS AND WESTERN STYLE INFLUENCES

While globalisation has initiated three main neo-liberal policies: deregulation, privatisation, and liberalisation in countries, the most affected groups are women (Guttal, 2001). The effects of globalisation on health related-behaviours are evidenced. Women, in particular, have changed their roles from merely being housewives and child-bearers to being more active in workforce and career positions in order to gain money for their families living in the trade-oriented and money-oriented world. Thailand as a developing country has been influenced by these trends. As one participant noted: "... and the mass media are important." (N1, 17 June 2004).

The six key trends of globalisation defined by the United Nations Research Institute for Social Development, involving economic, political and multidisciplinary dimensions are "1) the integration of the global economy with the marginalisation of the developing world; 2) the dominance of market forces; 3) the transformation of production system and labour markets; 4) the spread of liberal democracy; 5) the spread of technological change; and 6) the media revolution and consumerism" (UNRISD 1995, cited in Knauder, 2000, p.27). As Guttal (2001, p. 15) comments: "globalization is no longer just an economic phenomenon; it is accompanied by cultural, social and political changes and processes, and it is

difficult to say whether the economic, or the cultural or the political changes come first.”

... Today's world is changing, if our body is still at the same point and won't change to the changing condition, which is hard to do when you want to have good health. It's about globalisation when technologies are more advanced then it will affect the environment and pollute it so you can't live your life the same way anymore. Like you used to use the rain as drinking water but now there are a lot of industrial factories that are causing acid rain and if you're still drinking it then you might get sick. ... And don't fix on just one point of thinking that means that you will have to improve your point of view to the changing world. (N9, 30 July 2004)

The media revolution has had an impact on Thai females' self-image and health behaviours. The Thai mass media play an important role in explicitly instructing Thai female consumers as to what is modern, desirable, beautiful, up-to-date, and independent (Matzner, 2001). A study by Sharps, Price-Sharps, and Hanson (2001) revealed that college women in Udonthani province preferred a very slim body size, although the agricultural background of the region generally suited a heavy body figure. This may result from Western stylistic values. The study raised questions as to why young Thai women appear to have been more influenced by Western media than were the young Thai men. Some participants in this study congruently said that:

On television, they would mostly have a lot of health campaigns so I want to do this side of aspect too because personally deep down I wanted to have good shape when I looked at models or people with good shape. (N8, 9 August 2004)

I want to have good personality, good shape, and good look. The mass media shows that taking care of your health will make you have good shape and good personality... (N10, 26 May 2004)

No one told me. I felt it myself because I saw thin people and I wanted to be thin. I saw nice clothes and I wanted to wear them. (N7, 5 August 2004)

... From reading magazines, I would stop eating starch just like those Hollywood stars but couldn't do it so I would eat a little amount. (N4, 21 June 2004)

Fashion and sizes available in the market impacted on the way they evaluate their shape as being thin or fat:

... Not really proud but satisfied right now because I think that's okay and I have a good shape. It means when I go shopping with friends then it is easier to find the right size. (N4, 21 June 2004)

THE INFLUENCE OF EDUCATION

The opportunity to further their study in colleges and universities might affect their critical thinking and the ability to explore choices for health and well-being. Knowledge plays an important role in influencing Thai college women to engage in HPLBs

Knowledge, which is the most important thing, I didn't have it then, but I know more now since I began to study here. (N1, 17 June 2004)

Some, with the environment. I am studying in the university and seeing friends exercising is a motivation and the place is favourable. (N1, 17 June 2004)

The programme of study of the participants may have impacted on their thoughts like the meaning given to health, the knowledge to apply to energy expenditure and weight control, and the motivation to be a role model. These are health-related behaviours that will be illustrated later in this Chapter 8.

INFLUENCES FROM SIGNIFICANT OTHERS

When asked about their healthy behaviours, participants were likely to refer to their significant others who had an impact on their thinking and behaviours:

...it's people around me like family, friends, and teachers. I know now that people who care about me are more thorough than others. I realise their importance. (N1, 17 June 2004)

And another one said that:

I think it's because we live in a good society surrounded with people to whom we pay respect, can be our role model, and with someone that we appreciate. ... I also get good ideas about promoting health from my surrounding people and family. (N10, 26 May 2004)

When participants were asked about their healthy behaviours reflected in the high scores of HPLP II, most of the participants referred to the merits of their parents and family backgrounds that have constructed health-related behaviours in their lives. Most of the participants gave credit to their families' background, for example, they said that:

It's a warm family. My parents are open-minded and understand teenagers. We are all joyful and talkative. My father has a lot of humour. We would laugh every time he says anything, so there is smiling fill in the family. That's part of the things that make us healthy, I think. ... My personal healthy habits are my eating habits. I like to eat fruit and vegetables and also I would eat on time and do exercise especially badminton because it could be the whole family playing together. ... My mother has taught me to be a clean person and made me like cleanness since I was young. (N12, 26 May 2004)

Health-related behaviours are conveyed to younger generations by their parents:

...my parents always tell me to eat when it's time even when I am not hungry. They didn't teach me to eat when I am hungry but I have to eat on time. ...I have to help my parents at home but my father always tells us to eat when it's time to eat otherwise we would get gastritis. ...I try not to have it because I used to think that once you get it then it can't be cured. I didn't know what it is but it was nice because we were taught as a kid that eating is important. They said that breakfast is important so I always eat my breakfast. (NN2, 18 June 2004)

The Buddhist-based cultural self was conveyed from generation to generation, like:

My mother is interested in Buddhism. She used to be ordained to be a nun once, because my grandma was ordained, so my mother followed her for two years. I visited her at the temple when I was young so I might absorb some principles. My mother is kind of sympathetic and having great loving-kindness and wanting to help people, if she see an old woman wearing rag clothes or very poor, asking money 10 bahts, my mother would give the woman 100 bahts and give food to her. My mother would teach me to believe that we would receive many times back from what we gave. She likes to say things like this. And I believe it that way. (NN9, 30 June 2004)

A close relationship between female adolescents and their parents may provide the sort of emotional support that promotes commitment to an identity (Schultheiss & Blustein, 1994). Participants talked about parents who enhanced their autonomous motivation and facilitated experiential learning along with emotional supports in the family:

I think my mother's raising style and my environment makes me like this. My mother is pretty strict and we have to build the rules for living together like I have to be back home on time and have to do the assigned house work before I can go out with my friends. If I violate the rules, there would be some punishments. But it's not like something that is too strict. I can negotiate and always use my own reasons to do things myself, not my mother's decision for everything. ... and I think the results were good, because people would say that I am good, have self-confidence in my personality. I can decide myself for the things like how to spend my money buying things or what kind of friend I should contact with. My mother always tell me that if I am mature I can decide things myself because she will get old and cannot take care of me all the time and I have to settle my own family in the future. My mother would always give me will power and confidence and that made me able to comprehend and manage my life. (N12, 26 May 2004)

I think it's part of the raising style in family. ...My parents would let me have freedom in thinking and doing things, but would warn me when it came to be out of the line that they determined. Most of the time I would think through by myself until I couldn't solve the problems I would ask for their advice. (N11, 26 May 2004)

They have gained trust and freedom from their parents, and they were competent to do things. For example they said that:

...everyone will look at my parents as raising their children kind of unusual by giving too much freedom. ...because they trust me. Some might think that they worked us kids too hard because we did rice farming since we were kids. We did everything that our parents led us to do while kids in other family hadn't done anything at all. (N1, 17 June 2004)

There are also effects from my parents that their raising style which would let me think things through by myself, let me decide and solve problems myself. They would just give me advice from distance, and give me freedom to think. I will always remind their saying embedded in my mind that "Don't tell yourself that you can't do it, just try and then you'll know that you are able to or not, if there is no try, there is no knowing." "After you know your mistakes, so later time you'll do it better." I keep these saying in mind and try, like the first time I had to provide nursing care for clients, I didn't dare to, but when I thought of this advice, I would have the power to do things. I find that their advice is true. (N3, 26 May 2004)

Alongside the raising style that promotes autonomy and competency, their parents also give them emotional support and life skills guidelines. For example, participants said:

Pretend that I failed a test and told my parents about it. He would tell me to be more determined because I can't retake the exam. He would tell me not to worry too much and look at what's important. He would point out the issue for me to figure it out and relate them into a scheme. Also he would ask me if I've forgotten anything that the teacher has pointed out and to think back. I would think back and try to relate it with the future. He always would tell me to have some plan and be determining by knowing what's important by highlighting them. (N3, 27 July 2004)

My father had always taught me to decide thing myself and would comfort me when there was a mistake by saying that there're two sides of the coin and it's not easy. ... so, see things two sides. (N1, 17 June 2004)

This finding is congruent with the results from a study showing that parent-child interaction has positive effects on emotional support and self-perception and these variables accounted for 37% of the variance in self-esteem among 307 Thai undergraduate nursing students (Ross et al., 2006). Parenting factors involve the processes, and styles of parenting behaviours, and are also interwoven with the social environment in which parenting occurs (Taylor, 2004).

Apart from parents, other people have an impact on the health-related behaviours of these college women. Friends, boyfriends and teachers are influential. Even though participants have good knowledge about what normal body weight is, or what their natural looks are, friends and boyfriends always make them think about improving their looks. These reflections from surrounding people have both positive and negative effects. For example participants said that:

My friends too because they said that I am fat and it's time to diet. But to calculate according to BMI⁴, which I've studied, then I didn't surpass it but it's not what society think about. I am in the society so I have to think like it and use that to revise it for myself...I think about it and then do it. (N8, 9 August 2004)

...but If I see other people like my friends take care of themselves, I will be enthusiastic to take good care of myself for always look good. (N11, 26 May 2004)

Pretend that I go with friends and I feel why I am uglier than them then it would make me enthusiastic to take care of myself more. Ugly means acne, shape, something like that...in my opinion? If I go with friends and they are healthy and nice but I am ugly so it would make me lack confidence. (NN5, 2 July 2004)

Boyfriends have great influence on the way in which this group of women think about their health and looks. For example they said that:

Boyfriend also has a big effect. ...A man always wants to be proud when going out with his girlfriend and wants her to be beautiful and fresh. (N12, 26 May 2004)

...he likes to have the one beside him look good. ...to use regular skin cream because if I don't use it then my face will be dry and get worse so it has something to do with it. ...I would be like normal and without make up because normally I don't put on any cream or make up or add any color on myself. ...After having a boyfriend, then starting to add a little color and put on lotion after taking a shower which I never done it before. A motivation of wanting to be beautiful. Some, for myself, for him, and for his reputation also. (N2, 18 June 2004)

My boyfriend affects my health-promoting behaviours. Sometimes he would say that I was too thin, as a patient with disease. That makes me think that it's a must to take better care of myself, because I think that if I take care of myself, he will be glad and see that I take more responsibility with myself. If he didn't say anything I might not want to do anything. (N11, 26 May 2004)

And because boys are more physically active and more likely to play sports and have physical activities outdoors, so college women who have a boyfriend are more likely to have someone to accompany or encourage them to exercise.

Before, I didn't like exercising but my boyfriend, he is a physical educator and he would blame me that why I didn't exercise and why I was like this like that, like when it's time for eating he would tell me to eat this and that and cheer me to eat. He would take care of health. Umm...I think it may be true because sometimes I feel fatigue, like when I lift things I would feel tired and no energy or walking up stairs I would feel..oh...tired, like that. ...It's just him that keep telling me to go exercise, and so it's good for me then I go. ...And then I feel like I am always fit. (NN3, 18 June 2004)

...There would be some effects with health and study from him. He likes to play soccer and likes to take me for a jog in the evening. When it's time to go home, he would go to pick me up so he also has effect on my health. (N2, 18 June 2004)

⁴ Body Mass Index (BMI) is a number calculated from a person's weight and height. (Centers for Disease Control and Prevention Website, 2006).

Negative effects might occur. While some women will take care of themselves because of their boyfriends, some might even do the wrong things for thinness, like N1, who narrated her experience that:

...some might even kill themselves. Like a girl in a good shape and her boyfriend told her that she's fat and she would try to diet without thinking of the right way to do it. It's a mental matter because she wants to be the only one for the guy. ...Wanting to be thin, then in the future her child would not be healthy and strong or she could not get pregnant. It's too late, I used to see it and it's too late. Sometimes we can be supportive but we can't do anything because the baby is in there and no one knew that it will be that small. But it's about how we take care of it so this make her love her health evermore. And the media is important. (N1, 17 June 2004)

Teachers are important persons in the self-construction processes. From family to school, Thai women have been influenced by the ones they call teachers. Teachers' advice always affects their way of thinking and making choices for their lives. This can be seen in a transcript of N1 saying that:

For example, a teacher told me to think about something positive like to say that it's very nice that I studied hard today which might be sarcasm but it's like an encouragement. ...While with my teachers, I will realise that they have seen more and know more than me. (N1, 17 June 2004)

The construction of sense of self as an objective reality through social interactions and with significant others has been described by Berger and Luckman (1966, p. 151) as follows:

Every individual is born into an objective social structure within which he encounters the significant others who are in charge of his socialization. These significant others are imposed on him. Their definitions of his situation are posited for him as objective reality. He is thus born into not only an objective social structure but also an objective social world. The significant others who mediate this world to him modify it in the course of mediating it. They select aspects of it in accordance with their own location in the social structure, and also by virtue of their individual, biographically rooted idiosyncrasies.

The significant others of most importance to Thai college women are teachers and parents.

CONCLUSION

This chapter has illustrated the context in which Thai college women form their sense of self by interacting with the surrounding dynamic influences. In Thai

society where Buddhism is a strong root of the way of thinking, common social values also stem from Buddhist beliefs. By upholding Buddhism as an essential cultural background, the cultural self has also yielded psychological survival strategies in terms of a sense of non-attachment and morality when encountering world affairs. Gratitude emotion, a construct from historical Buddhist narratives, underpins a great number of health promotion and protection aspects from the individual level to the larger society level. It creates a sense of connectedness to others and a collectivistic sense in living in a reciprocal manner in society.

The religion also influences social values reflecting the usual feeling of people that one must accept the external forces beyond one's control when something unexpected happens. If it is agreed that control is central to empowering people to achieve a state of well-being through the health promotion process (Lindström & Koelen, 2005), there might be some points in Thai culture to be discussed. There would be three areas of external locus of control that may affect people's commitment to attain controlled well-being by their own efforts. First is the extreme belief in the old karma determining all current aspects of life. Second is the tradition of hierarchical rank of people or the seniority-oriented system in the society might lead them to think that other people who are superior to them can determine their well-being. And third is the external locus of control of believing in the power of the Supreme Being that may influence their well-being. These notions might sabotage a sense of control, critical thinking, and well-being in the society, on the other hand, could yield well-being for the society at large.

Thai women believe that they are 'the elephant's hind legs', and have to hide their feelings. At the same time, because of the impact from globalisation, media revolution, and the widespread new fashions, Thai women are actively stimulated to improve their appearance. They have to look good for many reasons, such as to keep their boyfriends loving them, to get a good job, to gain self-confidence, but also to feel good about themselves. These health-related behaviours are demonstrated later in Chapter 8. There are a diversity of discourses that impact on their well-being and health-related behaviours. Knowing self is a crucial step at their age to form a firm basic stance to keep wellness in their lives. The next chapter provides aspects of the self-formation of Thai college women compared with relevant literature.

CHAPTER 7

SENSE OF SELF AND IDENTITY FORMATION

Study A showed that sense of coherence and achieving one's sense of self or identity in terms of exploration and commitment predicted Thai college women's health-promoting lifestyle behaviours. Sense of self is the product of self in context. It is important therefore to explore how people's sense of self is constructed, enacted, and sustained over the life course (Burton & Hudson, 2001). In this chapter, positive identities and sense of self are presented in relation to their contribution to healthy behaviours. It provides knowledge extracted from the participants' narratives to expand the explanation of their sense of self-functioning to encourage them to know the self and behave healthily. Firstly, components of the Mindful Self are explored, and then the paths of knowing self from the participants' worldview are presented. Evidence of expressions of their sense of non-attachment influenced by Buddhism-based culture is presented last.

THE SENSE OF MINDFUL SELF

Tua eng means self, in Thai. Sense of self and sense of self-and-others are the products of the continual narrative, from the external narratives around social interactions to the inner self-narrative constructed within their selves. The self functions in various aspects to learn to know the own self, to ponder its positions in the context, to take control and achieve a desired self, to rely on its own self and to connect to others, and to survive in a positive way. Through interactions with its own self and with the surroundings, by learning over time, the mindful self has been developed. For this group of young Thai college women, the *tua eng* has developed into various positive aspects which I relate to the model of the Mindful Self as shown in Figure 7.1.

Related to



<i>Tam puer krob krua</i> (Do things for family) <i>Tam puer sung kom</i> (Do things for society) Buddhism-Based Thinking and Collectivistic Sensitivity Gratitude emotion	The Cultural Self
<i>Pen tua khong tua eng</i> (Being one's self) <i>Puo jai tua eng</i> (Be contented with self) <i>Roo koon-ka tua eng</i> (Knowing self-value)	The Authentic Self
<i>Kooy gubb tua eng</i> (Self-talk) <i>Thham tua eng</i> (Self-reflection) <i>Doo tua eng</i> (Look at own self)	The Connected Self
<i>Rak tua eng</i> (Love one's self) <i>Tam puer tua eng</i> (Do things for self)	The Sensible Self
<i>Kidd eng, Tam eng</i> (Think and do it myself) <i>Poom jai tua eng</i> (Proud of self) <i>Munn jai nai tua eng</i> (Self-confident)	The Autonomous Self
<i>Pueng tua eng</i> (Self-reliant) <i>Doo laae tua eng</i> (Self care) <i>Jad karn tua eng</i> (Self management)	The Competent Self
<i>Roo tua eng</i> (Be aware of one's self)	Developing The Mindful Self
Encounter with death issues is a path of knowing self Interpersonal relations is a path of knowing self Experiential learning and exploration is a path of knowing self	Paths of Knowing Self

Figure 7.1 Summary of the Aspects Related to the Sense of Mindful Self and the Paths of Knowing Self

The sense of the mindful self comprises various components of sense of self that emerged from the participants' interviews. They are the cultural self, the authentic self, the connected self, the sensible self, the autonomous self, and the competent self, presented respectively below.

THE CULTURAL SELF

***Tua eng, krob krua, and sung kom* : The self as the beginning of wellness linked to family and the society**

Sense of self is the product of self in the context. The sense of self as a whole is a collection of identities (Stryker, 1968). Burke and Tully (1977, p. 883) state that we may think of role/identities "as the meanings a person attributes to the self as an

object in a social situation or social role ... and, in fact, can only be understood in relation to counter-roles, so too it is the case with identities.”

When the participants talked about taking care of themselves, usually they linked their motivation to their loved ones and to the society consistent with the culture of collectivistic sensitivity outlined in Chapter 6. Education might enable them to engage in critical thinking and feel that the whole of society affects each other. The motivation of wanting to help other people and the family promotes their commitment to take care of the self as the beginning of wellness responsibility. Thai college women would often talk about a sense of connectedness to others, so their sense of self was always a sense of self-and-others. The three levels of mindful motivation extracted from the participants’ talk about their healthy behaviours reflecting the Cultural Self and collectivistic sensitivity are illustrated in Figure 7.2.

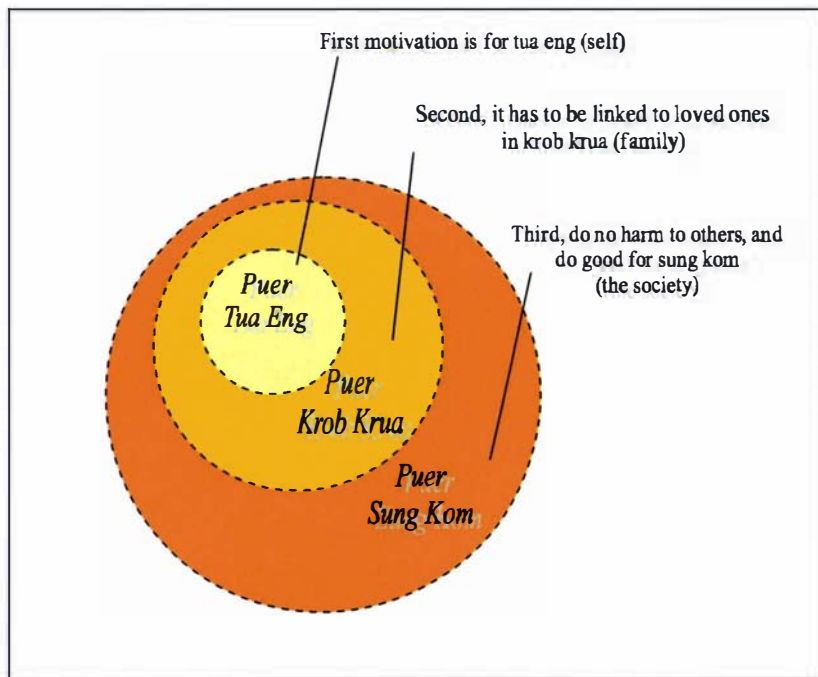


Figure 7.2 Three Levels of Mindful Motivation

They would do things *puer tua eng* or for the self as the function of the sensible self – that is:

First is *puer tua eng*, for my self to have good health. Second, for my self to feel better mentally, cheerful, and get rid of the tenseness. Third, for my self to have more time to confront things in this wide world. (N1, 17 June 2004)

And do things *puer krob krua* or for their family as an additional motivation; for example N1 added that:

... People will do things for themselves but it will involve their loved one. For example, I said that I love my health then it's to take care of myself while I am in good health. If you say that you love your health then you will be able to take care of someone that you loved like your parents for a long time. This is a supplement to make you know that you should take care of your health. (N1, 17 June 2004)

Gratitude emotion seems to be the grand root of the motivation and responsibility to do things for others in their family, and to the larger society. This was described in Chapter 6 and when N3 said that:

I think that if I have good health so I would have energy to earn money to support my family longer. (N3, 27 July 2004)

And do things *puer sung kom* or for the society, like NN1 and N3 said that:

I think that I should be myself and this should be good and maybe for others too. It might be good for society, by society I mean friends. I would think of my friends so much that others would tell me that I think for others too much. I felt good. Sometimes it might be wrong thing that I think for them but it's okay because I did my best. ... To think and do good things. I don't think that I will do anything bad to the society. I would do good thing first inside myself and I will be a good person who do only good thing *puer sung kom* (for society). (NN1, 19 June 2004)

The important thing is I want people around me have good health like I have in order to reduce the cost of curing. These amounts of money could yield other benefits for the society. (N3, 27 July 2004)

This collectivistic sense guided participants to help one another, do not trouble anyone, involve others, live in appreciation from others and give gratitude to surrounding people who were part of their success. This was illustrated by a participant saying that:

...I don't think I will succeed if I do it alone without others at all. To be successful all alone and not taking in others then people would question your success and that's probably not a good thing for me to be outstanding without receiving the appreciation from surrounding people. To help one another. Like to do a job, group job then you might do it with friends and not saying that you will do it and present it yourself. I would say that I have this idea and do you think like I do, or this and that, is to make others join in and be part of the job. (N5, 22 June 2004)

The emotion of gratitude as a morality in the society entails well-being for individuals and those around them. As Emmons and McCullough (2003, p. 377) said "... a conscious focus on blessings may have emotional and interpersonal benefits." Accordingly, gratitude morality and the collectivistic sense that young Thai women in this study hold as their values can be seen as contributors of well-being. This is a valuable cultural self formation in the Thai cultural context. When gratitude is the core emotion in people's lives, they will be grateful for the self as one's agency, grateful for surrounding others and the society together as external sources of their well-being. Gratitude is an important aspect in their cultural self and helps create a health motivation discussed in Chapter 8.

THE AUTHENTIC SELF

***Pen tua khong tua eng*: "To be my self, I won't do it if it's not me."**

Pen tua khong tua eng can be considered similar to identity achievement which is defined along the dimensions of crisis and commitment; where crisis refers to the exploration of alternatives, and commitment refers to an investment in ideological and interpersonal issues (Bennion & Adams, 1986). Participants explored alternatives as well as their own feelings.

I would do it right away once I knew it [useful]. I would see if it will match with me because I might think that it's okay but when I actually did it then it's not for me so I have to back off. ...My feelings, like or dislike. Is it me? Does it contradict with me because I try to always *pen tua khong tua eng* (be myself). If there is compensation involved then there might be a lot of measurement. ...Look at yourself first because the goal can be the same but you have to see if you are ready for the road that you are going to travel. [change] The path not the goal, like wanting to be thin and beautiful but can't do it this way so you have to find a new way to do it. ...Some might put success before themselves and nothing matters as long as they got there. But I would do as long as I am happy; I won't do it if it's not me. (N1, 17 June 2004)

If it's good then I would do it but I won't if it's against my nature. ...humble means to do it because you want to do it and feel good about it. You want to go in and pay respect because of love and respect. Humble for me is not just act as you pay respect or something like this. I won't do it. ... I think that to look good is *pen tua khong tua eng* (being myself). (N3, 27 July 2004)

Exploration was a crucial step; for example, some participants said that:

My strength points would be that I would look at many things to compare before doing anything. I would not do things that I am not confident about. I will wait to look at it or ask other people until I've got the confidence that I know its pros and cons before doing the things I want to. I would consider for enough reasons for any actions I do. (N11, 26 May 2004)

Compare the value and the thing that I like. Even if it had great value but I couldn't do it then I should do the thing that best suited me. (N1, 17 June 2004)

...I will have to look at the matter and situations also. I don't just think as I like but will look at the information that was given by others and to look back at myself to see which point that isn't right. Others look at you will mostly finalise rather than you look at yourself. ...But I would come back to look at my point. If I were really confident, then I would use my own idea and do it myself. I wouldn't choose new idea when I think that my idea is right but I would come back to think about it first. ...There would be choices and I have put them together, use part of this, and some of that to decide which one is the right one. (N3, 27 July 2004)

Investment and commitment when each participant has explored her own situation might eventually mean that she determined the worth of her daily life activities. This implies that the authentic being with mindful self will choose to do sensible life activities. For instance, N2 who said that she knew the value of time and money, and explained her philosophical lifestyle as:

...A simple life which is worthwhile, simple like to do whatever I like in 24 hours that it would make me so happy. For example, I divide my times to bed time, eating time, relaxing time, family time, or something like this. I would like my 24 hours to be worthwhile. We all have the same 24 hours so it's up to you to allocate the time to suit you. That's all. (N2, 18 June 2004)

Exploration is an operation of experiences learnt over time from life's circumstances. For a young woman like N2 to learn to commit to healthy behaviours, choose healthy food, spend free time in exercise, engage in close relationships, and take good care of herself, she said that the reasons were that:

...First is the age because it made me learn a lot. Other is that money is hard to come by and [to consider about] supports from home. (N2, 18 June 2004)

Puo jai tua eng, roo koon-ka tua eng: Be contented with self and knowing your true self-value

Knowing their true self-value is an component of the authentic self. This attitude protects them from external narratives that pressure their sense of self and health-related behaviours:

Like I said, okay I am in good health now but someone told me that I am fat, ugly, and can't stand to look at me. But really, I am so beautiful since I was born and I have other thing that is beautiful. Some told me that a bisexual guy has better look than me but I told them that I have an ovary, there! [you mean *roo koon-ka tua eng?*; knowing your true self-value?] Yes, I want that to be my identity or personality because I saw some women try to be more beautiful for their boyfriends while others look very plain but they really love one another, got married, and live together. Beauty is an element but it's not the goal that we should really be expecting. (N1, 17 June 2004)

I like the teaching about *Sandote* (Pāli=*Santosa*: contentment, satisfaction with whatever is one's own). I get it as a way to let things be and *ploay-wang* everything as it be, don't keep thinking or worrying, let it go, don't attach to any things. With other people I would not take their things to think too much, it's theirs. (NN7, 29 June 2004)

Santosa (pronunciation in Thai=*Sandote*) means contentment or satisfaction with whatever is one's own. There are two qualities of *santosa*: *yathālābha-santosa* which means contentment with what one gets and deserves to get; and *yathābala-santosa* which means contentment with what is within one's strength or capacity (Vipassana Research Institute Website, 2006). This means appreciation of what one has, thus entails mental well-being:

I like to think positively about things and I would look at what I have all the time. I don't care when people told me that I am fat or ugly because I know that my father raised me well and even if I am fat I still have good health from taking care of myself. I don't have to be perfect as long as I have knowledge, good personality, and am able to stand on my own with problem solving skills – that is enough for me. (N3, 27 July 2004)

This kind of authentic self is influenced by the cultural self, and the reader will experience the interrelatedness of each self functioning together in a given social construct and context. I would also note that the sense of self-contentment here might catalyse gratitude emotion or make people sensitive to feel grateful. Such gratitude would stem from the perception of having received positive things which one thought one would not necessarily deserve.

Congruent with these expressions is the 'authentic being' depicted by Jourard (1974):

Authentic being, or being one's real self, means that the person explores the opportunities and challenges afforded by each situation, and then chooses a response which expresses his true values, needs, feelings and commitment.

(Jourard, 1974, p. 167)

THE CONNECTED SELF

In the following excerpt, the connected self and the mindful self functions are illustrated about self-control, which have the cultural self as their background:

Sometimes I would be annoyed when it's hot and if I couldn't catch up my emotion then I would be annoyed too. Sometimes I was annoyed alone in my room and then I would think I would change my clothes if it were too hot. Normally I don't have problem emotionally. ...I would be in a good mood. Like when I studied Buddhism, taught me that things would not be as I desire or hope or expect. I can't control it. Whatever will be will be. I know in my mind that I cannot go back and correct the mistakes so I don't worry too much about it and try to relax. It's impossible to be like this or like that as I think. If I can do like this I have to.... So if I can catch up with my consciousness I would pull my mind back to myself. (NN2, 18 June 2004)

In this sense the authentic self and the connected self are interwoven to enable the sensible self to function. By connecting with one's own organismic feeling, one would feel the good outcomes from health enhancement activities and these could ignite the commitment to engage in healthy activities discussed in Chapter 8.

Kooy gubb tua eng, thamm tua eng, doo tua eng: **Self-reflection and self-talk**

Self-talk or self-reflection was a prominent characteristic seen in the student nurse participants. It is one of the functions of the connected self to connect and communicate with the self. They said that:

Friends might see that I am murmuring something but in fact I am *kooy gubb tua eng* (asking and answering myself) to see if there is anything else that I am missing. (N1, 17 June 2004)

By evaluating my thoughts once in a while and *thamm tua eng* (asking myself), why did I do it ? or what was I thinking ?, then I would know about my mood. If it were a past then I would let it go. Some I would try to improve. Some I would think that it's a little matter and won't do it again. Don't be sorry about the thing that you did. Be sorry about the thing that you haven't done. The next time, do it better than before. (N7, 5 August 2004)

Self-reflection could encourage the self to be contented with self, and the question one asks self could be a challenge and self-encouragement or retrospection. For example, when participants said that:

...It's a challenge. If I felt discouraged then I will look at people around me and telling myself that there are a lot of people who are successful so why wouldn't I be able to do it? (N1, 17 June 2004)

Like, I got to have my diary with me when I was reading. I would write when I am away from the textbook by asking myself for permission. Permission to think of other things for a while then back to the textbook. ... To honor, respect, value, and always think of myself. Sometimes I even pardon myself. ... This person is I, I talked to myself and I read in front of a mirror so I could see myself. My self would be about my personality and understand that I am this way. It's me talking to myself and not with someone else. ... No white or black angel, just me talking like this. I talked to myself. I would say to myself that I have something to tell so listen. I would tell myself that I got this and that or sometimes I would say oh no and that I'd better go read a book. There would be a contradiction in myself like this. I knew them both because it's myself with different versions. It's probably the good and the bad and it would contradict each other. If they both agreed then there won't be any resistance. (N5, 22 June 2004)

The process of self-talk is useful; Smith (1998, p. 891) reviews three key stages of the process of reflection: "firstly, the awareness of uncomfortable feelings or thoughts, followed by critical analysis of those feelings, leading to the uncovering of new perspectives." These stages are associated with mindfulness in Buddhist practice.

A healthy characteristic was that participants gave themselves time for pondering.

Another thing is like *hai wela tua eng* (giving time to ourselves) and we will see the importance of ourselves. To gain benefit from what we do in 24 hours then we have to *hai wela tua eng* (give some time for ourselves) too. (N1, 17 June 2004)

Sometimes I would sit alone and ponder about what others have told me, or when I couldn't think of anything. (N3, 27 July 2004)

Self-reflection requires time set aside exclusively for the specific purpose of self-reflection; a space with some degree of isolation that limits external disturbance is beneficial; and questions which help one examine life events with a focus on one's conduct in relation to other people, creatures and objects (Krech, 2004). These three aspects of self-reflection were identified in particular amongst the healthy participants in the student nurses group. Self-reflection is beneficial by providing a pause to appreciate "what is being given to us rather than focus on what we don't have." (Krech, 2003, p. 8). So, it helps women to be authentic and contented with self as discussed earlier in this chapter. Also, it helps them to develop their sensible self. Self-reflection is a crucial practice for self-development and health promotion.

Kidd buag, kidd dee: Positive thinking and positive self-talk

The majority of the student nurse participants mentioned positive thinking and self-encouragement as a way of achieving mental well-being:

...Inner resource is self-encouragement with the thinking. I was born alone so I have to be able to live alone that is encouraging yourself. Also, finding little reward for myself like I love to collect novels and I would tell myself that I will buy this for myself if I succeed with what I am doing. This is to make myself more determined with commitment. (N1, 17 June 2004)

And added by N6 who explained the inter-connection of mind and body:

... but they (body and mind) actually come together at the same time because you really can't separate them. Someone who's optimistic will look fresh and cheerful all the time like a friend of mine. ... Your body and mind will show it. ... I want to be the one with a good spirits. ...try to *kidd dee* (think positively). ...To look at the good things from the past. I mean normally I will not think about it. Like studying, sometimes I would think and would say that it's okay to start over. That's all and I am happy. Don't think too much. I would take it easy and think about the future. Sometimes I think of something that I did that I shouldn't have, and will not do it again. Then again, if let bygones be bygones so I won't think to make me headache. Only to *kidd dee* (to think only good thoughts). (N6, 22 June 2004)

Seeing others as role models: A product from critical self-reflection

A product from critical self-reflection is a self-narrative or self-questioning that leads to engagement with well-being. The participants who see others as role models, take what they see to ask the self, look back to the self, and take it as a motivation to engage in health-promoting lifestyle behaviours. This kind of self-reflection could be seen when they said that:

...From the people that I see each day, like I see a nurse as my model. It is to look at yourself (*doo tua eng*) and then your model and back at yourself to see what you need to do or change for a better you. ... I also have role models in mind that is someone who I would like to be, the one that succeeds in their life. I would behave in the similar way as the one who has achieved good life, select from their good points to apply to myself. ...The beginning point to make me want to be healthy is seeing role models from some women, even though they get old but still look nice and healthy and have good skin complexion. (N3, 27 July 2004)

...and also I see the presenters, models and parents whom I pay respect and appreciation to make me want to take care of myself. (N10, 26 May 2004)

Going to public park ...with cool breeze, fresh air, and see other people exercise then you will feel motivated to have better health. Seeing old folks exercising and compare that to myself and wonder why I, still young, don't care about my health at all. I would get this feeling and use this as a motivation to exercise. (N8, 9 August 2004)

Role model sensitivity is a kind of health responsibility expressed by these participants in this research. It has been said that actions speak louder than words. It is important to realise that one is a significant other for many others. Role model sensitivity should be constructed as a healthy value among Thai college women.

THE SENSIBLE SELF

Rak tua eng, tam puer tua eng: Love one's self, do things for self

The sensible self would select positive meanings and values for the self. Since there are many kinds of self-talk and discourses in each moment in self and social interactions, the sensible self will function to lead the self to wellness. In relation to critical self-reflection, the sensible self is a space of selected meaning for an upward self-development. To *rak tua eng* is a sensible saying to urge young women to take good care of themselves. Some said that:

It's a motivation when I see an aunt or a grandma exercising. So I am at the cheerful and energetic age then why wouldn't I *rak tua eng* (love myself)? It's a kind of stimulation. (N1, 17 June 2004)

The first thing is because I *rak tua eng* (love myself). Pretend that if I have and live with a partner now and then if I meet a good man later but I used to live with another guy I would feel pity with the good guy. So, that makes me have no boyfriend now and there is no one courts me, but I am looking. (NN5, 2 July 2004)

And when they learn to *rak tua eng*, they would *tam puer tua eng* or do good and reasonable things for themselves. Instead of confining themselves to old understandings of karma which is believed to control the destiny of their health and lives, the educated college women in this study constructed more healthy ideas regarding karma in their lives, a future-oriented karma.

You can plan ahead but you don't have to fix or do anything with the past. It's better to move on by doing good deeds (*tam dee*) for the future and by thinking that I used to make those mistakes. To think ahead and don't do this because it would have this result, so it should be planned for the future. (N5, 22 June 2004)

Some situations can't be proven because it's both scientific and occultisms too. (What is there that you can control?). It's probably I, myself, because it depends on what good things that you would do for your life. ... I believe in fate sometimes because it might already been written what would happen next, what I will meet, at what age. But it's not like I believed it so much that I wouldn't do anything or believed in fortuneteller. ... Like when a doctor told a patient that he can live for only 3 to 6 months but if he has mental supports and behaves correctly then maybe he can live longer than what the doctor had told him. (N8, 9 August 2004)

This is another healthy neither/nor position which would encourage young Thai women to take control over their behaviours and health. It is to cultivate a valid understanding of the effects of one's own behaviours from the past until the current moment, decide and design each moment of one's own life in a healthy manner and avoid the extreme views as described by Pasadika (2002, p. 152):

The two extreme views with respect to karma, according to Buddhism philosophy, are on the one hand the quasi-fatalistic assumption that whatever one experiences in life are the consequences of one's previous actions, and on the other hand, all one's experiences are due to pure chance.

THE AUTONOMOUS SELF

The behaviours of the autonomous self would be self-determination and the self would reflect about the ownership of its behaviours, *kid eng tam eng*.

Kidd eng, tam eng: Think and do it myself

For N2 and others who reported taking good care of themselves without relying on friends or others, usually the answers would be like this:

I would still exercise without them because it's my health and eat my own foods. If I was down this week it's all me, myself. (N2, 18 June 2004)

I don't like life that is too in order while I wanted to be free to *kidd eng, tam eng* without anyone bothering me. If I have already decided, then don't bother me or get involved with my life too much. (N1, 17 June 2004)

We also have to have vision and think positively; solve problems by ourselves without relying on other people all the time. (N10, 26 May 2004)

As Jourard (1974) comments, an authentic person is less predictable than an inauthentic one. The authentic person experiences each life situation, each problem, or each encounter with another as new which creates different issues and demands different responses. Authentic being requires a person to face decisions with the awareness that the outcomes of one's life are one's responsibility. Increasing sense of "ownership" of one's behaviour has been suggested by humanistic and organismic theorists to be an important and life-long developmental task (Sheldon & Kasser, 2001).

Poom jai nai tua eng: Proud of self

The autonomous self includes the characteristic of pride, once one can manage one's life autonomously well:

I am *poom jai* (proud of) my determination and commitment because I am a kind of person that will do my very best when I do anything. I *jad karn tua eng* (manage my self) well and know what is suitable for my life. (N1, 17 June 2004)

We would be *poom jai nai tua eng* (proud of self) when someone sees that we have good health. ... I am very *poom jai nai tua eng* when people look at me as a healthy woman. I feel that the things that I have done yield their results. I would like to take even better health. (N3, 27 July 2004)

Again, a sense of *poom jai nai tua eng* was also linked back to the gratitude emotion connected to the self, others, and family; for example, N5 said that she was:

Proud of myself when others understood me and are friends with me. Also I have never troubled anyone and I am proud of it. Other good aspects are that I always smile and was cheerful when someone came for consultation. I never got angry or had any contradicting points with anyone. That was part of it. ... Other part would be with school, which is probably the effect from my family that made me successful in taking care of myself. (N5, 22 June 2004)

Munn jai nai tua eng: Self-confidence

Self-confidence could be cultivated by motivating one's autonomous self to take care and manage one's self:

... I *mun jai nai tua eng* (have self-confidence), so if I have poor hygiene or be obese or have a lot of acne something like that, I would lose my self-confidence. Therefore I have to look good all the time. When someone says that I look good, I would be glad and motivated to find good things for myself like going exercise, eating well, and skin care ... I want to be joyful and look good to avoid boring characteristics. (N12, 26 May 2004)

In this sense, when one has self-confidence and takes good care of one's self resulting in good responses from surrounding people, so there would be a positive loop of self-development in appearance. These components of the autonomous self could trigger a sense of believing in self-capacity and may open the loop of competent self-management discussed in Chapter 8.

The autonomous self could be seen as an essential element for women's wellness. For women, having less autonomy but holding responsibilities in families and communities could be a source of psychological distress and female excess

morbidity across the life-span (Lazenbatt, Orr, Bradley, & McWhirter, 1999). This implies that the autonomous self is a crucial aspect of women's sense of self. It also links to the parenting style proposed in Chapter 6. This aspect of the sense of self contributes to the competent self to invest efforts in health-promoting behaviours.

THE COMPETENT SELF

Pueng tua eng:

Self-reliant, “to take care of yourself before relying on others”

To be self-reliant can be seen as sense of self as well as a motivation to take care of one's health.

... because I am still asking my mother for money. Until I have a job, a house, some conveniences, and being content then I would have to put in a fair amount of effort so I can live on my own. ... When I had a younger brother I understood that he's still little and my mother had to take care of him. So who's going to take care of me if I don't take care of myself.... Think and do it myself. ... When I am old then I would look at health as not being a burden for others. I want to keep on being healthy like this ... I would feel bad if I was sick and someone has to take care of me. When it comes to health I don't want to bother anyone. At the end I want to take the best care of myself so I can *pueng tua eng* (rely on myself) ... Because I don't want anyone to take care of me when I got old. It has to be health since I would have everything and won't need anything more except my life or health. I don't want to be sick. I would see a doctor so I won't get any worse. (N9, 30 July 2004)

To be self-reliant and not to be a burden could give a strong sense of competent self; to work and to take care of one's own self both in physical terms and financially, motivated some participants:

When I have free time I would get a part time job because I don't want to be a burden. I'm older now and don't want to bother them. Their situation (my parents') is not good.... In the country side, people my age are married and have children. They are supporting themselves but I'm in school.... I'm *poom jai* (proud) to be studying but I'm not going to ask my parents for money. I would borrow and payback for sure, because the earning is little at home. If I asked my parents for money then people around my house in my village may look down at me and I don't like it. (N7, 5 August 2004)

Women need to study too because back then men had to be leaders, bring home the income or something like this but not any more. We can support ourselves when we don't have men or leaders by having knowledge from studying real hard. To take care of yourself before relying on others so it's better to study a lot. (N5, 22 June 2004)

However, this did not mean that all competent Thai women would engage in health-promoting lifestyle behaviours, for example, some of the non-nurse participants who worked to earn money for their studies might ignore exercising because of the negative attitude towards exercise:

I won't do anything long with physical activity. I feel tired and don't like to sweat. I don't like feeling dirty and sticky. (NN8, 6 July 2004)

It has been suggested that Thai people generally live in extended families and that they are less likely to be self-reliant or emphasise independent achieving lifestyle because of the supportive social networks (Cederblad et al., 2003). This critique may not be congruent with the data in this study. Thai college women with more education who were striving for work success in the transition period of the society were likely to be self-reliant and independent.

The competent self may help one to survive in society, however, for health, it has to deal with health motivation, health-comprehension, and health competency which are discussed in the next chapter. Self-reliance is crucial for participants' health practice only when they have health motivation, health-comprehension, and health-competency.

Doo laae tua eng, jad kann tua eng: Self-care and self-management

Being connected with the self is an underlying characteristic of Antonovsky's manageability. In this sense, the self is a resource for manageability, and there would be a loop of self-communication and planning. For example N5 said that:

I would tell myself that okay I can start to read and I would have a reading schedule for next week's exam. To let myself know what I have to do and what I am doing. I would have a plan and I would apologise to myself when I didn't follow it through. ...When I could I would praise, smile, and be happy with myself for I am who I am like this. And when doing it in front of other people then I would remind myself that it might seem zany, crazy or something like that. (N5, 22 June 2004)

...I've tried to find ways to *jad kann tua eng* (manage myself). ...If it was me and I was determined to go exercise then I would tell my friends that I am not free from 6-7 p.m. because I will go exercise so please avoid during this time if you want to do anything with me. I would write myself a note saying that I wanted to go but something came up when I can't make it because I have to go and do activity with my group. (N1, 17 June 2004)

Self-management in every aspect of daily life could be called competent self, however, for health-related behaviours, for the self to engage and commit, it needs various coordinated factors which are discussed in the next two chapters.

These components of the Mindful Self may contribute to the healthy sense of self among Thai adolescent women and may help them develop self-esteem. A study done to compare level of self-esteem among 120 Thai student nurses and 101 UK undergraduate nursing students found no significant differences in mean overall and subscale self-esteem scores between the two groups (Sasat et al., 2002). The sense of mindful self is a positive growth of the self. Both the organismic needs model and the Eriksonian model define growth as “deepening one’s self-knowledge and self-expression while forging strong connections with others.” (Sheldon & Kasser, 2001, p. 493). Accordingly, it is proposed:

Organismic integration refers to the most basic developmental strivings of the self ...toward unity in one’s “self,” that is, toward coherence in one’s regulatory activity and experience ... toward interacting in a coherent and meaningful way with others so as to experience satisfying personal relationships with individuals and a harmonious relation to the larger social order.

(Deci, & Ryan, 1991, p. 243)

DEVELOPING THE MINDFUL SELF

In Thai belief system the development of the mindful self is connected to being aware of the self.

Roo tua eng: Being aware of self

The mindful self is the central function for balance of the expression of all other aspects of self. The mindful self is developed when one gives time for self to ponder things and give some thoughts to the things which one has been doing. This is also an important component of self-reflection.

Use *sa-ti* (consciousness) with what you do

Mindful self could be seen as self-consciousness. In Thai, they would say to live with *sa-ti* and to keep in *puao-dee* (just-right) manner. When one used *sa-ti* and *puao-dee* as one’s philosophical lifestyle; it was to keep in the middle path methodology, and this is the effect of the cultural self. As N1 said:

Looking at both sides of the world and second is to think or use your head all the time. Use *sa-fi* (consciousness) with what you do ... Teaching us to know when enough is enough or to think in a *puao-dee* (just-right) manner is Thai way. (N1, 17 June 2004)

Puao-dee could mean balance which is the central practice of wellness discussed in Chapter 9. Mindful self could be seen as good conscience, as a participant said:

...Good conscience would bring good thoughts and good actions. (N11, 26 May 2004)

So, the mindful self would give them conscience and also monitor their inner constructed narrative. It gives the higher order function while other aspects of self are developed by social interactions amidst the outer constructed narratives. For example, NN1 said that:

One essential thing for me is to always think before I speak or do anything. (NN1, 19 June 2004)

And it could be a buffer when one's need to *pen tua khong tua eng* (be one's real self) needs to be balanced against societal expectations that the behaviour should not do any harm to anyone, as N6 explained:

...Good in my case would be something you did and society accepted it. If what you do is neutral and give it some thought. Remember the thing your parents taught you. Consider before you do it and do the thing that society will accept. What I am saying is that it depends on the situation. Sometimes you have to think of yourself if it won't harm anyone. ... Sometimes I want to *pen tua khong tua eng* (be myself) but I don't know how you decide what is good or not. Sometimes I would choose myself and sometimes, society. *Pen klang* (being neutral) is like.... To do what society can accept. Consider it and if it doesn't hurt anyone, then do it. (N6, 22 June 2004)

They might choose to do an activity for self-advantage rather than socialise with friends, without spending time engaging in self-development activities; this is a function of the Sensible Self. To commit to healthy behaviours and to exercise, even alone, are evidence when they said:

Although when I jogged with 4-5 friends we would jog separately not in-group. Kept running and wouldn't stop together. So might as well go alone since we would never talk while running anyway. ... I think those friends will not always be with you. You have to rely on yourself first, and then help your friends. Ask for help when you can't do it. (N9, 30 July 2004)

I would mostly go by myself. It would be nice to have a friend to go with but it's easier to go alone because then I can go anywhere and stop at any time while I could also *roo tua eng* (know my self) how tired I am. (N2, 18 June 2004)

One could have mindful self-reflection and be mindful of the consequences of one's act while keeping in mind the connectedness of others living in an environment. For example in the transcript of N1 below, the mindful self and the connected self functioned together to think positively:

Sometimes I think that it's hard, but you should say it positively like – today I am so tired and this would make my friend tense with what I said. If I am tense then people around me will be tense too and the tenseness will increase. (N1, 17 June 2004)

The mindful self also functioned for dealing with interpersonal relations. While the cultural self affected the way Thai women expressed their feelings such as anger management or concealment of negative feelings, the mindful self also stopped the behaviours that would disturb others' feelings and pondered to give reasons to each situation one faced. So, the self and emotions had to be adjusted when the participants approached people. In relationships with others, the self had to be mindful, and connected to self and others:

To relax and then face the situation is a point of concentration. Pause to think of what to do next. To stop and put things in order and think then go in and talk nicely even if I think that I am right or not. (N3, 27 July 2004)

Because it's better to be a *jai yen* (calm, cool-hearted) person and don't have to be sorry later. I would think first before arguing with someone. It won't be good for both sides if you were angry and started to yell and say harsh words. You wouldn't feel good, he won't feel good, and others that are listening won't feel good either. ... You would receive better things when you are *jai yen* (patient) more than a person who is *jai ronn* (hot tempered). (N5, 22 June 2004)

So the mindful self would function as a self-watcher, being aware of the developing self, and keeping the self engaged in useful activities for self and others. The Buddhist practice of mindfulness is also called "the watcher self" by Deatherage (1975, p. 136). Hirst (2003) demonstrates that mindfulness can be articulated in different philosophical positions. However,

When seeking to apply the concept therapeutically or developmentally at least five positions emerge:

- Non-attached and non-judgemental observation of phenomena.
- Un-censored articulation of phenomena for interpretation.
- Embracing phenomena for incorporation, identity and personality development.
- Ongoing interpretation and evaluation of phenomena for the purpose of creativity, continuity or change in respect of meaning or understanding.
- A precursor of reflection and choice.

(Hirst, 2003, p. 365)

Mindfulness, in contrast to mindlessness, helps individuals learn and behave with awareness and intention and not fall into habitual ways of thinking, feeling or responding (Langer, 2000). Langer asserts that repetition is one route by which mindlessness comes about. The mindful self and the connected self with one's own organismic needs would help monitor routine behaviours and adjust them into healthy ways. Another way mindlessness occurs is "on initial exposure to information" (Langer, 2000, p. 220); for example the huge impact on Thai adolescents' health-related behaviours of mass media. Mindful awareness in the Buddhist sense is "the energy that allows us to recognize habit energy every time it manifests" (Thich Nhat Hanh, 1998, pp. 24-25). For health promotion, mindfulness helps individuals to avoid unhealthy habits and seek to engage in healthy ones.

The model of the Mindful self encapsulates the three main themes extracted from the in-depth interview data: the context, the self formation, and the health-related behaviours as outcomes of the sense of self in this group of Thai college women. Figure 7.3 summarises all sub-themes and components impacting on Thai college women's sense of self and the paths of knowing self. The Buddhist-based cultural context affects their sense of non-attachment. The socio-cultural Thai context also forms the sense of self interrelated to health-related behaviours. The sense of mindful self plays an important role in individuals, causing them to ponder and engage in various aspects of HPLBs. Sense of self could be strong or weak in each individual and that affects wellness enactment.

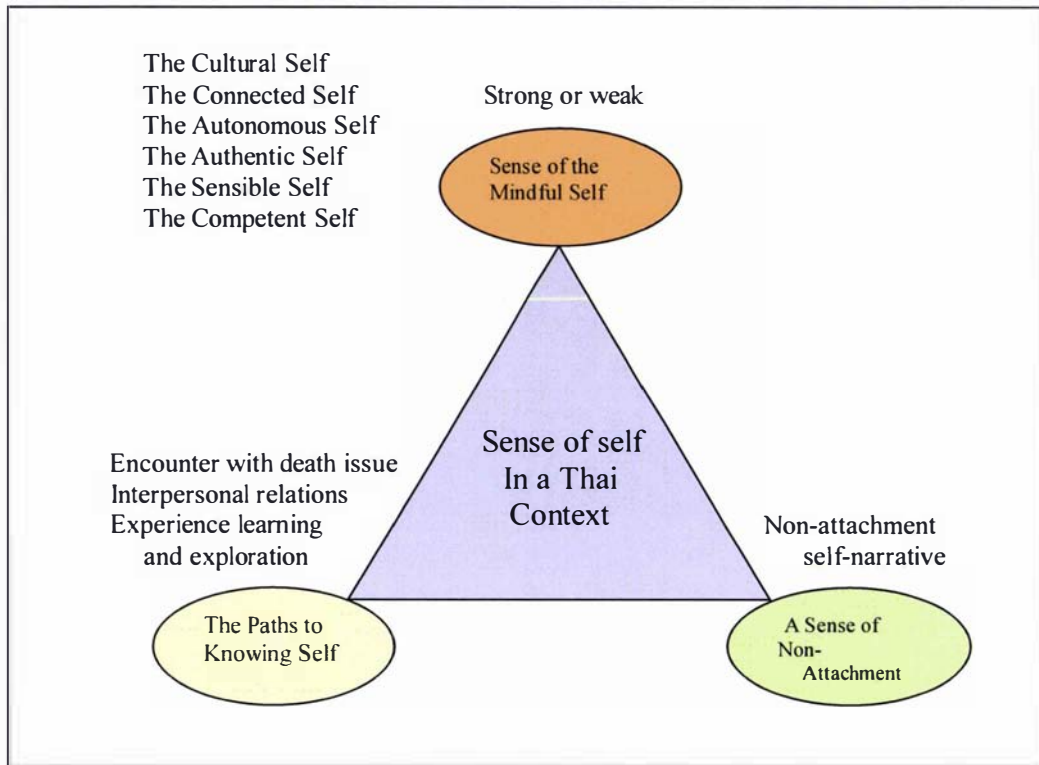


Figure 7.3 Summary of Sense of Self and The Paths of Knowing Self Derived from a Thai Context

THE PATHS TO KNOWING SELF

ENCOUNTER WITH DEATH ISSUES IS A PATH TO KNOWING SELF

This was a prominent point found in the nurse participants' ideas. Most of them learnt something from death and dying of others. They said that:

For example, pretend that you met this dying person who regretted that he had never taken care of himself when he was healthy and you will start to realise that you should take care of yourself now that you are still alive. (N1, 17 June 2004)

...sharing ideas with people of different ages, genders, careers, institutions would make us know the fact that to originate, to decay, to get sick and die is the natural veracity of the world, so I had better do good things for the world in this life. (N10, 26 May 2004)

I saw other people when I went on hospital round such as a cancer patient who is wealthy and has a lot of loving relatives but his health is deteriorating. There's nothing that can make it better, just waiting for the end. (N8, 9 August 2004)

What life means? I used to think that it's uncertain, too doubtful. Uncertainty is most certain that's how I think and I will die someday. Before I die I have to do something and look for a lot of experiences so I would die in peace and not worry. It's just a plan. It doesn't mean that I am dying, just from seeing people dying but they have a lot of things to do and they weren't happy. (N3, 27 July 2004)

It is also because of the death-oriented culture influenced by Buddhism (Tambiah, 1970), so it could be viewed as a cultural self of Thais. While the non-nurse participants did not explicitly say about death issues, they expressed their cultural self in a kind of non-attachment sense of self which will be illustrated later in this chapter. Studying in a nursing programme in which students have to directly encounter death issues might facilitate reflection for the student nurse participants, and may encourage their authentic self-assertions. Jourard (1974) confirms the link between death issues and authentic being that when people have realized with intensity the fact that they will die someday, they are stimulated to live their lives more decisively, more intensively, and more authentically.

This is consistent with Bilsker's (1992) view that an encounter with death issues or the possibility of death or nothingness which surrounds one's being would trigger the exploration state of moratorium identity. He asserts that "... the possibility of biological death may well be an important aspect of the identity formation process." (p. 186). In this sense, the nothingness discourse of Buddhism may be a cultural resource for identity exploration in Thai culture. The 'dying' issue was also a prominent theme which urged reflective thinking or self-reflection which in turn provided a way of 'learning about self' among student nurses in a study conducted by Smith (1998) in England.

INTERPERSONAL RELATIONS ARE A PATH TO KNOWING SELF

Sense of self is self in context and interactions. So, friendships and social interactions are important for the participants' sense of self and identity formation, and also reflect their position in the family and in the society.

...I would tell my mother about some matters and stop if "umm" is her response. Sometimes I forgot like when I was with a lot of friends and said something that I would only say with friends to my mother. She would ask about what I just said so I knew that I shouldn't have said it after I've thought about it. ...my friend was always saying "Huh" and my mother liked to say this too so I got in the habit of saying it too. Lately when I remembered that then I didn't want to say it so I told myself to change and stop saying it. ... I am close with my mother so I would talk normally like best friends. ...It would be like a warning like what did I just say or that she's not one of my friends. She would be in a role of a mother sometimes. (N5, 22 June 2004)

When I worry about things I would consult friends first because if I think of it alone it might be a narrow perspective so I would listen to my friend's opinion. Some points I might not think of before. Friends would help thinking and it might be a kind of warning. I am *jai ronn* (hot-tempered) so it's good to have warning from friends. I know I am kind of hot-hearted. I believe in friends. I would consult many friends and then keep their advice to analyse whether it's correct or not. I believe in the closest friend. It's like... fifty-fifty, and apply their advice with my thinking, sometimes believe friend and sometimes believe in my self. (NN6, 29 June 2004)

Through personal relationships, knowledge of one's real self could be achieved. Jourard (1974, p. 169) suggests that "the individual who has a trusted friend or relative to whom he can express his thoughts, feelings, and opinions honestly is in a better position to learn his real self than the one who has never undergone this experience, because as he reveals himself to another, *he is also revealing himself to himself* [italics in original]."

Gilligan (1982) suggests that women mostly develop the morality of responsibility and care rather than the morality of rights which is principally the moral reasoning in boys and men. The responsibility orientation leads women's conception of self to be rooted in a sense of connection and relatedness to others, whereas the rights orientation leads men to define themselves in terms of separation and autonomy. This suggestion is consistent with the position argued by Burr (1995, p. 109) that "women's sense of self is that of the 'self-in-relationship', that women's identity is so closely bound up in their relations with others that for them the dividing line between self and other is less clear than for men." By the same token, in Study A of this research I found that interpersonal relations predict identity achievement in this group of Thai college women.

However, in some cases, the sense of *Kreng Jai* (to be considerate) in Thai culture and the cultural self is applied in self-reflection and in social interactions.

I chose mostly to talk and complain to myself rather than talking with other people. I thought that if it's about me being sorry or angry then I shouldn't be telling others about it. Everyone has his or her own thing, like if I told someone about my matters then that person won't feel good because it's not his or her matter to be involved with. (N5, 22 June 2004)

I like listening to the music, would turn on the music when reading. It makes me feel relaxed and be able to read longer, but if my roommates are in the room I would reduce the volume. I feel *kreng jai* because they like silence. ... I don't often consult about my difficulties with anyone because of *kreng jai*, just throw the tenseness away, it's no use to keep tenseness in my mind. I learn from observation, for example, I have to think before buying things because that would make me have trouble running out of money for necessities and I dare not to borrow money from friends, I *kreng jai* them, but if I know that they are running out of money I would be the first one that lend them my money ... I don't like going to night life, hate the smell of tobacco smoke, but sometimes have to go in a while because of feeling *kreng jai* my friends, because if you don't go at all, friends would think that you don't like going out with them. (NN7, 29 June 2004)

So, dealing with interpersonal relations was an everyday task that influenced their mental well-being.

I probably try to do as best as I can, and mark today's mistakes as an experience so that I won't repeat them again. ... Emotional mistake like argued with friend maybe because I was too impulsive. Too *Jai ronn* (short-tempered) and I would use this to remind myself so that I wouldn't do it again or should be *Jai yen* (calmer). ... I don't know but I would care for others feelings when someone is sorry even if I wasn't the one to cause it. If he or she is angry or not happy then I will be the one to clear it right away. It's not often for me to leave it too many days because both sides wouldn't be happy so I would clear the problem as quickly as I could. (N8, 9 August 2004)

In addition, interpersonal relations were an important mirror for them to develop their sense of self. Social interactions and interpersonal relations work as multiple mirrors for individuals forming their sense of self in the context, usually in the form of criticism (disapproval) and compliments (approval). Obviously, these interactions affect women's sense of self. Criticism strongly affected Thai college women's self-confidence in this study. For some, it could stimulate self-concern, especially about physical appearance.

If someone criticises that I've been getting fat or tarnished skin complexion I would lack confidence and consider myself to get improving these points. (N12, 26 May 2004)

The participants also commented that compliments motivate them to take good care of themselves.

When someone says that I look good, I would be glad and motivated to find good things for myself like going exercise, eating well, and skin care. Compliment is the potential motivation. (N12, 26 May 2004)

... it (compliments) does make you keep making it better. ... Like it looks good now then make it even better looking. It might not be by increasing the products or expenses but rather increase on what we can afford like to drink a lot of water each day. It helps the moistness of your skin which is the way to take care of yourself. (N2, 18 June 2004)

The process of knowing one's real self through personal relationships is "... the act of stating one's experience to another, making oneself known to him, permits one to 'get outside oneself' and see oneself." (Jourard, 1974, p. 169). The reflections from others are like mirrors that help for knowing one's self. Burr (1995, p. 109) would argue that "the person's identity lies in their relation to others, and is not an entity to be found inside the person." This is one aspect of social constructionism in use. Through relationships and the language used, identity is formed.

EXPERIENTIAL LEARNING AND EXPLORATION IS A PATH TO KNOWING SELF

It is important for people to learn from real experiences and explore real life events as they learn about themselves and develop their identities. The participants in this study mentioned the value of experiential learning by engaging in the real situation, learning by doing, and encountering with experienced people.

When bad things happened then you should think and make it better and don't let it happen again. ...If not successful, then try it one more time and one day it has to be my day. It's an experience when it doesn't work but this experience should be different from the first time, right? That's it. (So it's trial and error.)Yes, and got something better from it. ...we're like our behaviour. We have to learn and try to do things because it's not like we can do it right the first time we do it. You would get more experience than someone who got it right the first time would. ...You would remember it more from actually doing it than a theory. ...I think that I should ask someone with experience because I could use their mistakes as a guideline and don't make the same mistakes. My father always told me to ask someone that has done the thing before. ... I think you get more from listening to others' experiences than from a theory. (N3, 27 July 2004)

They valued sharing ideas and learning from others' experiences.

To tell them about the experiences, I think that this is one way. I would tell them that this had happened to me and it's like this and that. To share ideas but they would think clearly if there was some sample situation then it will be their trend of thoughts. It's a part of it because some might not be serious about what I told them. But for me, I got it from the experiences ... it has effects on me but to have effects on others then it's up to them ... I think you get more from listening to others' experiences than from a theory. Also with their families like I got from my father's experiences. From the people that they see each day like I see a nurse as my model. To look at yourself and then your model and back at yourself to see what you need to do or change for a better you. (N3, 27 July 2006)

It's like an experience like when I went out to do activities. There were a lot of activities and I was in my 2nd year, it was like should I go or not because sometimes I got lazy to participate in those activities and I went so much that there was no personal life left. But I go and do it because I have to learn by myself because it's my benefit. And I didn't feel bad about it that I participated in the student activities and my grades will be down. It's an experience. ...I got to practise it also. I got to be in the meeting and I've been less excited because I was excited and shaky voice before I could say anything but not that much now. (NN1, 19 June 2004)

In this sense, experiential learning activities both for self-development and health promotion are important in educational institutes.

In Thai culture, it is evident that participants express their sense of non-attachment as part of their sense of self. This component is presented in the next section.

SENSE OF SELF IN A NON-ATTACHMENT STAGE AS A HEALTHY SENSE OF SELF IN THE THAI CONTEXT

Achieving sense of self and the development of positive self-identity have been proved to be key factors that predict people's healthy behaviours. In the Thai context, sense of self is affected by the culture constructed in a Buddhist-based society which has conveyed a sense of non-attachment at a certain level. This sense of self-negation and non-attachment stage could be seen in many participants' self-narratives as *Bplohg-Dtohk*, or *Ploay-wang* which mean *tam jai* in many situations they faced. These concepts were previously discussed in Chapter 6. The sense of non-attachment is that:

Every problem would have a way to solve, so think and solve it, and then *sabai-jai*. I now find my self and understand more. In the past I would think too much and never solve the problem, but now I would think a lot and then *bplohg* about it. If there was the same situation again, I would not get mad, but would be calm because I faced that before. I would think and solve by *bplohg* and accept it. (NN10, 30 June 2004)

Tam jai means to accept and not think too much about adverse life events. College women in this study, as educated women, also used '*tam jai*' as a coping strategy congruently with the findings of Jongudomkarn's (2001) study of women in the socio-cultural context of poverty in northeastern Thailand. This psychological strategy stemmed from the non-attachment discourse in Buddhist ways of thinking which might entail optimism and happy feelings to the participants, even when living in a disadvantaged stage and adverse life events.

Another saying which is similar, but has more elements of critique (weighing up situations) is to be neutral about things, or *tam jai pen klang*. This is a healthy way to cope with events in life which could be seen to be equivalent to Antonovsky's comprehensibility, but comprehended in a neutral way, and requires the ability to see things from both sides.

My father had always taught me to decide things myself and would comfort me when there was a mistake by saying that there're two sides of the coin and it's not easy ... look at both sides of thing ... Looking at both sides of the world I started to choose and know that there are always two sides of things. (N1, 17 June 2004)

... to look at the good and the bad. To always weigh them both so you will see it clearly. Some situation there might be more of the bad outcomes or sometimes more of the good ones. (N3, 27 July 2004)

This discourse urges more critical thinking. It is to ponder things as they are and not to have lack of control. In fact, sense of self in Buddhism is the link among *atta*, *bhava*, and *karma*, and most importantly, they are narratives constructed in the mind, as Lax (1996) explains below:

In the Buddhist view, "Our sense of self is created by our thought processes and by the habit of grasping in the mind". And it is this sense of self, and a habit in it, that causes suffering. What we usually consider to be the self (*atta*), character, or personality is actually the "sum total of body parts, thoughts, sensations, desires, memories, and so on." More specifically, our character or personality is *bhava*, that is, a continuity of consciousness over time. It is the moment-to-moment connections that we string together and make into a narrative, which we then hold on to. Moreover, each successive moment is conditioned by our karma: the causal factor that determines what is possible to happen next. One might even say that *karma* is the narrative that guides and begets actions in the future (Lax, 1996, p. 198).

The Buddhist view of *anatta* or no-self is beyond Western concepts of self-esteem or self-actualisation. However, the two concepts complement each other and may provide a more useful way of self-development than each view by itself (Das, 1989). By combining the Western concept of self with the Buddhist model of the self, David Fontana (1987) proposes three stages of achieving "a profound realization of true human nature" as self-assertion, self-negation, and self-affirmation. To illustrate these stages, he cites Suzuki's work using the example of a circle:

A circle has a point and a circumference. Realization of this circle and this circumference is the stage of self-assertion. The self is both the point and the circumference, with the latter representing the boundary between the self and the outside world. With self-negation, both the point and the circumference disappear, to be replaced by a oneness between the individual concerned and the rest of creation. Returning after this enlightenment, however, one returns to the realization that this disappearance, in its own turn, is not the final truth. The point now reappears, but as Suzuki tells us, it now “finds itself to be at the centre of a circle with no circumference...The circle now ceases to be the threatening wall. The point is now everywhere, filling as it were the whole area of the circle which has no circumference.” As a consequence, the “Self-point is shorn of its fictitious contents which are now replaced by an infinite number of Self-points overflowing the circle. Every one of such Self-points is my Self – the self in its original just-so-ness.”

(Quoted in Fontana, 1987, p. 191)

Each failure in any stage of self-development leads to problems. The important stage of self-assertion is that it is this self that has been emphasised in relation to self-esteem, self-actualisation, and self-knowledge. For optimum psychological health, it is vital that one comes to know the genuine needs and aspirations of this self and its value, its personal and social rights, its strength and weakness, and also come to anticipate its likely reaction to the events of daily life. That is, “through self-assertion we build up the concept of a separate, real, individual self, a self that seeks to maintain itself in the face of the various levels of challenge present by the external world.” (Fontana, 1987, p.180). At this level of self-development, a number of psychological deviations could occur, when the individual fails to develop this necessary sense of personal identity and personal worth and the strategies of self-guidance and management that go with them (Fontana, 1987). Likewise, the ability of this self might be equivalent to the stage of achieving sense of self or Eriksonian identity achievement for obtaining individual well-being. The evidence of achieving a sense of self among healthy college women that encourages them to engage in health-promoting lifestyle behaviours in this study, confirms the merits of the self-assertion stage. Nevertheless, a social constructionist would argue:

The subjective feeling we have of continuity and coherence can itself be seen as an effect of our language-based social interactions with other people, and is an effect which is more illusory than real.

(Burr, 1995, p. 41)

This is congruent with the sense of self in Buddhism. It is empty, impermanent and insubstantial. The balance of knowing this sense of self and non-self may be healthy. There are, therefore, three levels of knowing self inferred from this research – achieving a sense of self, achieving a sense of connectedness to others, and achieving a sense of insubstantiality of the self. These three levels of knowing self are proposed for women’s wellness and moral health. In this sense, achieving a sense of identity and developing a sense of coherence is only the first step of well-being. The cultural context that stimulates the relatedness sense of self with others is another step of self-formation contributing health responsibility and practice.

The sense of non-attachment with one’s self may be affected by the teaching that “our individual thoughts occur almost as bubbles emerge in the ocean: they arise and pass away.” (Lax, 1996, pp. 198-199). This teaching influences many participants to let go their own feelings and attachments.

Central to this path is the practice of meditation. It is through meditation that the individual can observe the ongoing movements of thoughts, recognizing their impermanence and not becoming immersed in them. As a meditation practice develops, observer and observed even merge, so that the meditator observes merely a continual flow of phenomena. The boundary between inside and outside blurs, with the distinction between self and other becoming less pronounced.

(Lax, 1996, p. 198)

This sense of non-attachment achieved by meditation is a component of wellness enactment and has to be balanced with the sense of control and manageability. In Theravāda Buddhism “the self is conceived not as reified entity but as narrative.” (Lax, 1996, p. 201). Therefore, not only should the sense of self be developed, but also an awareness that the self is the product of inner and outer narratives. The non-attachment state is healthy in terms of avoidance of extreme views and behaviours. However, the ability to see the self and the context clearly has to be achieved. To be aware of the non-attachment or non-self state, the narrative that creates the sense of self has to be clearly heard. In the final analysis, sense of self has to be well developed, followed with the non-self stage to be a healthy person in Thai culture.

CONCLUSION

Throughout this chapter, the components of the Mindful Self have demonstrated how young Thai college women form their positive sense of self. Multiple roles/identities are formed in social interactions and form multiple sense of self to function. The functions of the complex sense of self are interrelated and influenced by culture and outer constructed narratives. The crucial points in the cultural self narrated by the participants are their collectivistic sensitivity and gratitude emotion. Their authentic self is equivalent to identity achievement which protects them from being alienated. A sense of connectedness to one's self and others is impacted by the cultural self as well. It is a practice of awareness of one's body, one's mind, and the others' well-being. That is a crucial part of the mindful self's function. Enacting health-related behaviours depends much upon health knowledge and the strength of the autonomous self and the competent self. The mindful self links their sense of self to function healthily and behave in a sensible way. These positive senses of self constructed in a particular context should be taken into account when thinking of health promotion.

The paths of knowing self are specific experiences and social interactions meaningful to them. Buddhism impacts on their self-development into some level of the non-attachment stage. This chapter has conveyed the healthy components of the functioning self that emerge in the Thai cultural context which remind me to realise the half full glass of water in my culture. Self is socially constructed and in my opinion it is important for an individual to achieve a sense of self before using the self as human agency for change for the merits of wellness of self and the society. This evidence of sense of self of the participants in the Thai context is the outcome of their historical inner and outer constructed narratives and impacts their health-related behaviours presented in the next chapter. The next chapter delineates the outcomes of health-related behaviours and the wellness enactment of the participants in the Thai cultural context both positive and negative. Positive and negative in any aspects of the context, the sense of self and its behaviours are two sides of the same coin.

CHAPTER 8

HEALTH-RELATED BEHAVIOURS AND WELLNESS ENACTMENT

This chapter builds on the understanding of the impact of cultural background and sense of self (developed in Chapters 6 and 7 respectively) on health-promoting lifestyle behaviours. In particular the chapter explores the impact of the health motivation, health-comprehension, and health competency of the study participants on the enactment of health-related behaviours. These factors are influenced by participants' cultural context and sense of self and contribute to a positive or negative feedback loop with respect to health-related behaviours. Figure 8.1 summarises the components of health motivation, health-comprehension, and health competency that influence the enactment of health-related behaviours. The summary picture is useful for health promotion professionals to consider in practice.

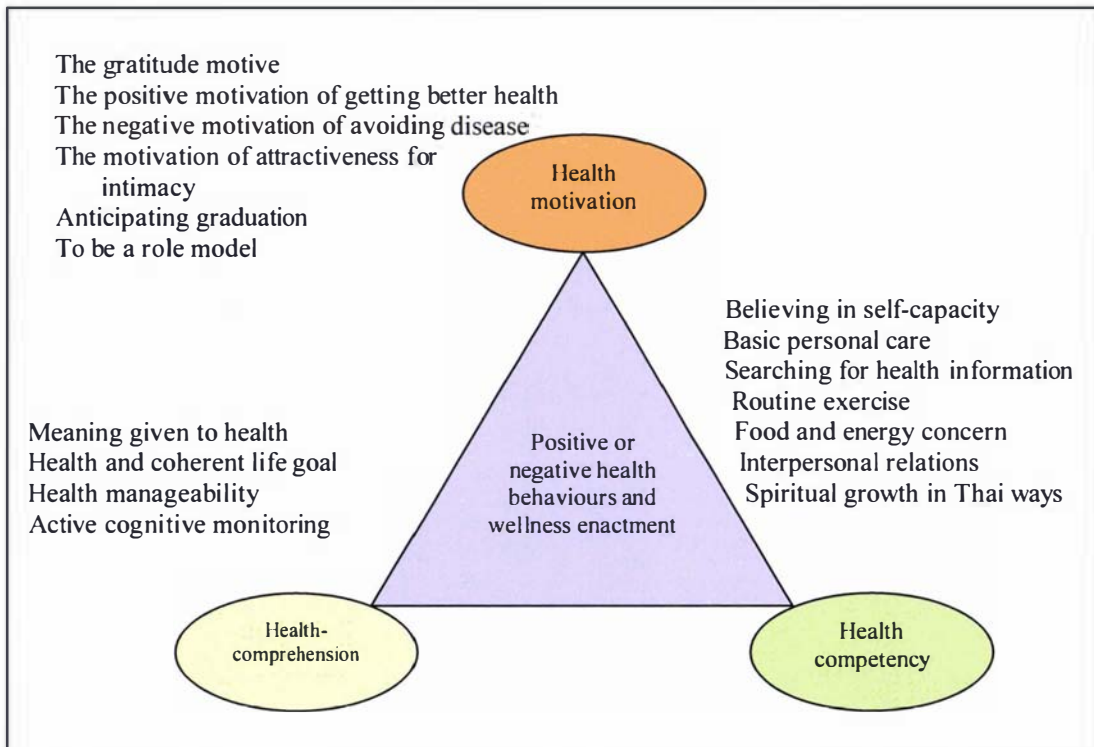


Figure 8.1 Summary of Factors Influencing Health-Related Behaviours and Wellness Enactment

HEALTH MOTIVATION

Health motivation is vital to urge this group of college women to engage in health-promoting lifestyle behaviours (HPLBs). Healthy lifestyle is described in terms of the two complementary aspects which may have different underlying motivation: health promotion with the desire for energetic well-being as the impulse for behaviour; and health protection or prevention with avoidance of illness as the incentive for action (Pender, 1982, 1987). Positive motivations stemmed from gratitude emotion, a desire for intimacy, and the motives to get better health or to be a role model. These motivations yield aspects of both promotion and prevention. Negative motivations were the motive of avoiding illness and negative consequences. All kinds of health motivation lead to life's goals of love and work. Health motivations suggested by the research participants are presented as follows.

THE GRATITUDE MOTIVE FOR HEALTH PROMOTION

Many aspects of gratitude expression were presented in Chapter 6, and this cultural background impacts on Thai women's health motivation. The gratitude emotion motivates many participants to think about taking care of themselves and engaging in HPLBs. This is illustrated by N11's comment that:

The reason why I want to be healthy is that I want to be strong to work for the future, live long with my loved one, and do merits for my family. (N11, 26 May 2004)

The gratitude emotion also helps many Thai college women avoid risky health-related behaviours when they consider that those behaviours would make their parents regretful. In addition to concern for protecting the self they wish to do their best for their parents as explained by NN5:

I see that I have been doing the best now. First, many students in Ratchapat they would live with their partners...Umm...I don't do that so this is my best at least I don't make my parents regretful. Next, many women would smoke and drink alcohol but I don't, this is another good of me, another thing is I don't go to night clubs or night life, just go have a stroll around the mall...like that...so I have done my best, but I don't know what will be in the future because I haven't gone out to the wider world. Right now I am in the stage of being a student so I have done the best. Not go night life, not smoke, not drink alcohol, and most of my friends don't live with partners. First, it's for myself. Second, it's for my parents...Umm... if they will be regretful then I don't want to do the things. (NN5, 2 July 2004)

Even though socio-economic changes have affected Thai society influencing young people's ability to find employment, and in effect, putting at risk the custom of reciprocity for parents' goodness, the gratitude emotion should be kept as a high quality factor which motivates HPLBs and promotes well-being.

Gratitude plays a significant role in an individual's sense of well-being. The links between religious thoughts, such as gratitude, and good health, both physical and mental, have been examined as happiness promoting factors. A number of studies have shown that experiences of gratitude may be associated with happiness and well-being (Emmons & Crumpler, 2000; McCullough, Emmons, & Tsang, 2002; McCullough, Tsang, & Emmons, 2004; Rossi, 2004).

For example, in a study by Emmons and McCullough (2003) people who kept a daily list of things for which they were grateful were found to have higher levels of alertness and positive affect and reductions in negative affects. They reported more positive and optimistic appraisals of their life; better sleep quality and more time spent exercising; and a sense of connectedness to others, when compared to a group keeping a diary of daily life events and a group recording daily unpleasant experiences. It is noted that the disposition toward gratitude appears to create and enhance pleasant feeling states rather than diminishing unpleasant emotions. Accordingly, grateful people do not deny or overlook the negative aspects of life (McCullough, Emmons, & Tsang, 2002).

In this thesis, I demonstrate that a motive of gratitude encourages Thai college women to engage in HPLBs. This is influenced by a specific cultural narrative which impacts on their cultural self and health behaviours. This motive is crucial for designing health promotion messages for this population since it contributes to health promotion and health prevention behaviours.

THE POSITIVE MOTIVATION OF GETTING BETTER HEALTH

For young Thai college women, good appearance is linked with being healthy. A desire to look good was their underlying motivation for health-promoting behaviours:

It's true that the body is still healthy but it would last longer if I take care of it. And the most important thing is it might be getting better than it is now and it will look more beautiful and dignified. (N1, 17 June 2004)

Mostly, I engage in health-promoting behaviours like exercise when I have motivation. I want to look good and have good shape, not to be too skinny. At the present, I exercise because I think I should begin now for a strong body. (N11, 26 May 2004)

To maintain health-promoting behaviours, this kind of motivation is crucial. It keeps the participants taking care of themselves, even though they are still in a healthy life stage.

THE NEGATIVE MOTIVATION OF AVOIDING DISEASE

Negative motivation stemming from attribution of meaning to health as a stage of no diseases, may be effective in prompting health-related behaviours:

My father goes to exercise sometimes but my mother has a backache problem because she hardly exercises and I am afraid that I would be like her so I exercise ... I'm probably afraid of having diseases, afraid of illnesses. I don't want to be admitted in hospital. I think it [exercise] should give better results than using other means like eating vitamin supplements. I think it should be better than other ways ... I'm just afraid that I might not have strong bones when I get old because I've heard that we will have decayed bone when we get old like that. I heard my mother say that it would be hereditary because both of my grandmothers used to have that problem. And like diabetes, my grandmother also used to be diabetic. (NN3, 18 June 2004)

Another negative motivation was the fear that illness may impair performance at work expressed by NN6:

I want to be healthy all the time. In the future, if I work, and if I am unhealthy, or have illness, that would be the obstacles for work. I want to be healthy always. When I work, if I am healthy with good mental health, so I can make good cooperation with other people, but if I have sickness and that will make me annoyed and cannot do good work, then I'm afraid of blame from the boss or losing job if I can't make progress at work. That would make me keep thinking about it ... umm ... I did not do it well ... and was blamed. (NN6, 29 June 2004)

The motivation of avoiding illness and adverse effects is another side of health motivation complementary to health promotion which may help participants engage in HPLBs.

THE MOTIVATION OF ATTRACTIVENESS FOR INTIMACY: TAKING CARE OF SELF FOR MY LOVER

Intimacy is a stage of self-development to adulthood. Intimacy gives various kinds of motivation for taking care of physical appearance, both positive and negative effects. For example N12 said:

I am a woman who is fond of beauty and believe that good health will make us look good. Even though I am not a very beautiful woman, I feel confident, fresh and lively and I think these will make people want to contact, associate and make friends with me... I want to be joyful and look good to avoid boring characteristics. A man always wants to be proud when going out with his girlfriend and wants her to be beautiful and fresh. So I would do my best on my health to make him love me long. (N12, 26 May 2004)

This motivation was further illustrated in Chapter 6. The motivation of looking good and joyful in a balanced manner may be health promoting for women. Health promotion professionals should take responsibility for providing knowledge and awareness to Thai adolescent women to promote their health properly.

APPROACHING GRADUATION TIME TRIGGERS SELF-AWARENESS AND CHANGES

Graduation time is an important life transition period for this group of Thai college women, and it triggers a certain level of self-awareness and self-improvement. The participants said that:

A part of it is about graduation because when I graduate I have to go places and meet people. It's the wider world, so I am trying to take care to always look good. (NN5, 2 July 2004)

You have to be smart and have self-confidence because we were raised to be smart and confident so we can survive in society. To be proud and dignified wherever we stand ... It could be your personality, like to stand at a point where you don't have to be the same as someone who does not have self-confidence. When you graduate and go on hospital round, not to work like you're scared. To be at that point, you have to be dignified. (N6, 22 June 2004)

I am close to graduation and if I don't improve my personality then my chance of getting a job will decrease compared to someone with good personality. There are a lot of contexts to think about improving myself ... that it's important by observing upperclassmen. Some with median grades while some with high grades but with poor personality like hunch-backed, cannot communicate, or dress poorly then chance of getting a job is not that excellent. (N1, 17 June 2004)

This implies that health knowledge and motivation need a crucial period of life transition to trigger real health-promoting behaviours. The senior year in college may be a good time to promote positive health motivation.

PENN BAEB YHANG: TO BE A ROLE MODEL

While knowing their self-value encourages Thai college women to take care of themselves in general, the competent self and the feeling of self-value are expanded into an affirmative role model for society in terms of health and well-being. The

desire to be a role model, then, plays an important role in their commitment to take good care of their health, especially in the group of student nurse participants:

They would question our abilities to take care of others when we can't even take care of ourselves while studying nursing. ... I would get compliments from surrounding people that I can take good care of myself and the most important thing is I will also be able to *pen baeb yhang* (be a role model) for others. (N3, 27 July 2004)

What will people think of us when we are studying health education and we couldn't do what we are telling them to do? ... You have to be able to do what you are telling other people to do. (N6, 22 June 2004)

I think that there should be some kind of a model first so I could tell other people. They would come back and look at me to see if I am doing too when I told them. I think that I should be okay first before telling anyone else. (N8, 9 August 2004)

This is not only the image responsibility, but also the responsibility to develop the self to take care of other people. As when N9 said that:

...when I'm about to graduate someone would ask about how to cure or handle some illnesses. My view is that I only studied this much and not so sure about myself then am I brave enough to give them advice? If I don't start at myself, then how could I take care of anyone? (N9, 30 July 2004)

This motive of being a role model could be a crucial point to cultivate women's sense of self as they would be the significant care givers and role models for family. Role model sensitivity, therefore, means individuals are sensitive to role models they see, and are aware that they are others' role models for health-promoting behaviours and social well-being.

Participants in programmes of study other than nursing had not necessarily been inculcated with the motive of being a role model and some lacked cognitive education in health. For example, the following excerpt demonstrates low motivation for enacting health-related behaviours:

I start to control weight but I am kind of let loose with my self and lazy, like ... urr ... I would eat when hungry or craving. Seeing friends in good shape and looking good in their clothes might make me think and want to be like them, but the motivation is periodical. Sometimes I won't eat but then feel very hungry, so let's eat. I try not to eat and get to think that will I stay fat like this forever? ... I think but I can't control my craving. I motivate myself to control weight when I see other people can control their weight then why can't I? I won't eat dinner but then feel very hungry so sometimes have to eat instant noodles and drink a lot of water, or sometimes try to go to sleep. I think I'd better go to sleep but I still can't fall asleep because I get used to sleeping late at night.

I intend to go exercise but then I would think...tomorrow will be OK and keep postponing again and again. I have no motivation about health because I can't see the outcomes or consequences obviously, not like with study, like have to finish assignments on time or something like that. I'm really lazy with taking care of my health, but more serious with study because it would have consequences and I have to rely on myself with studying. ...I don't think much about health but seeing friends' behaviours makes me think. I don't think I can, but keep trying.

Sometimes I didn't eat dinner and then no breakfast and have only lunch. That made me too tired to even walk and feel fainting. It might be also because I get older now. I think I don't exercise so I'd rather don't eat dinner and drink only water. I know the importance of having breakfast so I eat some cereals. In the evening I would drink milk and eat some fruit instead if I had lunch already, but not feel satisfied, still feel hungry. But I won't use drugs because I know that it would be harmful for our nervous system. I know the good ways are to exercise, control food and control myself. I will. I don't want to feel that I can't control myself.

I know some health information from internet and some from the programmes on TV. But I am not keen on studying them, just only look at the magazines or the programmes by chance. I don't like to ...I don't search for it. I have not enough time to do that and have no motivation to look good for a boyfriend or to gain compliments from people. I don't have that motivation. Just want to look good but the motivation is not strong. (NN10, 30 June 2004)

Her self-narrative conveyed a kind of closed loop of health-related behaviours, from weak health motivation, uncertain belief in self-capacity, to enacting fewer health-promoting behaviours. This participant evidently showed weak areas in the competent self and the sensible self.

HEALTH-COMPREHENSION

MEANING GIVEN TO HEALTH

Generally, body and mind were the focus of health, for example participants said that:

For example, if you have a weak mind and are sick with some illness like cancer then it would affect your mental health in the first stage. It then will affect your thought to think that you're dispirited and won't make it, which will have effects to your body that is you don't feel like doing anything and your health will degenerate. Mental mind is to look at the emotion and feeling but spiritual mind will be idea and aspiration. (N8, 9 August 2004)

It might mean about state of the mind too. If you have good health, then your body should be healthy first and then your mind. Other meaning would be your mind should be ready first or ready to face it first. If you have a good mind then the body should be well.... I weigh them both about the same. (N9, 30 July 2004)

For participants who had not studied much about health, there could be a notion that health was mainly up to the state of the mind because of the cultural belief that mind is the master of the body. Health depended on a happy mind, for example NN10 said:

For health, mental would come first, if we *sabai-jai* (have a happy mind) and have hardiness with mental mind then we can stand for our health and well-being. (NN10, 30 June 2004)

Most of the non-nurse participants would emphasise the physical body aspects of health in terms of having a strong body with no diseases. Some linked health to both physical and mental aspects, but none of them referred to the social aspects of well-being. For example:

In my opinion health is totally everything in our body, completeness and strong in everything in the body. Perfection in everything is health. ...Everything, body, mind, everything. (NN5, 2 July 2004)

Health is healthy body without illness and not easily ill. ...I don't think that beauty pertains to health. It has to be about taking care of your health. (NN1, 19 June 2004)

Body, our body, *Mai Mi Roak Pai Khai Jeb* [no diseases, harms, fevers, and pains], thinking, strong body with no diseases, good shape. (NN11, 20 June 2004)

Health is the strength of the body. It should be about the strength of the body, like good health is having a strong body and bad health is having a weak or incomplete body. I mean *Mai Mi Roak Pai Khai Jeb*. (NN3, 18 June 2004)

The meanings given to health were broader in student nurse participants compared to non-nurse participants and these would influence their positive motivation toward health, not merely a motivation for avoiding diseases. They said that:

... Health is satisfaction and happiness from taking care of oneself ... You should be satisfied with yourself. (N4, 21 June 2004)

For me it might mean not getting sick, good thinking, good living in society, and good relationship with others ... You have to be able to relate with others too and be happy about it. It's not merely not to get sick ... If it's just not getting sick then you would only take care of your body. You have to relate with others too because there would be some communication with others and not just taking care of yourself. Good society will affect work and success ... Health is not to be angry, don't think too much, don't ask for anything, and don't be tense. Don't be on bad terms with yourself when you're having a problem with someone else. (N5, 22 June 2004)

In my mind it would mean to have healthy body, healthy mind and the readiness to face anything within your abilities, suitability, and situation ... with daily situation with school, friends or anything. It's our readiness for any situation. (N9, 30 July 2004)

The meaning given to health influences the individual's health-related behaviours. If health is related to beauty, looking good, performance at work, and relations with others and society, health-related behaviours would be expanded. This finding is consistent with that of Pender et al. (1990, p. 330) who reported that "defining health as wellness (adaptability, role competence and exuberant well-being) appeared to increase the extent to which health-promotion programme enrollees engaged in health-promoting behaviours, while defining health clinically as the absence of illness contributed nothing to the explanation of lifestyle." Defining health as wellness was also found to be the strongest determinant of overall HPLBs among rural older women in the USA (Pullen, Walker, & Fiandt, 2001).

The whole picture of health from individual, interpersonal relations, and societal levels could be seen in the minds of these participants, and this might affect their health comprehensibility as an important cognitive-based factor that promotes commitment to HPLBs. Health is linked to both the function of individuals and the function of the society, like a participant said:

For me it is the combination of body, mind, society, emotion, and spiritual mind. I would look at it whole and can't separate one from the others. (N9, 30 July 2004)

In terms of wellness, Dunn (1961) proposed key elements of high-level wellness which are having direction and purpose in life, meeting the challenges of the environment, maximising potential, looking beyond the needs of self to the needs of society, and having a joy or enthusiasm for living. The extent to which health is given meaning will determine the participants' health motivation and behaviours.

HEALTH AND COHERENT LIFE GOALS

The following data shows explicitly that health and well-being are linked to meaningful life goals. For college women who had their life goals, good health would always be interwoven beneath their life goals. They would give some priority for health and their clear and coherent life goals are set in relation to health.

Having good health is for happy future life and to acquire other good things in life

The notion that health and well-being are the basis of a successful life and a path to obtain other good aspects in their lives is clearly evident in the data. Most of the college women described their life goals as dependent on health. For example they said:

Having good health means you can give it all when doing work and don't have to worry about it. When you have poor health then it might make you miss school ... Society nowadays there is a value of emphasising education so I would believe that good education would bring life success. (N3, 27 July 2004)

Health means having strong body, cheerful mind, and no tenseness ... It's important for me. It's an important part of our living. There are things that might make us success in life or not. So it partly depends on our health. (NN4, 19 June 2004)

...I want to be a smart one and I think that if I am healthy then the good things will come. (N7, 5 August 2004)

[Having good health] ...For happy future and reduce health care expenses because with building health by myself then I don't have to spend money. But to fix it then I have to spend a lot of money and waste many things like time, money, and family aspects. (N8, 9 August 2004)

I felt that to have a happy life then you should have a good health with no illness. To have everything like knowledge and good financial position, if I don't have good health then it would make everything meaningless ... I am thinking that if I have good health then I can acquire other good things for my life. With good health I can study, work, have income, and acquire good things for myself. (N9, 30 July 2004)

Life goals are believed to influence behaviours. A person will engage in a chosen behaviour when it is conceived of as a means to a desired end state or goal (Sheldon & Kasser, 1995; 2001). Intrinsic goals such as personal growth, and inherently satisfying things like intimacy or love and a sense of connectedness to others and community, are more likely to promote subjective well-being than are extrinsic goals focused on the attainment of external rewards and praise (Deci & Ryan, 1985). Sheldon and Kasser note that people with personality integration will have high self-esteem, subjective well-being, and adjustment. They propose that "integration occurs when the aspects of one's personality both cohere with one another and are congruent with organismic needs [competence, relatedness, and autonomy]." (p. 531). For personal goal systems, goals should be both vertically coherent and horizontally coherent. Coherent goal systems will contribute to coherent personality. Personal strivings will help bringing about possible selves (Dunkel, 2000; Markus, & Nurius, 1986). In this research, a woman's strivings to be a competent working woman who has autonomy and is able to relate to others are the possible selves of a healthy woman.

Sheldon and Kasser (1998) further report that although goal attainment can entail satisfactions, not all progress is beneficial. Participants in their study whose goals were not self-integrated felt little change in well-being regardless of how well they achieved their goals. Therefore, Sheldon and Kasser argue that non-concordant

goals do not satisfy essential psychological needs even when those goals are attained. As a result, differentiated goals in life in terms of coherence and congruence can affect behaviours and well-being. Goal systems which are expressive of intrinsically satisfying values are present in the excerpts of these participants, as seen below:

...to think about the future and think ahead. Like there are a lot of beautiful things that I haven't done but I want to do in this world. But I will have less chance to do it if I don't take care of myself or do something that will ruin my health. (N1, 17 June 2004)

Because I want to reach my expected goals like the dream to further my study in Doctoral programme, have good firm job, have good family, and to be refuge for our parents to take care of them and make them feel comfort when they are getting old. ...I feel good taking care of myself to maintain it in normal level, and not to get sick too often. To make myself healthy, good skin and good shape are also the good points because to take care of health is not merely to get strong, but also make us look good in personality, good face skin complexion. ...For personality, beauty, working, and feeling good to my self are the points. (N10, 26 May 2004)

Goal self-concordance combined with goal attainment will lead individuals directly to changes in well-being (Sheldon & Elliot, 1999). Therefore the construction of healthy goals and values is a valuable contribution to well-being.

Health enhancement and appearance enhancement are to be viewed together

In contrast, to satisfy organismic needs, not only intrinsically satisfying values such as personal growth, intimacy, and community were held to be important by participants in this study, but also some of the extrinsic goals, such as material success and physical attractiveness, were found to affect their values inevitably. For women of college age, physical attractiveness is believed to be a contribution to their intimacy and work success through their self-confidence. Material success affects their sense of security because most of them hope to be a refuge for their parents and families. This is an important gratitude value and also a life constraint in the Thai context. Accordingly, these two extrinsic goals, material success and physical appearance are believed to be tangible and therefore contribute to the well-being of young Thai women at some level:

I want to look good and have good shape, not to be too skinny. At the present, I exercise because I think I should begin now for a strong body. Exercise will protect being easily tired when doing little chore.... I want to be strong to work for the future, live long with my love one, and do merits for my family. (N11, 26 May 2004)

The common purpose shared in this group of young women is that they 'have to look good.' They are heavily concerned about their appearance. Undeniably, in their eyes, to look good is evidence of a healthy person. As Daruna (2004, p. 8) asserts: "health is a characteristic of life, which may be evident in the appearance and behaviour of organisms." In this sense it has to be accepted that health, appearance and behaviours are aspects going together for well-being. For this group of Thai college women, a strong motivation for wanting to look good is conveyed from many sources of significant others, media, and some concern from their expected professional area of study. They said that:

...when I go out then I would meet many people. They are watching me so I have to be good and behave well.If we're working, to be that chubby is not suitable. (N7, 5 August 2004)

...For me to succeed, I want to graduate and have a job overseas. It is related to health because when I have good health then I will have good personality too. It's one of the important things for an interview. With work as a nurse then I got to have strength to work so I think that they could be related for my success. ...And I wish to go overseas to get experience because I like the freedom, seeking experiences, and learning new things. (N3, 27 July 2004)

The data here do not support the exclusion of appearance from the goals of healthy women. Therefore, not only intrinsic motivation for achieving organismic needs are important for this group of Thai college women, but also health and appearance are aspects expected to go together. The point is to raise their awareness of knowing their healthy values and being sensible in relation to external pressures around them from media, fashion, and unrealistic attitudes towards thinness and health. The idea of thinness and slimming has affected Thai women physical and mentally. For example, they said:

I think about how other people would think that I am fat, other fat friends could improve their shape but why I can't. (NN10, 30 June 2004)

To think about health promotion for college women, health should be linked to coherent life goals. A participant replied to me when I asked her what she thought about how to promote health for women her age. She said:

It's like a motivation and doing the same thing to reach a different goal. If you're asking me what I am looking at [for health promotion], then you have to look at the goal for each person and see what he or she really wants. (N9, 30 July 2004)

HEALTH MANAGEABILITY

When the participants manage well with all demands in their daily lives, this means they can process things under control, toward their goal systems. This can expand Antonovsky's manageability toward goals. "Manageability means that they have the resources to cope with the demands posed by changing events." (Antonovsky, 1987, p. 19). The participants asserted that:

...it's possible to manage many things at the same time by putting them with one another, for example, money and weight control. If you eat less, then you'll have more money to buy whatever you want. As for school and boy friend, there's reinforcement for taking care of yourself. And It's like you'll have used up some energy if you go to sleep late for preparing the exam, so it might reduce some weight. So, eat less, use less money. (N4, 21 June 2004)

For me, it's more like the readiness for work. I try to take care of myself so I can attend school everyday. I have to endure with school because my duty right now is to go to school and keep on taking care of myself until I am fully ready then I would do it for real [for health issues]. I mean to give priority to health. ... because if you're not prepared, then it's no go. I would go right away when I had free times. I give exercise some priority but it depends if there's work in the evening. (N9, 30 July 2004)

Manageability is a crucial component of their health-comprehension and this also confirms the result from Study A that SOC is a factor predicting their level of HPLBs. The constructed sensible self is also a resource to cope with their health issues in their lives.

ACTIVE COGNITIVE MONITORING TO MAINTAIN HEALTH

This aspect of health-related behaviours functions from the mindful self and sensible self of the participants. If health is meaningful for them, participants will engage in active cognitive monitoring of their actions about health like thinking before eating, maintaining meaningful relationship with others, and caring about one's self and others' well-being. It is to be aware of the ongoing becoming of health:

Take care of yourself always, because you see yourself everyday, and you might not notice it. Like boiling a frog in cold water, it will gradually die without knowing it. (N7, 5 August 2004)

Thinking before eating

The student nurse participants showed mindful behaviours about their eating, like food composition they chose, or timing of eating:

Like with food, sometimes I wouldn't eat or would think while eating. Like putting sugar in the noodle, I would think that oh I better not put it in. From watching television and reading books I should be taking care of being fat so I won't eat sweet or fat. (N5, 22 June 2004)

If I am sleepy from not much sleep the night before then I would drink some coffee without sugar, just caffeine and not diabetes please. And no cream, no coffee mate. Part of it, yes, it's a way of not putting on weight and my mother is a diabetic so I have to be careful because I am afraid that it might be hereditary. (N1, 17 June 2004)

I would avoid food that makes me gain weight. I would be uncomfortable when my weight increased.... Avoided deep-fried, I wouldn't eat any fried bread like *patongko*. Mostly I eat local foods like fishes and vegetables. (N9, 30 July 2004)

I wouldn't eat dinner but would eat a little if there were something delicious. Mostly I wouldn't eat dinner.... because I would think that I will get fat but I don't think like that now. My weight is always at this level and not over 48 so it's normal. Right now I would eat. But I would choose what to eat. To eat rice or milk, sometimes she (my mother) would bring me some milk. If it's too late then I won't have dinner, or if it's too much for the day then I won't eat. After 6 o'clock in the evening I won't eat a plate of rice or full meal, I would eat snack, Thai vermicelli or noodle. I would feel guilty inside after I ate so it's a habit from then on. I read that after 6 o'clock in the evening it's hard to digest food and you would go to sleep soon because there're no activities or go anywhere when you are in the dormitory like this. (N5, 22 June 2004)

These excerpts are contrasted with the following excerpt where the participant did not give much thought about eating and therefore, accepted the circumstances without options:

It's impossible when eating two choices of entrees at the cafeteria ...just eat normally without thinking much about it. (NN1, 19 June 2004)

Active cognitive monitoring needs specific health knowledge to be a resource for action. Knowledge and motivation when combined will help the participants to commit to health monitoring habits:

At a store, I would look for nutrition contents. Compared sugar contents and chose the least one. It's like this since I studied the first year of nutrition. ... But it has to combine knowledge and desire too. (N7, 5 August 2004)

I think I am too thin. I'd like to gain more weight so I would do anything to gain weight like eat more amount and frequencies. But I still choose low fat food because I don't like greasy or too sweet food. I usually read label of nutrition fact before buying food and drinks. (N11, 26 May 2004)

From what we learned, Meatballs have borax substance and in our group we would be aware of it ... we would know what food has what kind of substance that we should be aware and avoid it. I would eat it but less or just a little. (N13, 21 June 2004)

The components in the health-comprehension sub-theme are close to the participants' enactment of healthy behaviours which I have separated into another sub-theme, health competency. However, I see health-comprehension as the cognitive background contributing to their health-related behaviours, while health competency is their actions of healthy behaviours which begin from a belief in self-capacity.

HEALTH COMPETENCY

For real steps to be taken toward health-related goals, actual adjustment to health behaviours must be applied. There are varied levels of health competency which were expressed by the research participants as presented below.

BELIEF IN SELF-CAPACITY

Healthy behaviours are initiated from the belief of self-capacity. As Jourard (1974, p.3) proposes "a man's views of his capacities to cope, to survive, to grow, are decisive influences upon the course of his life."

I propose that this belief of self-capacity is an open loop to encourage the individual to take charge of taking care of the self. An open loop with two free ends; one end is for self-reflection and another free end is to continuously manage one's own healthy life:

...I've tried to find ways to *jad kann tua eng* (manage myself). (N1, 17 June 2004)

Right now I am trying to take care of my health and to study hard because my study would have effects on my future. (N8, 9 August 2004)

Other students who do not believe in self-capacity and have weak health motivation are more like a closed loop with no free ends of health competency, so it is like a circle of unhealthy excuses:

...There is lots of work lately so I haven't gone to exercise. Sometimes there was no free time and sometimes it's late in the evening so I better do something else. Sometimes I had to do homework, housework, or other kind of work so I couldn't go. Really, everyone knows that it's to exercise and to eat all five groups of foods but no one paid that much attention to it. ... I don't care much about my body or shape. ...I think that I take very little care of myself. (NN1, 19 June 2004)

I thought when it's boring time and I might be able to go alone [to exercise] but I dare not because I am kind of shy person because most of the time I hardly do anything alone. I dare not go alone. Like sometimes I call my friends and they are not free and I stay alone while my friends go home and I'd like to go for a walk but I dare not...I'm afraid. I am shy and bashful when people look at me when I am alone but if I am in a group of friends then I would go all out. This problem sometimes makes me not eat. I dare not to go eating alone. I am shy to buy food...shy to do anything alone. I don't know why I feel like this, but I dare not and I never go and do things alone. (NN12, 20 June 2004)

There is a difference between saying that "I try" and "I cannot" or "It's impossible to ...". This may be the beginning of health-promoting behaviours. It demonstrates a belief in self capacity.

BASIC PERSONAL CARE

A basic level of personal health care was described by most participants; for example:

In the morning I would take a bath, brush my teeth and then apply moisturizer, go to study. (NN5, 2 July 2004)

Even though we don't have enough time to go exercise, we have to have enough sleep at least 5 hours a day and have to drink a lot of water. I drink a lot of water for my skin health. (NN7, 29 June 2004)

I would go to see the doctor myself when I feel sick. (NN8, 6 July 2004)

The knowledge of basic personal health care from the level of primary school is insufficient by itself to enact health-promoting behaviours. To be healthy and live well is a life-long learning skill, because health and well-being are not static issues. At the undergraduate level, some profound health knowledge would help Thai women to take better care of themselves in addition to their career competency. The experiences of enhanced well-being could be used to reinforce the value of good health and to promote a more comprehensive lifestyle change (Kaplan & Cowles, 1978).

SEARCHING FOR HEALTH INFORMATION

Normally, students can search their interests on the internet, and the mass media provide all kinds of information. If health issues are their interests, they can search for useful knowledge by themselves:

I would search the internet, go out to look for it, buy magazine, or watch television. To find things in general. Right now it would be about beauty. It would be a variety like stars, entertainment, fashion, health, make-up, eating diet, and skin complexion. I do (follow it), like make-up techniques of putting on white or blue first. (N5, 22 June 2004)

I search for beauty tips using Google, like if I want to know about the formula for face masking and I would type and search for face mask formula then they would all show for oily skin, dry skin, mixed type or normal or tarnished skin. Pretend that today I have read about vitamin E that would make nourished skin then I would go and buy vitamin E to eat to make good and bright skin face. Now I take vitamin C for two months long, two tablets a day, but not take it everyday sometimes I forget to eat it. I would eat it the day that I'd like to. (NN5, 2 July 2004)

In fact, they have acquired a range of information which needs to be mindfully explored. Mindlessness of health practices would occur when exposure to information occurs without mindful exploration.

ROUTINE EXERCISE CREATES A CYCLE OF WELL-BEING

Engagement in routine physical exercise produces benefits from immune function enhancement, such as mental relaxation, sound sleep, social engagement, gaining lean body mass, muscle and endurance (Daruna, 2004). In essence, the preparation of the body and mind by engaging in routine physical exercise provides self-regulation at the physiological level. Exercise could create a cycle of well-being; for example participants claimed that:

My daily routine is exercise like aerobics dancing because first, I get to exercise and second, it's the mental health because there's music to listen to and just let it all out when I got tense ... I didn't exercise often at first because going on round at the medical ward is hard work. It's a kind of attractive work that like learning experience but very hard and tense also. And after I went out to exercise then I felt great with good mind and able to sleep well without being tense. I used to have a problem with my knees and it was hurting at the beginning but it's gone now as the time gone by. I really wanted to learn more at this hospital ward but I couldn't with this problem with my knees. Exercise can help me with this problem so I began to do it more often. (N1, 17 June 2004)

Normally I am a sports person since I was a kid. I felt more relaxed when I exercised and the readiness to work was increased too.... pretend that you exercise for a while and stop, then after 2-3 days you will feel tired and edgy. You would sweat when you did little chore like it's gone.... Then I would find free time. Maybe for a walk.... the preparation of your body. (N9, 30 July 2004)

I think that if I go out and exercise then you will have friends because they are all the same age as me. (N8, 9 August 2004)

Exercise and physical activity have been known to alter bodily systems including the immune system. The immune response to exercise is similar to that seen after trauma and infection and the responses to acute psychosocial stress, thus, exercise can be seen as a form of self-imposed stress which leads to transient changes in immune function. A routine of physical exercise tends to be associated with less morbidity and enhanced longevity. Daruna (2004) argues that regular exercise is best viewed as self-regulated chronic stress. It can be seen as body preparation:

In many respects the protective influence of exercise is reminiscent of the ways in which chronic psychosocial stress may toughen some individuals against adversity. It also brings to mind that training the body to deal with challenges makes the individual better prepared to cope with unexpected challenges.

(Daruna, 2004, p. 221)

This preparation is asserted by N3:

I feel I get much better because the time during my early adolescent age I would easily catch a cold but after I played some sports, even not so often, around 2 times a week, I feel better. (N3, 27 July 2004)

Exercise could also promote social interaction and give a firm intention to restrict caloric intake because of the consciousness of the investment of energy burning gained:

It (exercise) is good. I would get to walk, see a lot of people, point at this and that so it's good in a way. It's not like I plan for it or something like that. I would do aerobics dancing. At that time then it would be the whole month, every month. Every day at that times but never last till the end. It was fun at first because you get to tease friends when they missed some steps. ...It felt good because you get to talk to others. Also it felt good to sweat. I didn't feel like eating when I do aerobics because you shouldn't eat after you exercised. Right, it's a kind of investment when you dance. Exercise would utilise few calories and you would hurt it by eating afterward so why should you be exercising in the first place? (N5, 22 June 2004)

The participants identified physical, psychological and social aspects of health that were enhanced by physical exercise. Because they could experience the differences between the time of exercise and the time of no exercise, their commitment grew stronger:

Exercise will prevent being easily tired when doing little chore. I'd like to have firmed muscles and good shape. After exercise I feel that I have used a lot of calories, my body will sweat a lot and that makes me feel fresh. (N11, 26 May 2004)

I felt good when I jogged and felt stronger. I felt that at least I got to exercise every part of my body. The result was that I am less tense and with the mental health too. I could see the development too, like at first I would get tired but after a while then I wouldn't get tired so I know that my efficiency is increasing. I felt good after jogging.... I felt fresh when I sweated. Also I felt stronger at some level and at least it's a way of getting rid of little fats out of my body. Something might increase but some is decreased too.... It's the mental aspect, the feelings. (N8, 9 August 2004)

...after a round each day I would exercise first. If not, then I couldn't do any hard work. ...when I go I feel good and strong. And I would have a concentration when I work. I would be in a bad mood on the day that I didn't go. ...When I didn't exercise, I felt fat and swell up. I was not agile when I went places. I don't know. I've changed. I felt better and friends told me that I've changed. More mature too.... Exercise for health but we got more than health.... I wanted to be healthy and thin. I felt healthy, agile, and comfortable. I think that I am the same but friends told me that I've changed. Something like, more mature. ... Maybe more like an athlete? More like personality changed, because I don't feel that I am thinner but someone said that.... it's firmed. And friends are kidding me that to exercise to be thin and not for muscle. But I got all muscle, don't want it but it builds up. (N7, 5 August 2004)

Participation in physical activity may create a ripple effect to other dimensions of healthy lifestyle behaviours (Gillis & Perry, 1991). Regular exercise can also directly improve the competent self and positive sense of self. For example, Colchico, Zybert, and Basch (2000) reported that a twelve-week tri-weekly physical fitness programme with 30 female students resulted in significant increase in cognitive self-perceptions of scholastic competence, social acceptance, athletic competence, behavioural conduct, and global self-worth.

Generally, all participants understood the merits of exercise for health; however exercise takes time and investment. Usually, part of the commitment comes from the emotional merits of happiness and fun or feeling good while experiencing regular exercise, as described in the following excerpts:

... Not just aerobics because there's ballroom dancing in the morning. If I am tired and they are doing the same dance and music, then I would go jogging ... it's relaxing ... [exercise] for health, like I've told you from beginning. I exercise to be healthy, to be thin. These are for my health. But I get more than health from endorphins, I guess. I just want to be thin. But if I only want to be thin, and if I wouldn't be happy when I do it then I can't do this much ... exercise should be fun for the first time so you will continue to do it. (N7, 5 August 2004)

... I would go aerobic dancing when I have free time. ... They dance fast. I like it so I would go dancing with them when I have free time, around 4 times a month ... I feel good when eating food; it has more taste in my feeling and also has good sleep. But it's not that obvious for the outcomes but it is fun when I go exercise. (NN3, 18 June 2004)

After doing sit-ups the tiredness would be gone and I feel more active and sweat. In a day I would sit-up around 20 in the morning and 10-15 in the evening, depends on what I feel like, but not every day ... First for my feeling, when I take care of myself I feel happy and second, I have a little hope that my health is better when I take care of it. It might be physical or face appearance. It must have some results so I do it. (NN5, 2 July 2004)

However, not everyone thought exercise was good, for example NN8 commented:

No, I absolutely don't go exercise. I don't like the subject of Physical Education. I don't like it in any way, really don't like exercise. I never go for exercise. I don't know. I feel tired and uncomfortable. If we have never done it before, it will take time and gradually reach the outcomes, but for me I want to see the outcomes immediately now, so... Mostly, people will gradually do exercise step by step in long term. But I am hot-hearted. I want to see the outcomes now, so I'd better not exercise, no, I won't ... I would go for a walk for a while for muscle relaxing and then come to have a seat. I won't do anything long with physical activity. I feel tired and don't like to sweat. It feels dirty and sticky. I like my skin dry and comfortable, even after having shower I have to wipe my skin immediately. I'm afraid of dust coming to attach itself to my skin when it's wet. I don't like it sticky. (NN8, 6 July 2004)

There are few options for exercise taught in schools and colleges. Most exercise options are sports and the weather is very hot in Thailand. Diverse options for exercise have to be created to enable participants such as NN8 to find pleasure in exercise.

FOOD AND ENERGY CONCERNS: DO NOT FAST AND MAKE IT THE RIGHT WAY

The student nurse participants had particular ways of thinking about nutrition and energy expenditure. This knowledge helps them to control weight in the right way without fasting. Even though controlling weight and shape are big issues for women, they need to do it sensibly:

I do not go on a diet, but would care for it. From what I've learned it's hard to take care when you got fat. I would control it like this all the time by not eating so it won't increase because being fat is not good. (N5, 22 June 2004)

I would eat fruits at night....I didn't fast, but use it [energy] all and that's enough.... I've learnt about nutrition.... I can estimate. When learning about nutrition, we learned about calories and I had books in my room all the time. When I got worried about getting fat, I would read and read because I was taught that way and it becomes a habit. (N7, 5 August 2004)

Sometimes I would count my calories and compare it with my activities for that day. Then I would ask my friend to exercise. (N4, 21 June 2004)

.... I would have a food programme because many people won't eat rice even when it is their favourite and they will suffer. I used to try it but I couldn't make it.... The balance point of my needs is exercise. If I used a lot of energy then I will eat a lot and if I used less energy then I will eat less too ... But cheering class with younger classmen might last until 10 at night and some might not eat because of being afraid of being fat while I chose to eat because the night time is long and we need to supply energy. I will eat rice porridge or soft food. (N1, 17 June 2004)

Knowledge of nutrition and energy expenditure has given the student nurse participants extra concern about what they eat:

...when I felt heavier then I would be careful with foods. I would substitute sweet food with fruits and drink a lot of water before meal. It didn't help that much because I would eat double on the next meal. I wouldn't eat food that gives me a lot of energy and kept telling myself that I am overweight and taking care of myself. Sometimes I can't control myself but I would eat only a little. ... I won't tell myself not to eat because when I am very hungry then I would eat a lot. Eat only when my tummy says that it's hungry and not because of the craving. (N3, 27 July 2004)

No noodles and no clam or oyster. I think that they're seafood with high calories. I won't eat a lot of rice, just eat only things that eat with rice... I see from magazines, avoiding starch foods... But it's like a craving. I would eat as I please sometimes, but sometimes it's uncomfortable after a meal. I would start over by not touching and not eating food. I can't eat dessert that much. I would eat food or things that eat with rice but not eat rice. Normally, I would drink a lot of water but if I was home then I would eat rice. ... but not fasting. I would go to bed late and won't eat breakfast but drink milk instead. Lunch will serve rice and things to eat with rice but I will only eat things to eat with rice not to eat rice. And I won't finish the whole plate. Dinner would be fruit.... I would drink yogurt milk, or fruit juice, 100% fruit juice. (N4, 21 June 2004)

Lately I wouldn't eat rice and eat something else instead. I eat less rice and less of the food that goes with rice. (N8, 9 August 2004)

While taking note of the energy expended each day, the participants would find ways to substitute their routine exercise with various kinds of physical activities. In fact, if they engage in an active lifestyle and adjust their physical activities, formal exercise is not the only way to be healthy:

Like when I go shopping, I wouldn't ride but I would walk across the Nong Prajak Lake to Ngee Soon (a grocery store), pretty far, then walked back. I felt like it's close, but why did I say that it's far before? (N7, 5 August 2004)

Sometimes I get lazy with getting up in the morning while my friends sleep in. Come to think of it if I don't get slimmer, then I am still burning up calories. ... At least there's no harm while it's a good thing to do exercise. When I have time I would go jogging at Nong Prajak Park with my friend but I don't have time right now. Like after a meal, I would walk in my room or go out for a walk. Sometimes listening to a walkman I would do arm and leg lift. Felt nice when I did it but if I just eat and sleep then I would feel bloated. (N6, 22 June 2004)

Some days I finish school late in the evening, there is not enough time to go exercise at Nong Prajak Park and we don't have transportation to Nong Prajak, so I just go to the park occasionally with friends, anyway, I walk to the university every day and have to walk when changing building to study during day. That is also exercise. (NN7, 29 June 2004)

...pretending that I don't go to exercise and am home alone, and then I would sweep and mop the floor, the whole house. There're five rooms both upstairs and downstairs and I am home alone. (N3, 27 July 2004)

Some women thought that sleep deprivation would make them use more calories and get thin, however, knowledge would give them concern about having enough sleep:

... I wouldn't go to sleep late because I don't like it. From what I see when I go to sleep late and get up early, I would be thin but use a lot of energy. I tried a lot of ways that my friends suggested but I would get baggy eyes, wrinkled face, and not pretty. You probably won't work. I would sleep after school and when I didn't go out to exercise. I will get some sleep if I got to sleep late the night before. If I am very tired then I would eat first before going to bed. I would get some sleep to feel fresh, so I will have energy to work. (N3, 27 July 2004)

The point was that they explored alternatives and kept connecting with their own well-being, feeling, and life's functions. So, it was not a blind commitment. Sharps, Price-Sharps, and Hanson (2001) remark that the trend of following the Western fashion of valuing the slim body could initiate eating disorders such as anorexia or bulimia and health problems among Thai women. One participant warned that:

If it's about the matter of being thin, then there are two things. First, change the idea of the girl so she will know that having good health doesn't necessarily mean being thin. Second, change the attitude of a guy like when he will become your boyfriend then does he know what good health is all about or does he believe that thin girl is better if she can be fat or thin? (N1, 17 June 2004)

Although it has been proved that nutritional deficits are associated with suppressed immune responses, there also has been evidence found that some restriction of caloric intake can make organisms more resistant to disease, and that excessive consumption of food tends to be associated with immune suppression and the risk of cancer. Obesity is a risk factor for various immunological disorders. Evidently, the conclusion for nutritional consumption is that "more is not better with respect to immune function, and possibly even 'average' in an environment of abundance may hamper immune function." (Daruna, 2004, p. 218). Daruna also asserts that the combination of caloric restriction and body leanness can enhance resistance to disease and prolong life. Regarding eating and nutrition habits, therefore, the golden rule of the middle path and specific knowledge have to be conveyed to the population. In Thai, it is to live in balance or in a *pua o dee* manner.

INTERPERSONAL RELATIONS MAINTENANCE

An important task of wellness enactment was to maintain interpersonal relationships with others. To be mindful in relationships was also the function of the cultural self and the mindful self. Relatedness to others was part of the connected self:

... Being close to someone who got along with you felt good and happy. (N7, 5 August 2004)

To maintain meaningful relationships with others, they have to be mindful and patient:

Khan-ti means you've got to have patience. If I'm tense then I should be patient. If your friends are having fun then let them be, even if it's bothering you. Maybe just telling them that you're working. (N7, 5 August 2004)

However, this has to be balanced with self-reliance, as one participant pointed out:

I wanted to block the relationship so that I won't rely too much on another. ...I'm happy when I am by myself ... I want to be independent and not to rely on other. (N9, 30 July 2004)

Social engagement, social interaction, and social support could enhance immune function. Social engagement allied with verbal communication and the disclosure of traumatic events or negative experiences or a source of negative emotion appears to be associated with better health and improved autonomic nerve activity and immune function (Daruna, 2004). Being with others and being able to communicate what troubles the individual may counteract the negative effects of sustained distress on the body:

Like with books, I was angry because I can't negotiate with the teacher. ...I would murmur or complain to a friend, then I could be careless and let it go after I've thought about it. [complaining made your anger go away?] ...That's part of it. If I get to complain to my friend then it would be gone in a while. (N5, 22 June 2004)

Meaningful relationships are connected to spiritual aspects of the mind. Spiritual rituals are mostly the meaningful activities in meaningful relationships. For example, N13 said that:

I also like to go pay respect to the city pillar shrine ... There was a history in my mind. After I argued with a friend, we always went to pay respect to the city pillar shrine when we made up....It made me feel better but I can't explain. (N13, 21 June 2004)

The feeling of meaninglessness in relationships might occur, but sensible ways to manage loneliness were not to take risky activities:

It's hard, not to feel lonely, like when staying home alone would make me feel lonely and this and that, can't resist the feeling, but I don't know how not to feel lonely, have to meet friends. That helps some, but sometimes meeting with friends make the feeling even worse lonely, like no one understands my feeling, so I had better go to sleep. Sleeping is the least risk, no going out, no accident, no paying money, no doing anything, very comfortable, so better go sleeping. But it would feel lonely again when waking up, feel like airy empty, then release by calling friends and talking, but end up with sleeping again, the same. (NN9, 30 June 2004)

Curing the sense of meaninglessness in relations with others could be seen in the non-attachment stage of the sense of self – that is not to attach to one's feelings:

I don't know. When I feel bored I would find Dharma books to read. I mean when I feel terribly bored with life then I read them. It depends on my mood. Sometimes I read comics, novels, and Dharma...like that ... Feel bored with life is ... I don't know ... depends on mood ... dull ... sometimes I stay alone and all friends leave me alone then I would feel bored and dull then find some books to read. Mostly, it's because when I have no friends, just because most teenagers would care most about friends. (NN5, 2 July 2004)

I don't think that I should tell anyone if it's about other people or me. But if it's about majority then everyone can participate and I would be in the discussion. It was no big deal (about my matter), forget it, it's gone, and threw it away. (N5, 22 June 2004)

The skill of interpersonal relation maintenance is important for well-being. It is reviewed that dysfunctional interpersonal behaviours play an important role in the onset and maintenance of depression across the life-span. The underlying cause of the depression problems in adolescents has been identified as deficits in social self-evaluation which led to ineffective social behaviours (Marton, Kutcher, & Korenblum, 1993). The cultural self and non-attachment would help individuals keep balance in relationships.

SPIRITUAL GROWTH IN THAI WAYS

Spiritual growth has been conveyed as a path to wellness for Thai people; they would be taught that spiritual well-being has to begin from giving and generosity. Happiness from giving would eventually contribute to a peaceful mind that also kept moral behaviours. Thai culture provides a number of steps to meditate and purify the mind.

***Tam bun*: Giving is a path to psychological and spiritual well-being**

Giving or making merits (*tam bun*) is an important practice for psychological and spiritual well-being. Most of the participants reported good feeling by making merits and giving to others:

My farm is next to the temple so it gets absorb like living in the temple. It felt good to *tam bun* (make merit), offer food to monks, and to pour water for making merit. To give and expect nothing in return, just give. (N6, 22 June 2004)

In Thai culture as Buddhist-based culture the value of giving and generosity is a first step to purify the mind. This group of Thai college women also practised giving or *tam bun* at the temple for their mental and spiritual well-being; for example N13 narrated that:

At the temple, I would pay respect to an image of the Buddha, helped the housekeeper in the temple, and helped carry the tray of food to give to the monks ... Now and then since I was a child. My family doesn't like to go that much ... It felt good ... Started when I was in high school ... At my own will ... go to the temple near my home ... Just get up and go ... I saw monks walk past my home since I was a child. I woke up and saw monks but didn't feel anything. Growing up I would offer foods to monks now and then. Once a year then more often ... It made you happy that I can't explain. First, I got to wake up early along with the fresh air because I have to prepare foods for monks in the morning. It's like seeing something fresh early in the morning. I used to see my grandparents went to temple and thinking that I have to go to temple when I get old or what. I have to go when I get old as my grandparents for sure because my parents at their age are not going. I saw my grandfather went so I should try too. I went so I can pay respect to my grandmother too because she's passed away ... It was nice. After paying the respect and listen to the sermon, then I would walk around the temple because it's beautiful and quiet too. I can go by myself ... It's a good thing. First is putting your free time to good use and feeling better too. (N13, 21 June 2004)

Giving also triggers good feelings with one's self:

I like to go to temple by myself. I am not that serious and not practising the five Buddhist precepts. I am happy when I go and I would offer foods to monks, feed fishes ... For feeding the fishes, I haven't done it before and never thought about it. My boyfriend took me and it felt good because they (the fishes) looked happy while eating ... It's like a relief. Throwing down the bread is like throwing bad thing away ... I don't think much about the effect or merit. I thought that it should be delicious and thank myself for feeding it. I don't know, it's funny because I think that they should be happy to eat bread once in their life ... It's like a relief. Sometimes it's nice to throw away the worries that you have. I can't explain, just throw it away. (N13, 21 June 2004)

Cultural traditions have focused giving on the Buddhist monks and the temples because of the belief of accumulating merits for the next life and giving food for their dead ancestors. These practices maintain the monastery and monks as a strong focus for social morality. This is a good for society, but merits could be made in a

range of ways within society. This may be an idea that should be discussed and conveyed.

To keep in *sila* is self-narrative for basic conscience and well-being

All young Thai people are taught to keep in *sila* or the Five Precepts from their primary school years. This is to make their mind peaceful before it could be kept in *samadhi* or concentration. The Five Precepts (for details see Chapter 6) become a self-narrative for basic conscience. When one broke the precepts she would lose her peaceful mind and concentration as NN6 described:

...But I've been taught that we have to keep in *sila*, but still tell a lie for kidding friends and that might not make me feel wrong, except if I tell a lie to my parents then I feel that I'm seriously wrong and keep thinking about it, knowing that I can lie to others but I still can't lie to myself, so that will make me keep thinking about it. If there are bad consequences from my lying, I will keep thinking whether it will be bad and feel that I'm wrong, I should not do that, and tell myself do not do it again, one time is enough. (NN6, 29 June 2004)

So, basic conscience and morality are linked to mental and spiritual well-being. Practising the Five Precepts could be seen as contributing to wellness for individuals and the wider society.

***Tam samadhi*: To meditate for concentration and peaceful mind**

The word *Samadhi*, literally means 'put together.' It implies putting together your mind with your body and that provides a simple way to wellness. Some participants said that:

It depends on the opportunity. I did it almost every night at that time before going to sleep and I would sleep well. Sometimes I did it before reading textbook for about 15 minutes to calm my mind so I will understand what I am going to read. Before reading I would think of something and control and be mindful of my in-out breathing by saying "*Put Toh*". Before going to sleep is the same thing and to concentrate on the words and nothing else, then think of what I should do next. To read a book then just concentrates on just that. After *Tam Samadhi* (meditation), I was peaceful and able to think more in order. (NN1, 19 June 2004)

There are two basic types of meditation known generally in Thailand. *Samadhi*, or concentration meditation, involves mental exercises to focus on one-pointedness of mind. *Vipassanā*, or insight meditation, is a rigorous practice to cultivate mindfulness to insight. The practice of insight meditation is well depicted by Lax (1996, p. 204) as follows:

Insight meditation is the ongoing focus of attention on whatever arises in the senses and the mind, accompanied by a notion of the object of mindfulness. The meditator begins with attention to the breath, noting the in and out passage of air or the rising and falling of the abdomen. In this manner, the meditator can begin to experience the ever-changing nature of impermanence and see things as they really are. This seeing is a deconstructive venture.

Generally, women practise only the simple concentration meditation because of their constraint with multiple roles in the society. The principles and benefits of meditation were simple, as N1 said "... we can concentrate on one thing when we meditate." (N1, 17 June 2004).

They might report that they did not have enough time to practise formal meditation:

At night, I would. I used to *tam samadhi* late at night when I was in high school but not that much here. (N1, 17 June 2004)

... There are a lot of things. Sometimes I couldn't read a textbook when I got home because I am so tired and I have to practise sports. So I just wanted to do it ... Because coming up the second year there is lots of work to do with younger classmen. Less personal time because of the activities. But not more than 15 minutes for meditation is enough. (NN1, 19 June 2004)

Once meditation is cultivated into the cultural self's habit, it will create continuous wellness moments. These spiritual well-being practices are vital. As Pasadika (2002, p. 155) asserts, "it is, moreover, good news for the patient that he or she can get rid of suffering through the Buddha's doctrine covering ethics (*sila*), cultivation of the mind (*samadhi*), and wisdom (*panna*)." These healthy practices for spiritual well-being are influenced by Buddhism and their cultural self. The benefits of these spiritual growth practices are also at a physical level. Meditation can be seen as wakeful relaxation which has been thought to have health benefits because it counteracts effects of stress and increases immune function. Furthermore, the induction of relaxation is associated with decrease in negative affect and sympathetic nervous system activity (Daruna, 2004; Tacon, McComb, Caldrea, & Randolph, 2003). Positive acting, thinking, morality, and wellness activities can be seen as psychological survival strategies.

The student nurse participants showed high health motivation, health-comprehension, and health competency, but it is unclear whether this difference arises from their family background or because of their collective knowledge and attitude about healthy lifestyles learnt in the nursing programme, or a mixture of both influences. Muecke and Srisuphan (1990) reported that among 16 Thai nurses

with doctoral degrees, their parents guided the choice of nursing career for them as a female career with ideals of social service and family obligations. The nurse informants attributed their career success to hard work, family support, responsibility and commitment, self-sacrifice for the common good, and a calm manner. These findings are congruent with the world view of the student nurse participants in this research who were also influenced by the values of independence, higher education, and high salary. However, most participants kept valuing gratitude to parents as a reason for their positive efforts given to life.

CONCLUSION

The analysis in this chapter highlights factors that support the commitment of young Thai college women to engaging in health-related behaviours. The participants may engage in healthy behaviours with different kinds of health motivation, and life goals. The six components of the Mindful Self and the ongoing surrounding influences impact on their wellness enactment as well. Even though their cultural self may be similar, the level of awareness and strength in the other components of their sense of self may be different, and then entail different levels of health-comprehension and health competency.

Health motivation is influenced by the cultural context and life's transitions. While there are various kinds of health motivation expressed by the participants, most of the student nurse participants were more likely to show health-comprehension and health competency in their self-narratives. Health-comprehension includes the properties of the meaning given to health, coherent life goals, health manageability, and active cognitive monitoring to maintain health. Health competency begins from believing in self capacity, routine exercise, food and energy concern, relationship maintenance, and spiritual practices. Strong motivation and strong sense of mindful self are shown explicitly in some participants who engage in, and maintain, healthy behaviours.

Health-promoting behaviours need a high level of commitment. The merits of knowing one's self seem to be a good starting point for a fully grown individual to enter the society. Taking into account the effects of both outer and inner constructed narrative that form the sense of things as they are given meaning, the implications have to go beyond individuals' intra-psyche and focus also on the

context. Moral conscience, such as gratitude and a sense of connectedness, which is also socially constructed is obviously linked to well-being. While the ongoing influences from the mass media and the cultural context are considered, to be able to be aware of the socially constructed narratives that impact on life and behaviours is crucial. Establishing awareness and critical thinking in education may be a point for implications. In the last chapter, the three main themes presented from Chapter 6-8 are conceptualised in the Model of the Mindful Self. The developing of the sense of Mindful Self is discussed and the essential points for implications are summarised.

CHAPTER 9

MODEL CONCEPTUALISATION; IMPLICATIONS, AND RECOMMENDATIONS OF THE RESEARCH

The purpose of this study was to investigate the concepts of positive sense of self, and the influences of Thai culture on the motivation of young college women to take care of themselves and to engage in health-promoting lifestyle behaviours. Specifically, the aims of the research were: 1) to gain a more theoretical understanding of the relationship between sense of coherence (SOC), identity status (identity achievement, identity foreclosure, identity moratorium, and identity diffusion) and health-promoting lifestyle behaviours (HPLBs) among Thai college women in Northeastern Thailand; and 2) to generate a dense conceptual explanation of the interplay between identity formation and health-promoting lifestyle behaviours among Thai college women in Northeastern Thailand.

The first aim was achieved in Study A that found that achieving a sense of identity in both the ideological and interpersonal domains resulted in a significant contribution to the prediction of HPLP II. Sense of coherence could predict 12 % of the variances in HPLBs, and when SOC and identity achievement and identity moratorium were combined, the overall prediction increased to 27% of the variances in HPLBs. The second aim was achieved in Study B. The interplay between identity formation and HPLBs has been outlined in Chapter 6-8 and summarised in a model of the Mindful Self outlined in Figure 9.1. Although the model proposed reflects mostly results from Study B, the contribution that achieving sense of identity has to HPLBs is implicitly expressed in the model. That is, results from Study A have guided the course of Study B, achieving a sense of identity is perceived as a step of healthy behaviour development.

The following sections of this chapter provide the conceptualisation of the model of the Mindful Self, an interpretation of the research findings from Study A and Study B, and a discussion of them in relation to preceding studies. Implications for nursing regarding practice and education are presented. Limitations of the study and recommendations for future research are also described.

The Model of the Mindful Self

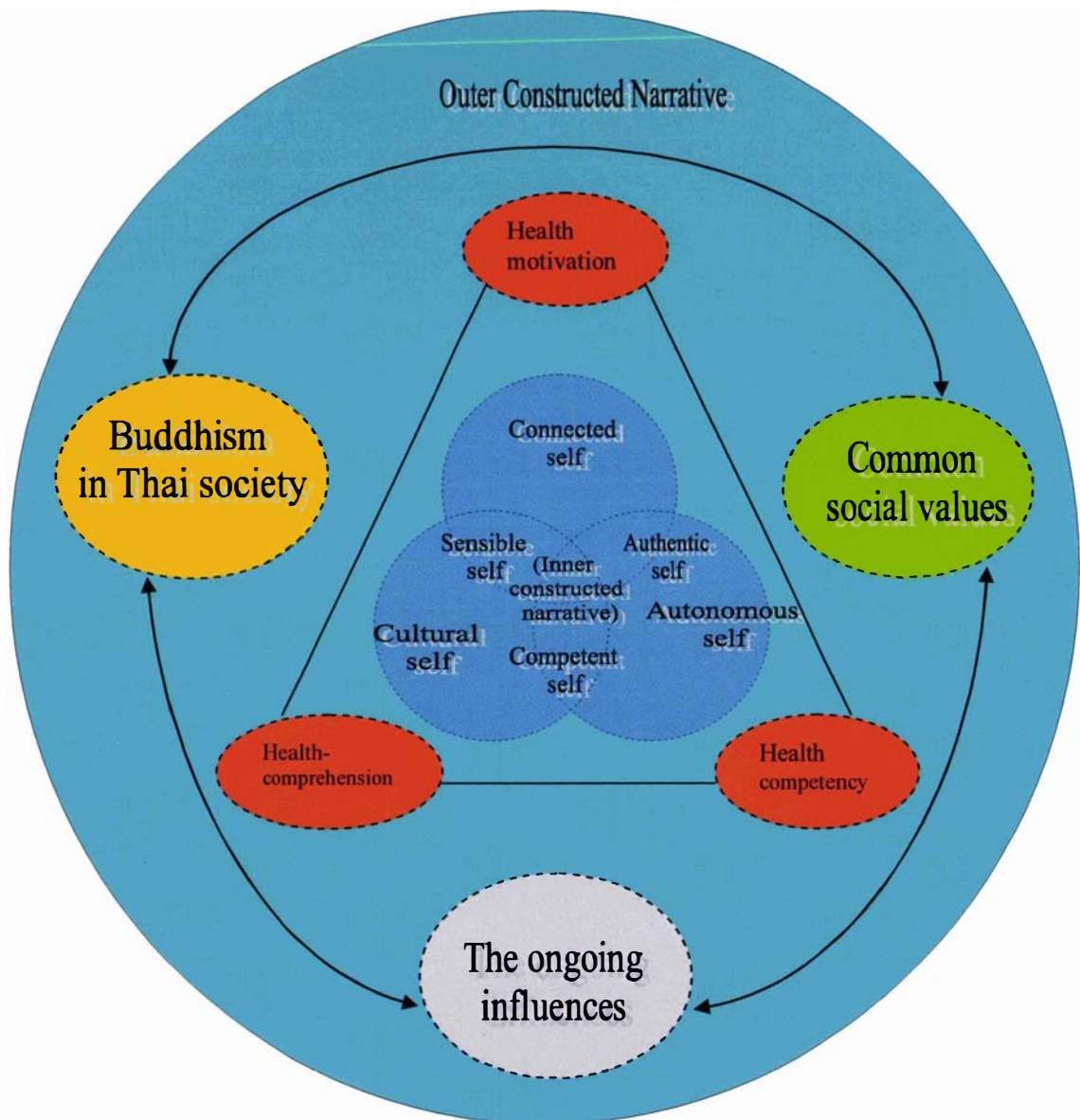


Figure 9.1 The Model of the Mindful Self in a Thai Context

THE MODEL OF THE MINDFUL SELF

The model of the Mindful Self illustrates the sense of self of Thai college women developed within a cultural context that includes Buddhist beliefs and practices, common social values, and ongoing influences. These factors make up the outer constructed narratives. The inner constructed narratives of individuals are formed amidst social interactions. The likelihood of commitment to, or enactment of, health-related behaviours is impacted by participants' health motivation, health-comprehension, and health competency that in turn are influenced by the inner and outer constructed narratives.

The nature of the process of self-formation in the context can be seen as the self constructed in narrative. Constructed narratives in the context penetrate through the broken line as a permeable membrane bounding each area displayed in the model to form the inner narrative of the self. It is a two-way interaction, and cumulative and dynamic in nature. That is, the sense of self is constructed through the inner and the outer constructed narratives.

The model of the Mindful Self serves as the explanation of sense of self in the Thai context. Giddens (1976, quoted in Crotty, 1998, p. 56) suggests that social scientists have to engage in the "double hermeneutic" task of "entering and grasping the frames of meaning involved in the production of social life by lay actors" as well as the subsequent task of "reconstituting these within the new frames of meaning involved in technical conceptual schemes." The task of the model conceptualised is trying to do the latter.

Mindful self in this model is overlapped between Buddhist and constructionist positions. Hirst (2003) asserts that "Buddhists like constructionists repeatedly question, but the assumptions and purpose of being mindful in constructionist discourse are different." (p. 362). Buddhists are mindful to let go all phenomena, while constructionists are mindful to cognitively re-frame and improve to attain a better purchase on reality for the person and the future. Constructionist thinking which is actively engaged in the present, noticing new things and sensitive to context (Langer, 2000) can be described as a form of attachment in the Buddhist perspective (Hirst, 2003). However, I would argue that it can be described as a skill of a well-practiced mind when dealing with worldly phenomena and not necessarily a form of attachment.

The Mindful Self, as posited in this study, comprises a number of components of self. The common cultural background and the surrounding influences have created a sense of cultural self, a sense of connectedness to self and others, and the autonomous self which is promoted by parenting styles and by education. Increasing age, knowledge and self-reflection, and interaction with others facilitate the development of the authentic self, the sensible self, and the competent self, which function in order to encourage young Thai women to engage in health-promoting lifestyle behaviours. In particular, the sensible self functions for manageability towards wellness. The sensible self selects healthy values and healthy reasons for well-being. The Mindful Self functions as a self-watcher being aware of the developing self, and keeping the self engaged in useful activities for self and others. The sense of Mindful Self may be congruent with the term “a fully grown being” proposed by Jourard (1974, p. 3).

The model of the Mindful Self proposed in this thesis may, or may not, fit all Thai college women. Their sense of self will depend upon their worldview and experiences from social interactions. However, the model of the mindful self has originated from the data generated from in-depth interviews with Thai college women in this study; it reflects commonalities in their cumulative realities.

INTERPRETATION OF THE RESEARCH FINDINGS

In this research, Study A shows that sense of coherence, identity achievement, interpersonal relations, and spiritual growth are a cycle of determinants for young Thai women’s HPLBs. The six dimensions within behaviour-specific cognitions and affect present in the HPLP II measure are considered to be promoteable by nursing action. Thus, they are critical for intervention. Indirectly, in this research I have explored a positive way to promote healthy behaviours via promoting a positive sense of self.

Spiritual growth for Thai women may mean giving or generosity, doing merits for others, gratitude to parents and others, and retaining moral values. These components may involve other-oriented and future-oriented acts. When examining spiritual growth items in the HPLP II, the lack of other-oriented acts can be observed. This observation reminds researchers to be aware that HPLBs may be

different across cultures, and that the measurement tool may require adaptation of items in particular dimensions.

The results from Study A show that Thai college women engage in HPLBs at similar levels compared to normative data across cultures. They also have a similar level of SOC compared to Western college students. However, the interpretive approach in Study B shows that there is a specific culture which forms their distinct sense of self and motivation. These specific sense of self and health motivation in the culture are knowledge useful for designing health promotion messages for this population.

According to the themes that emerged from this combined study, gratitude emotion, a sense of non-attachment, and the collectivistic sense conveyed to people in Thai culture can be viewed as important values for maintaining wellness across generations and the population in the society. An individual's behaviours to promote and enhance health are contingent on valuing health, and prioritising and acting on health-promoting behaviours congruent with personal values. There are resources from the culture to be examined as strengths for contributing to people's well-being such as gratitude, a strong sense of connectedness to others, and many useful practices in Buddhism and morality that promote well-being for self and the society at large. This could also be seen as a self-coherence in a collectivistic culture, unlike Antonovsky's SOC which is derived from European individualistic culture. So, this could be seen as a distinction between the individualistic SOC and the collectivistic SOC. The cultural background of these kinds of thoughts, a strong sense of connectedness to others might stem from the gratitude emotion conveyed from the Buddhist-based culture. This can be an explanation for the comprehensibility, and meaningfulness in Thai culture and definitely determines the way they manage their lives. Achieving both self-identity and a non-self state would help adolescent women to resist the overflow of unhealthy social values, such as all extreme beliefs in karma, slimming, patriarchalism, and materialism, which might lead them to either a lack of control state, or an unhealthy slimming control state.

Bowman (1997) suggests that different ethnic backgrounds and differences in urban and rural environment determine the different pathways to SOC. For example, rural Native American students were more likely to stress moral and religious values, and urban Anglo-American students appeared to emphasise

achievement and independence, while both groups had the same level of SOC (Bowman, 1997). This explanation was useful to understand the participants in this study who were in transition to urbanisation. Most were from a rural family background and came to continue their study in colleges in urban areas. While they appeared to stress moral and religious values, they were also impacted by an achievement-focused culture and became more independent and autonomous in city life. It has been found that people living in a transitional phase between a traditional lifestyle and the modernized living style, had the lowest SOC (Cederblad et al., 2003). If this is the case, more research on SOC and interventions to develop SOC to be a protective factor increasing stress resistance are crucial in the transitional period in Thai society.

In this research, identity achievement predicts 15% of the variance in HPLBs. Identity is a cumulative product of the meanings attached to everyday behaviours. As the primary psychosocial task of adolescence, identity formation is the important point of entry to establish the foundation for plotting a consistent and feasible life course.

The results of Study A show that interpersonal relations are associated with identity achievement, and that interpersonal identity achievement encourages college women to engage in HPLBs. Interpersonal relations as the paths to achieving a sense of self through social interactions are also shown in the qualitative data in Study B. There is evidence that women's sense of self and commitment is formed by close attachment with parents or in close relationships (Schultheiss & Blustein, 1994). Strategies to promote relationships in families are crucial.

An important point asserted by Pastorino (1997) is that identity formation is not only a 'developmental process' but it is also an 'environmental process' where individuals, choices and decision-making are influenced by the social contexts. As Erikson (1968, p. 22) asserted: "we deal with a process located in the core of the individual and yet also in the core of his communal culture." When taking Buddhist-based culture in the Thai context into account, a healthy sense of self operates at multiple levels. Those designing health promotion messages for individuals' wellness should attend to achieving sense of self and sense of non-self. Because health has less meaning in itself in a collectivistic culture, health motivation may be initiated by linking from self to loved ones and society.

TO PROMOTE 'HEALTHY REASONS' AND 'HEALTHY VALUES'

There are various kinds of underlying factors influenced by both inner and outer narratives that promote healthy behaviours. Negative and positive motivations are two sides of the same coin. To promote healthy values in order to promote commitment to healthy behaviours is to be aware of the negative factors and to reconstruct the positive ones.

Coherent life goals linked to healthy behaviours

From the results of this research, life goals that recognise health as the basis of well-being encourage Thai college women to commit to healthy behaviours. Health-promoting lifestyle behaviours are the base of any self-concordant goal attainment. The common shared goal in this group of young women is 'to look good.' They are very much concerned about their appearance. Undeniably, to look good is evidence of a healthy person. A strong motivation for wanting to look good is conveyed from many sources of significant others, the media, and some concern from their expected professional area of study. There was also evidence in this research that young Thai women were striving for healthy reasons to achieve well-being and to be a refuge for their family in the future, but also were influenced by external pressure like fashion and the value of being slim and looking good, and materialism. The problem is if they allow the narratives of consumerism and materialism to lead their goals, or if they pursue goals with superficial extrinsic values; they might face the endless feeling of not being thin enough, or not looking good enough. Teaching young college women to be aware with the notions of fashion and social approval of looking good is crucial.

It is argued that intrinsic goal pursuits give positive contributions to well-being by promoting satisfaction of the basic psychological needs, so they promote individuals' natural growth tendencies. Goal pursuits aimed at external indicators of worth and associated with excessive social comparisons, and thus leading to unstable self-esteem have been found to be negatively associated with well-being (Vansteenkiste, Simons, Lens, Sheldon, & Deci, 2004). However, it is not bad for them to hold the extrinsic values of social approval, status, and material gain to a degree that serves their self-confidence to be working women as long as they hold their 'healthy reasons' and 'healthy values' of health. As long as they can operate the physical and psychological survival strategies, in this sense, the extrinsic values are not the ultimate goals themselves but rather the intermediate outcomes between good health and their healthy values of gratitude which entail their organismic

needs. That is, organismic personality integration can be operationalised in two different ways: to strive for 'healthy reasons,' and for 'healthy values,' as suggested by Sheldon and Kasser (2001, p. 492).

The common goals of the women in this study are intimacy, competency at work, material gain, collective merits and good deeds, grateful motive, or doing good for society. These are the collectivistic determinants which need to be reinforced in Thai society.

Tam Dee or Tam Bun

The evidence with respect to health promotion on how to utilise the local community health-creating resources in Thai culture has given an idea to utilise the perspective of making merits (*bun*) with HPLBs. Accumulating *bun* by virtue of the HPLBs could be a good point to motivate Thai people to engage in HPLBs. Another resource for healthy behaviours commitment could be from the collectivistic motive of Thai culture composed of a grateful attitude towards parents, benefactors, and people in the society, a sense of connectedness to others and a mindful sense of avoiding doing harm to others and society.

Making merits should not be confined to merely religious practices. These are the determinants needed to be introduced. For example, being environmentally mindful, such as separating dry recyclable rubbish from wet and dirty rubbish could be introduced as accumulating *bun*. All health enhancement activities should be promoted as the ways of accumulating *bun*. For Thai college women, to be a role model of HPLBs should be introduced as to *tam dee* as well. These motives, if brought in to fine-tune details of practice, could yield healthy narratives in Thai society. The notion of *tam dee*, or to do good deeds is to do future-oriented and other-directed acts. However, the future is the future of every here and now.

Karma, negative thinking, and the lack of control

Thai culture values neutral thoughts, and in most aspects these are slightly deviated to negative expectations most of the time. Thai people are embedded with a death-oriented and suffering-oriented view of life itself by Buddhism. Positive thinking is something which has to be taught, pointed out and cultivated. The perspective of seeing everything in a just-so-ness manner usually leads them to the thought that nothing is going to be better than ever. To let go the just-so-ness day by day as a consequence of the old *karma*, and accumulate merits for the next life, leave

today's life here and now forgotten. This is a drawback of negative thinking that keeps lives in taken-for-granted boundaries. These are a mind-set, so the determinants need to be changed.

Another drawback of the extreme karma belief in Theravāda Buddhism culture is that it sabotages the sense of connectedness of all things. The notion that an individual possesses his/her own karma and its consequences, creates a kind of extreme individualism and sabotages the collectivistic sensitivity in some ways. To create a healthy notion about karma, it is important to cultivate awareness of avoiding extreme beliefs. The perspective of neutrality or equanimity is to visualise that there is the simple and profound awareness that everything, including each thought, word, act – and every being – is interdependent and mutually conditioned in the vast web of life. This is a prominent perspective in Mahāyāna Buddhism which should be taken into consideration (Macy, 1984). Macy also asserts that there is not one single cause that has to be sought and attacked because everything is so interrelated, and anything which is created is equally valid for each endeavour toward human well-being.

To combine social constructionism with the notion of karma in Buddhism, I conceive that many things have gone astray. Buddhism teaches that one owns one's karma, and one has to be self-reliant in order to conduct one's own life and cultivate one's own mind to reach the enlightenment state. This may be correct, but there is the fact that one is within the environment of others, ones are 'significant others' for many others, and we live in an interrelatedness of all things, so karma could be interrelatedly woven. This is associated with the lens of social constructionism. Humans have constructed everything *together*. There is a hope placed on each individual who is a functional unit of the society, and the positive reality we can create continuously in each moment. There are two ways to convey these two notions into practice of everyday life. On one hand, we can see karma as the already-done-reality and live with it. This is a backward looking (look-back) notion. Or we can see the construction of reality and karma as a beginning point in every moment by moment, on the other hand, and this is a look-forward or look-to-the-future notion. I think these two notions would yield different drives for practice, but could they be integrated or combined?

Even though the belief in karma is common in Thai culture, and many people would believe that all current difficulties and diseases have resulted from their old

karma, the educated college women in this study constructed more healthy ideas regarding karma in their lives, a future-oriented karma.

Women empowerment

The notion that has created a belief such that women are as the elephant's hind leg is embedded in Thai society. For example, even though women were found to have better health-promoting behaviours at the personal level and to have more influences and involvement in health on the family level compared to men, they had almost no role involving community health activities and projects (Thongkrajai, Srisanthisook, Techamanee, & Phunphruk, 2004). To encourage women's involvement in the health promotion process beyond the personal and family level is to reconstruct the way women see themselves, and the way society sees women to make them recognise that women are vital contributors of social development. For example, the notion that 'women are the elephants' hind legs' which expresses the view that women are not important could be reframed as 'the elephant cannot walk without hind legs' which means that women are vital contributors to social development.

The grateful motive

The gratitude emotion affects well-being from individual to social levels, and can be used as a strong motive for health-promoting lifestyle intervention in Thai society. Emmons and McCullough (2003) note that gratitude encourages a positive cycle of reciprocal kindness among people, since the act of gratitude inspires another and creates positive social effects. Motivating grateful emotion can be seen as human strengths and virtues that promote reciprocal kindness in society. McCullough, Emmons, and Tsang (2002) also report that grateful people are less materialistic and have less anxiety about status or the accumulation of possessions. This could be a buffer to the effect of striving for superficial extrinsic values that Sheldon and Kasser (2001) find to sabotage well-being. Grateful people also experience fewer physical and psychological symptoms, take better care of themselves, and engage in health-promoting behaviours like regular exercise, a healthy diet, and regular physical examinations. More, grateful emotion is a factor helping people cope with daily problems and stress (McCullough, Emmons, & Tsang, 2002; Emmons & McCullough, 2003).

Gratitude can be seen as a coping response, a personality trait, an emotion, an attitude, a moral virtue, or a habit (Emmons & McCullough, 2003). Gratitude as an

emotion is an attribution-dependent state consequent of a two-step cognitive process: “(a) recognising that one has obtained a positive outcome, and (b) recognising that there is an external source for this positive outcome.” (Emmons & McCullough, 2003, p. 378). *Moral behaviour* is defined as behaviour that is provoked out of concern for another person. Functions of gratitude as a morality are summarized:

Gratitude has three functions that can be conceptualized as morally relevant: (a) a moral barometer function (i.e., it is a response to the perception that one has been the beneficiary of another person’s moral actions); (b) a moral motive function (i.e., it motivates the grateful person to behave prosocially toward the benefactor and other people); and (c) a moral reinforcer function (i.e., when expressed, it encourages benefactors to behave morally in the future).

(McCullough, Emmons, Kilpatrick, & Larson, 2001, p. 249)

Gratitude typically results from, and stimulates, moral behaviour. Moral behaviour is now connected to health-promoting lifestyle behaviours.

MORALITY IN SOCIETY AS THE GLOBAL CULTURE

I did not realise that Buddhism was so closely linked to the health of Thai college women before conducting this research, and have ended up with a finding that Buddhism is healthy. The Buddhist’s ethical codes, for example the Eightfold Paths and the Five Precepts for ethical behaviours offer universal wellness for a harmless life. The precepts provide a clear moral foundation which supports how we interact with others and our spiritual progress (Flanagan, 2006). For large-scale health promotion, morality is the backbone of well-being.

The evolution of thought concerning health has evolved from health maintenance in the form of basic survival towards various levels of complexity in social structures, since humans are social organisms. As humans have lived in communities and developed the ability to cultivate the land and exploit localised resources, moral and ethical considerations began to be added to the list of causes of sickness. People are socially differentiated and the causes of sickness have been focused on religion, morality and cosmology. The growing awareness that a sense of connection of the individual to family, group, and setting contributes to the healthy state has been noted (Daruna, 2004).

The significance of cultural beliefs and value systems in determining health has long been recognised. However, human cultures are diverse and controversial in many cases. It is difficult to decide what is good for whose reason in the globally diverse culture. Kikuchi proposes: “The more people possess the moral virtues and prudence, the more they are likely to make morally sound choices and decisions, choices and decisions made in light of right desire (i.e., that which is good for humankind) and extenuating circumstances.” (Kikuchi, 2005, p. 305).

In this thesis, I have searched for knowledge for health promotion and ended up with the knowledge of the moral virtues which in fact back up the healthy behaviours of the young women in the Thai context. To say again that morality is the global and universal culture for human life and well-being, this thesis therefore has added up to the knowledge that moral virtues are natural human desires. By recognising the commonality of the common moral obligation and the natural rights or moral rights inherent in common human nature, nurses will be able to develop a global perspective to serve the needs of people as human beings, and not merely as cultural beings (Kikuchi, 2005).

Health-promoting behaviours should be added as a moral quality. Lennick and Kiel (2005) propose the term ‘moral intelligence’ which includes various aspects of morality; I would argue that health responsibility and behaviours are also important aspects of morality because of the connectedness of all things. One’s responsibility affects others. Common values such as commitment to something greater than one’s self and caring for others with responsibility and respect are central doctrines in the major world religions (Lennick & Kiel, 2005). For example, a famous practice called Naikan was developed in Japan by Yoshimoto Ishin (Krech, 2004). The word Naikan means ‘inside looking’ or ‘inside observation.’ It is a method of self-reflection based on three questions: (1) What have I received from others?; (2) What have I given to others?; and (3) What troubles and difficulties have I caused others? (Krech, 2003, p. 5). This self-reflection uses one’s relationships with others as the mirror in which one can see one’s self. Naikan uses gratitude as well as guilt at its core. However, it is a beneficial guilt and can be very restorative as well (Emmons, 2004). Therefore, morality is the crucial base of healthy behaviours and healthy behaviours are themselves morality.

Health-promoting activities have the moral meanings. The pursuit of virtue and moral life is essentially an aspect of the pursuit of wellness (Conrad, 1994).

Crossley (2002) asserts that health is still an intrinsically moral phenomenon. Therefore, health promotion discourse is best conceived in terms of the moral self-management of lifestyle and behaviour. This is original contribution to knowledge both at the international level and in Thailand that shows the relationships between sense of coherence, exploration and commitment aspects of identity achievement and HPLBs, and also the crucial issue of morality that has never been linked to HPLBs before. Even the World Health Organization has never focused on morality when making policy on health promotion. It is the time to ask whether empowerment policy for health promotion contains aspects of moralizing people's habits and lifestyle choices, and what the aspects of morality actually are.

UNINTENDED IMPACTS OF THE RESEARCH

Inquiry and change are simultaneous. David Cooperrider calls it "the seeds of change" when he explains that "the things people think and talk about, the things people discover and learn, and the things that inform dialogue and inspire images of the future – are implicit in the very first questions we ask." (Cooperrider & Whitney, 2000, p. 18). I experienced the truthfulness of this notion after I had used the three instruments in Study A with a number of participants. When we met with each other in College and I greeted them and asked 'how are you?' many participants told me that their life perspective had been changed after being questioned by the three instruments. They said that they had never thought of such issues as those presented in the instruments before. The instruments made them think about many aspects of their lives, and consequently gave some new directions to their thinking. For example, issues about ideological identity, interpersonal identity, aspects of SOC and HPLBs, had been developed in their mind by being questioned. The eight domains in the EOM-EIS (occupation, politics, religion, and philosophical lifestyle, friendship, dating, sex roles, and recreation) are the constructs in human society that are useful tools for adolescents to examine choices, values, and beliefs. Equally important, it would be useful for health promotion if health-related issues were also questioned in terms of exploration and commitment. Adolescents would be triggered to think about and explore health-related issues by being questioned. Data in Study B were information rich also because of the triggers provided by the instruments in Study A to the tool-approached participants. The research impacted on participants' and my perspectives as well.

WELLNESS IMPLICATIONS

The merits of exercise at the physical level are quite well evidenced and shown in Chapter 8. That is why healthcare professionals should promote behaviours such as social engagement, exercise and sound sleep, spiritual practices in religions, energy concern, meditation, and humanistic values. However, multiple realities have to be dealt with. At the level of psychoneuroimmunology, the merits of exercise are real. The narratives from most participants who actually engage in routine exercise is proof of the merits. However, there is another notion here that is also true for some – that is exercise is tiring, sticky, sweaty, and grubby. To deal with people who hold this truth, other kinds of exercise have to be created and taught for options. Instead of limiting out-door sports and vigorous exercises for the physical education subject in school and colleges, isometric exercise, or Pilates and yoga, or Swiss ball exercise, or dancing, or swimming, or water exercises, as non-impact exercises could be introduced. Ideas of exercises have to be created and openly facilitated for women.

For nurses and health professionals to promote well-being for individuals, it is important to understand the responsiveness of these bodily systems evidencing well-being at the physiological level. The implications from these issues are, first, nurses should realise and acknowledge the feeling of clients conveyed to us, because they are the ones who are connected with their own physiological responses. Second, while the programme of promoting physical exercise is the emphasised strategy addressed in the health promotion policy in Thailand, we need to initiate self-knowledge by asking and teaching the clients to be sensitive with their true feeling by responding to the various activities in daily life, such as the awareness that exercise can create a cycle of well-being. To teach women to know their bodily responses to well-being is a kind of empowerment. This should eliminate the notion that doctors and nurses know best, both from people and from the professionals themselves. Nurses should recognize and evaluate what are the imbalance issues that send clients out of their paths to well-being, what are their health-creating resources and how to help them increase their ability to use their internal and external resources to obtain wellness. In this sense, to know the self, therefore, is not only to achieve ideological and interpersonal identity, but also to achieve the self-sensitivity of knowing which healthy values give life force and internal well-being. Realising this knowledge, wellness activities and options would be variously created.

Mindfulness in Buddhism is linked to the belief that individuals with awareness do have a choice in the phenomena they attend to and how they behave (Hirst, 2003, p. 360). Development of the Mindful Self could be created in education. Activities can be created to promote and develop each component of the Mindful Self listed in Figure 7.1. Knowledge of the human body and nutrition contributes to the differentiation of wellness practice among participants. Healthy life goals, essential health knowledge, life skills, and salutogenic characteristic, or resilience, could be created in college years.

A reflective process of learning, which creates critical thinking in order to develop students both intellectually and morally, is important (Daly, 1998). Critical thinking and self-awareness could be cultivated from the Buddhist-based culture and in colleges' curricula. Activities for self-development should be planned for each target goal. Activities could be writing a diary journal, self and group reflection, movie study, role play, meditation, gratitude promotion festival, nutrition week, analysis of current social narratives, moral discussion, and so on.

Strategies have to be planned appropriately year round for each generation of the institutes. The point is that school and family have to be connected. As suggested by Tongsong and Taitae (2003), health promotion activities in schools could be conducted by enhancing students' Perceived Benefits to action and by reducing Perceived Barriers to action. Teachers, parents, and colleges were also suggested to be the crucial points of entry for any programmes initiated to create mutual understanding about health-promoting behaviours.

Health education courses have been proved to have an impact on improving students' wellness scores. A cognitive-based instructional approach proved less effective than an activity-based instructional approach integrated with participation in physical activity and a variety of learning experiences to enhance level of wellness (McClanahan, 1993). Nonetheless, participation in discussion in wellness classes plays an important role. To enhance students' wellness score, activity-based courses such as providing various kinds of exercise were found to be less effective than wellness courses that provided students with the opportunity to talk about their personal goals and health issues (Welle & Kittleson, 1994). All in all, to think of wellness is to emphasise balance as a key concept. Balance must exist for ultimate health and wellness as a multifaceted phenomenon. Welle and Kittleson (1994, p.12) demonstrated that wellness educators need to be "a little cautious in assuming

that physical activity automatically equates with improving one's lifestyle or wellness ... optimal wellness includes the concept of balance, and that an overemphasis on one aspect of health will be to the detriment of overall wellness."

Positive sense of self may contribute to people's well-being in psychosocial aspects in HPLBs such as spiritual growth, stress management, and interpersonal relations which are contributed by positive cultural resources. However, half of the HPLBs like health responsibility, nutrition practice, and routine exercise or physical activity, need more knowledge, commitment and investment. Unique barriers such as resources, skills, and facilities were found to contribute to poor eating habits among college students (Felton, Parsons, Misener, & Oldaker, 1997). Nutrition and energy management are important knowledge for well-being. For health-promoting behaviours like exercise among women, Felton and Parsons (1994) suggest that interventions should be designed to be sex and race-specific, building personal-control skill, promoting interpersonal support systems, and providing multiple forms of physical activity – especially recreational forms. In addition, Monahan (1995) suggests that it is important to use positive affect when designing health messages. Congruently, VonBothmer and Fridlund (2003) report that positive affect/optimism is the most potential prediction of sense of coherence. The positive self-talk and beliefs could shape expectations which are "players in the organisms' physical response to any intervention." (Daruna, 2004, p. 208).

Therefore, interventions pertaining to motivating the full range of healthy behaviours have to be designed in balance for all aspects. Education institutes are also the crucial points of entry. Positive cultural resources and sense of self complemented with health knowledge and practice could entail positive outcomes of health and well-being. The mass media are also crucial points of widespread information both positive and negative. For those who have the ability to access knowledge from the information technology, awareness and critical thinking are crucial.

To apply the main ideas of social constructionism in health promotion is to see individuals immersed in their historical ongoing outer and inner constructed narratives in a distinctive context. So, to empower them to take care of themselves is to raise their awareness of the surrounding narratives that construct their sense of self. Healthy discourses should be created. For health promotion: "discussing changes in lifestyle without first discussing the changes in the social conditions

which give rise to them, without recognizing that lifestyle is derivative, is misleading, and, in effect, victim-blaming.” (Arney & Bergen, 1984, p. 124).

IMPLICATIONS FOR NURSING

In Thailand, nurses in the primary care unit (PCU) are the key to health promotion. However, their routine tasks have neglected the college aged population because of two beliefs; the first is a belief that college students are healthy, and the second is that health promotion for this population is the colleges’ responsibility. Nurses in PCUs are usually involved in physical health promotion programmes for school-aged children only. This research provides knowledge for promoting positive sense of self and healthy choices in the Thai cultural context.

Health promotion is increasing in prominence, and is becoming an important role in nursing practice. The concept of empowerment has been explicated in various health disciplines including community health, community psychology, health promotion, health education, and nursing. There are three aspects of empowerment: perception of self; acquisition of resources, knowledge, and skills; and participation in concerted action (Springett, 2001). Public health nurses conceptualised empowerment as “an active, internal process of growth that was rooted in one’s own cultural/religious/personal belief system, reached toward actualizing one’s full potential, and occurred within the context of a nurturing nurse-client relationship.” (Rafael, 2001, p. 4). Nurses could be the sources of power for clients to promote their health. Nurses can facilitate the empowering process in clients by developing a trusting relationship, advocacy, providing information and developing skills, and building capacity (Rafael, 2001). In summary, nurses should be people’s mentors for the pursuit of wellness. In this thesis, an awareness of the construction of self is added as another essential component of the task – that is to build the capacity of knowing and being aware of de-powering and empowering narratives and factors.

Nurses work in a multi-disciplinary team, but they are the important professionals who have crucial opportunities to intervene with clients from birth till death along all stages from health, through ill-health in a wide range of settings in societies. Nurses can help the clients go through the process of achieving their self-identity and self-development from what they have learnt from their context and culture,

and help them find personal goals and meaning in life. Nurses have to keep in mind individual differences while realising the importance of the general components contributing to well-being, like the characteristics of comprehensibility, manageability, meaningfulness, exploration and commitment, which are all however, subjective. Nurses can focus on each person's personal plan of self-development and regulation by encouraging her to create coherent and congruent life goals which have health and well-being at the base contributing to any life goals. In this sense the conversation about health or health education is not merely about health per se, but rather is linked to people's life goals, sense of self, self-image, and their loved ones.

There is a need for nurses to understand the complexity inherent in health-related situations. The foundation of such a paradigm shift is rooted in nursing education. The Thai nursing curriculum now recognises the issue of health promotion as an important effort to sustain population health, yet, it is rarely linked to people's sense of self or identity formation. Encouraging nurses to realise the need to help Thai college women to achieve a positive sense of self, and therefore a commitment to health-promoting lifestyle behaviours through interpersonal relations, is crucial. Nursing in Thailand has followed the bio-medical perspective of curing disease and illness for so long. Even though the emphasis on health promotion has been pronounced, most of the perspectives for promoting health have been conveyed from Western theories. Most nurses are trained to promote health congruent with the routine work in healthcare settings. Unfortunately, the awareness of knowing that the clients' sense of self, in a specific context, may affect their behaviours, has not been addressed in the nursing curriculum or within practice. Not only does the basic nursing curriculum need improvement, but also post basic curricula or in-service training for nurses should be reviewed to use the salutogenic concept and a positive sense of self to promote healthy behaviours by encouraging people's healthy values and goals.

In nursing education, there is little prominent strategy to develop health promotion competencies for nurses. Liimatainen, Poskiparta, Karhila, and Sjögren (2001) suggest that during the years of nursing education, nursing students need learning from practice, via critical reflection, to reach the concept of empowerment approach to health promotion in order to perform an effective role within the modern health promoting implementation. During years in nursing education, nurses should be educated by experiential learning to form themselves as role

models who are fully grown as healthy persons. Self-reflection and group discussion to develop a positive sense of self are crucial. Instead of studying only propositional knowledge and practical knowledge, it is confirmed that experiential knowledge can not be reduced from education where schools are the places to encourage students to learn only the 'knowing that' and the 'knowing how' kinds of knowledge conveyed (Burnard, 1987). Reflective thinking and self-reflection were found to be important in 'learning about oneself' (Smith, 1998). Nevertheless, the models and contents of developing a healthy personality and habits are not confined only to nursing education. They can be developed and used in education institutes countrywide concomitantly with research in this area, and these are determined to be the important tasks for social development. Concerning about wellness as the interrelatedness of all things in the society as a whole needs to be developed. Critical thinking should be a highly valued educational outcome in general, and in nursing in particular (Daly, 1998).

As a researcher, by engaging in the journey of this dissertation, I have also developed my self through the processes of knowing self. I have learnt many things from the processes of inquiry, my supervisors, my colleagues, my participants and my own Thai context. The knowledge from the study is useful for reminding me to help young Thai women to achieve their sense of self in the Thai context and engage well in HPLBs by promoting them to search for their healthy values, healthy life goals, healthy reason, and healthy possible selves, through the construction of a positive sense of self, and an awareness of the inner and outer narrative constructed. The salutogenic concept has been the core change in my perspective which had been embedded in the bio-medical ethos of the pathogenic concept for so long. I have also realised that the cultural resources in Thai culture have long been taken for granted, such as the Buddhist doctrines and practices of wellness, gratitude value, and the collectivistic sense which are valuable for promotion as the core strengths of the society's wellness from the individual to the societal level. At the same time I have also realised the drawbacks of the culture that sabotage the process of empowering people to increase control over their health. For example, the extreme taking old karma as a determinant of current life well-being or ill-being has been misused as a selective meaning for excuse.

LIMITATIONS OF THE STUDY

The use of this study is based on the limitations presented as follows:

1. Generalisation of the findings of this study is limited to Thai college women at the age of late adolescence living and studying in areas of Udonthani and Khon Kaen Province, northeastern Thailand. The research was conducted during the year 2003-2005; the inferences might be culturally changeable over time.
2. Data collection took place in uncontrolled settings. Thus, environmental conditions might affect participants' responses.
3. Bias related to social desirability during the face-to-face interviews might have occurred, and the fact that student nurse participants might feel more familiar with the researcher than with other programme participants might have led them to give information at greater depth than non-nurse participants. Because nursing study is human and health sciences related, the qualitative data obtained from the nurse participants may be obviously rich in health-promoting aspects.
4. On the basis of this study it is not possible to answer the question of whether or not the student nurse participants are fully aware of health issues before or after studying nursing. Also, it is not possible to make any assumptions as to whether they come to study nursing because of a strong sense of gratitude to parents or because studying nursing inspires them to think about taking care of their parents. The impact from parents and parenting style have also raised what Taylor (2004) calls 'chicken and egg questions' about some aspects of salutogenesis. Study A showed that studying the nursing programme was correlated with strong SOC, but it could not explain whether the nurse participants had strong SOC as a result of their study programme or from their family backgrounds.
5. The nurse and non-nurse participants in this study were considered to be a homogeneous group of Thai college women. In Study B, the nurse participants differed from the non-nurse participants with respect to encountering death, role modeling, and monitoring nutrition and energy. These differences may be attributable to their programme of study. However, I would argue that the findings overall are applicable to all college women not only the nurse students.

Despite these limitations, the themes which have emerged from the study are useful for promoting positive self-development and healthy behaviours consistent with Thai values and culture for youths. The study has shown that family background, the gratitude emotion and a strong sense of connectedness to parents, and profound health motivation and knowledge are powerful factors to promote healthy behaviours in this group of young Thai college women. Family and work, the functional and developmental units of the society are the two areas that will gain merits from social and educational preparations put into each generation, educated people in general, and women in particular.

RECOMMENDATIONS FOR FUTURE RESEARCH

The predictors used in Study A are in turn implying factors influencing commitment to healthy behaviours. It would be useful to repeat Study A with more detailed methods of probability sampling, such as simple random sampling to get more accurate prediction power of the independent variables. To gain more confidence, the multiple regression analysis for the predictors may be applied to the study in different cohorts, gender, or settings. And if achieving identity is an important factor for young people to develop themselves to obtain well-being, the instruments then should be useful as a diagnosis to find young people who are in the stage of identity diffusion and then to design interventions for them to achieve their sense of self. Also, as I have already mentioned earlier the three instruments are themselves tools for triggering the participants to think about many aspects in their transitional period of life to adulthood. The three instruments are useful for evaluation and intervention for college students for both genders. A longitudinal study of identity formation and its impacts on health-promoting lifestyle behaviours is strongly recommended to be conducted with Thai adolescents in the future.

The Model of the Mindful Self that emerged from the merging of Study A and Study B needs more research in depth, if each component, the context, the self, and the health-related behaviours is to be manipulated. As from the results analysed from the qualitative data, gratitude, collectivistic sense, meaningful life goals, Buddhism understanding and practices, seem to be potential predictors of well-being for college women in this study. It would be interesting to explore further for their prediction power in future research. The components linked to different dimensions of well-being have been studied by different researchers. For example,

the effects of gratitude and sense of self have been linked to subjective well-being, whereas satisfaction of autonomy, competence and relatedness needs and goal attainment has been linked to eudaimonic well-being, such as the degree of vitality, psychological flexibility, and deep inner sense of wellness (Ryan & Deci, 2002). Factors that promote distinctive well-being, hedonic and eudaimonic, should be systemically studied in the Thai cultural context to build knowledge of well-being promotion in culturally sensitive ways.

The Mindful Self proposed in this research has been derived from women's world view, as a result, it is not certain that men would think that the same sense of self, such as the connected self would promote their healthy behaviours or not. It is recommended that in-depth interviews be obtained from male participants in order to highlight the gender-based health promoting programmes within the perspective of self-formation. It is crucial that all components presented in the model should be adopted when creating a wellness course for Thai college women. In addition, themes regarding extreme belief in the old karma and the belief in the external power of a Supreme Being, and some contextual factors such as the seniority-oriented system are to be explored for their impact on people's sense of control which influences the processes of self-empowerment.

A participatory research process could be seen as a tool for empowerment to point out the participants' potential resources and then they could initiate a healthy agenda for themselves in the future. A longitudinal study would provide confirmation of the outcomes from the process. Different groups and genders of participants are recommended to be studied in the future. All inferences from this study could be used for self-development programmes in colleges and evaluative research could be done for their outcomes. However, care needs to be taken with the design of evaluation protocols as health promotion interventions provide multiple outcomes – some intended and some not (Springett, 2001). There is not a clear linear relationship between inputs and outcomes. Any given outcome may arise from complex interactions between facets of health promotion strategies. An evaluation framework needs to be sufficiently flexible to capture such interactive effects. I would rather recommend evaluating health as a kind of self-development and this is described as individual differences in value, culture, and practice.

CONCLUDING STATEMENTS

Recognising the relationship between lifestyles and health outcomes, institutions of education should embrace a wellness philosophy. To motivate people to explore and make a commitment to healthy choices needs more developing of a distinctive body of knowledge applicable to nursing practices. It is apparent from this research that nurses might promote young women's health by developing their sense of coherence and identity achievement through meaningful relationships, and addressing these issues in families in communities via health education programmes. Partnerships can be created between nurses and families or colleges in communities and among peer groups to help educate and promote a positive sense of self and identity for young women and help them make healthy choices for wellness. The model of the mindful self would help health promotion professionals to check the weak areas of the sense of the mindful self. Generally, young Thai women are embedded in a similar cultural background; still, the important point is to raise their awareness of each narrative in the self and in the culture. Nutritional habits, exercise and energy management, and specific health issues should be taught at a level that can create effective self-management. Seeking for health knowledge should be cultivated as a habit of wellness enactment. Researchers should better find out the ways to develop sense of coherence and a positive sense of self such as the gratitude emotion, life's goals, and various positive components in the mindful self in the wider young population in terms of health education and women's health promotion. After all, wellness interventions need a mixture of resources, including multiple strategies from cognitive-based, activity-based, to positive sense of self to instill a commitment to life-long health-promoting lifestyle behaviours. To achieve health-promoting practice for young Thai women needs multidisciplinary teamwork and sensible strategies which sustain women's well-being. In the near future, their essential care-giving roles will usually be multiple roles. Nurses, as integrated health providers, have to develop their performances of gender-based health promoting practice as an essential nursing competency. Understanding and empowering women are tools for sustainable development in societies, since they form half of the community population who will ensure the quality of the next generation.

APPENDIX 1

RELIABILITY OF THE THREE INSTRUMENTS

The reliability of the questionnaires from the pilot study are as follow:

1) Cronbach alphas of the Health-Promoting Lifestyle Profile II (HPLP II)*

Health Responsibility	.762
Physical Activity	.704
Nutrition	.501
Spiritual Growth	.673
Interpersonal Relation	.562
Stress Management	.527
Total Health-Promoting Lifestyle Profile II	.861

* For Health-Promoting Lifestyle Profile II, the Cronbach alphas from the original authors are as follows: Health Responsibility (.861), Physical Activity (.850), Nutrition (.800), Spiritual Growth (.864), Interpersonal Relations (.872), Stress Management (.793), and Total HPLP II (.943), indicating high internal consistency. (informed in an attached letter with the permission to use the tool, September, 2003).

2) Cronbach alphas of the Extended Objective Measure of Ego Identity Status (EOM-EIS)*

Ideological	
Achievement	.673
Moratorium	.600
Foreclosure	.646
Diffusion	.741
Interpersonal	
Achievement	.645
Moratorium	.423
Foreclosure	.811
Diffusion	.630
Total EOM-EIS	.786

* For the EOM-EIS, the Cronbach alphas from the original authors are as follows: ideology for achievement (.62), moratorium (.75), foreclosure (.75), diffusion (.62); interpersonal for achievement (.60), moratorium (.58), foreclosure (.80), and diffusion (.64), indicating good internal consistency (Bennion & Adams, 1986).

3) Cronbach alphas of the Sense of Coherence Questionnaire (SOC)

Total Sense of Coherence (Comprehensibility, Manageability, Meaningfulness)	.843
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APPENDIX 2

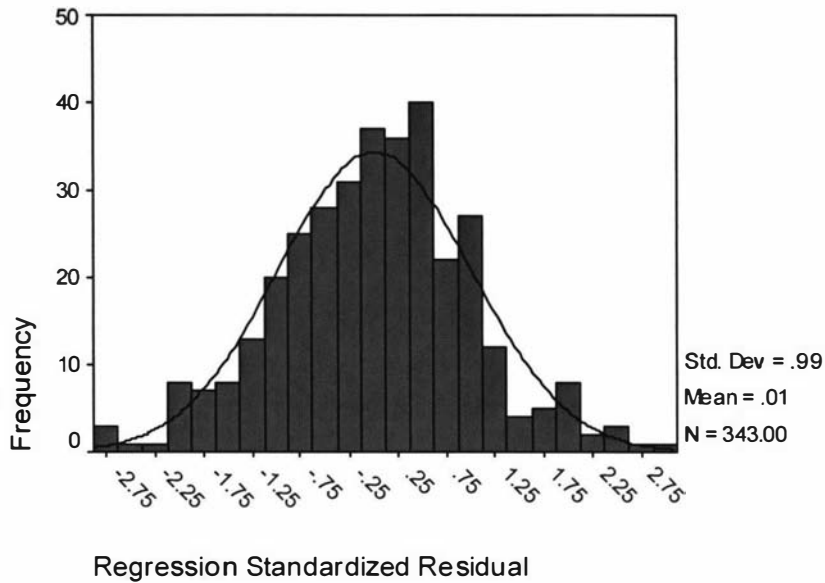
**MAJOR PROGRAM OF STUDY
OF THE PARTICIPANTS IN STUDY A**

	Ratchapat University (n)	Technology Ratchathani Institute (n)	College of Physical Education (n)	Boromarajonani College of Nursing (n)
Food technology and sciences	24	-	-	-
Human resource management	8	-	-	-
General sciences	8	-	-	-
Business administration	2	-	-	-
Tourism	3	-	-	-
Marketing	6	-	-	-
Community development	8	-	-	-
Thai dances and musics	2	-	-	-
Elementary education	2	-	-	-
Management	5	-	-	-
Chemistry	3	-	-	-
Home economics	4	-	-	-
Environmental sciences	3	-	-	-
Business economics	1	-	-	-
Health education	2	-	-	-
Veterinary	3	-	-	-
Education	1	-	-	-
Accountancy	11	4	-	-
English	11	-	-	-
Health sciences	1	-	-	-
Physical education	3	-	-	-
Computer sciences	2	36	-	-
Laws	-	6	-	-
Nursing	-	59	-	100
Sports management and training	-	-	1	-
Sports sciences	-	-	4	-
Health promotion	-	-	15	-
Mathematics	-	-	2	-
No answer	7	3	-	-
Total	120	108	22	100

APPENDIX 3
HISTOGRAMS
PRESENTING NORMAL DISTRIBUTION
OF THE VARIABLES IN STUDY A

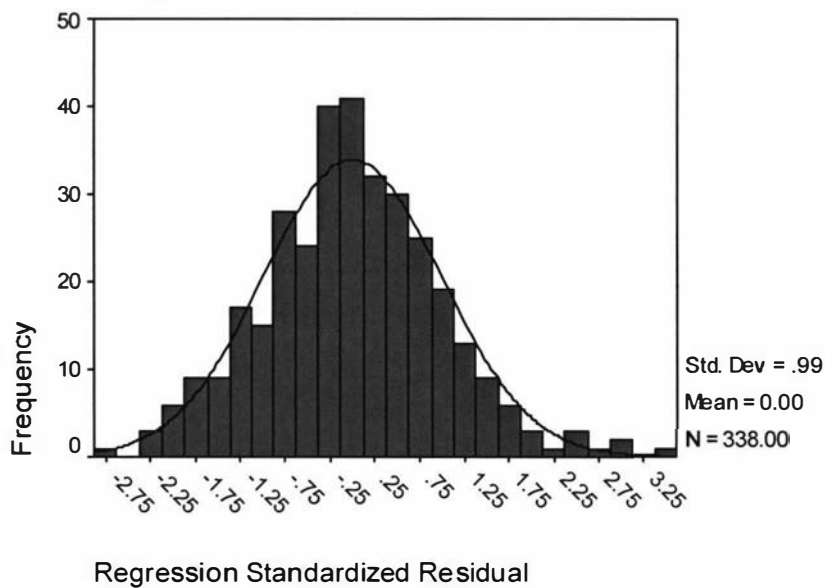
Histogram

Dependent Variable: hlp



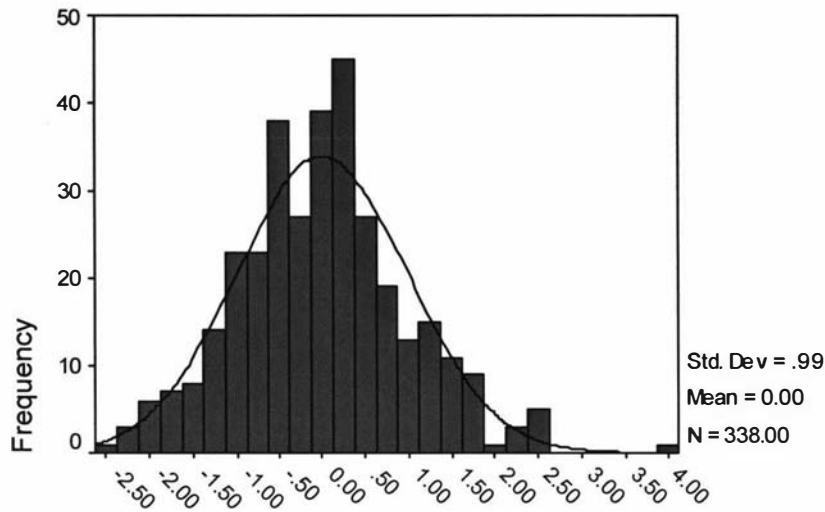
Histogram

Dependent Variable: health responsibilities



Histogram

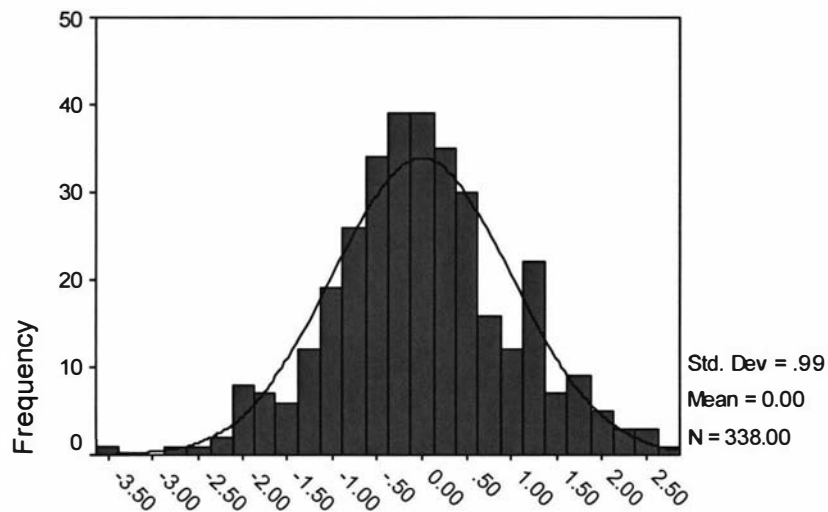
Dependent Variable: physical activities



Regression Standardized Residual

Histogram

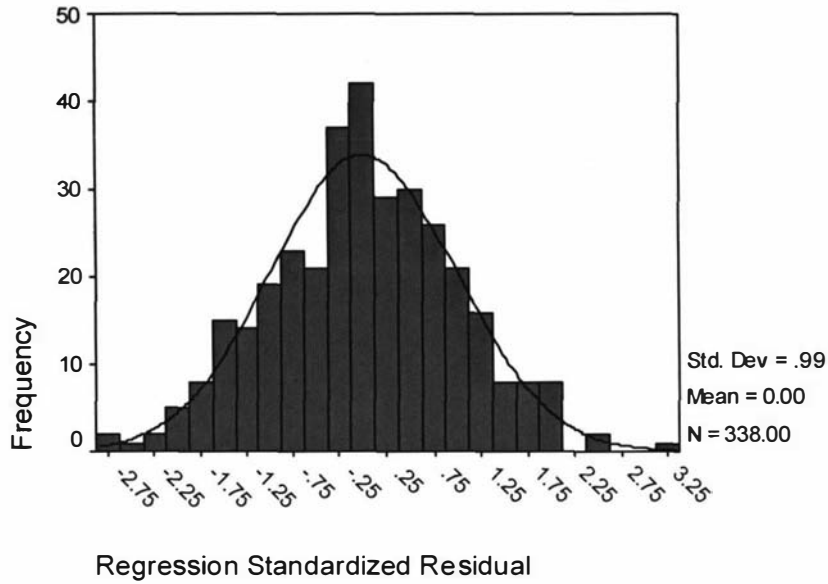
Dependent Variable: nutrition



Regression Standardized Residual

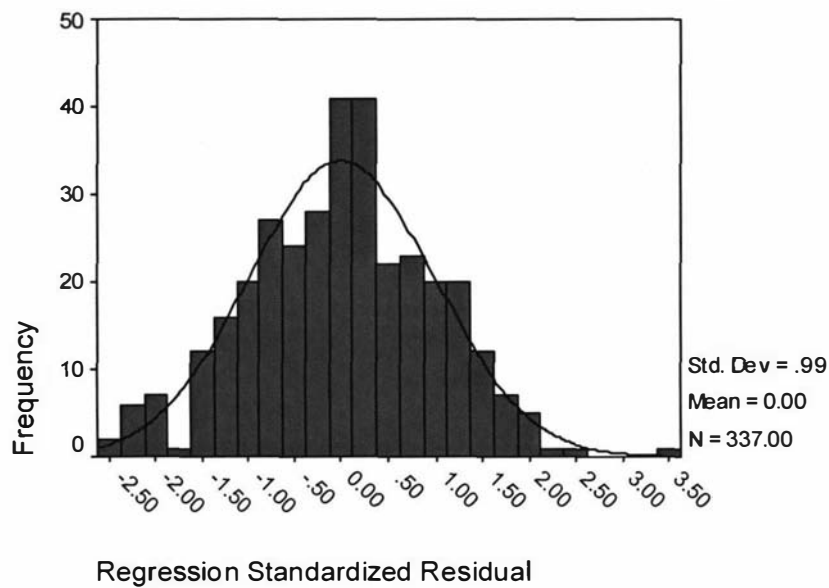
Histogram

Dependent Variable: spiritual growth



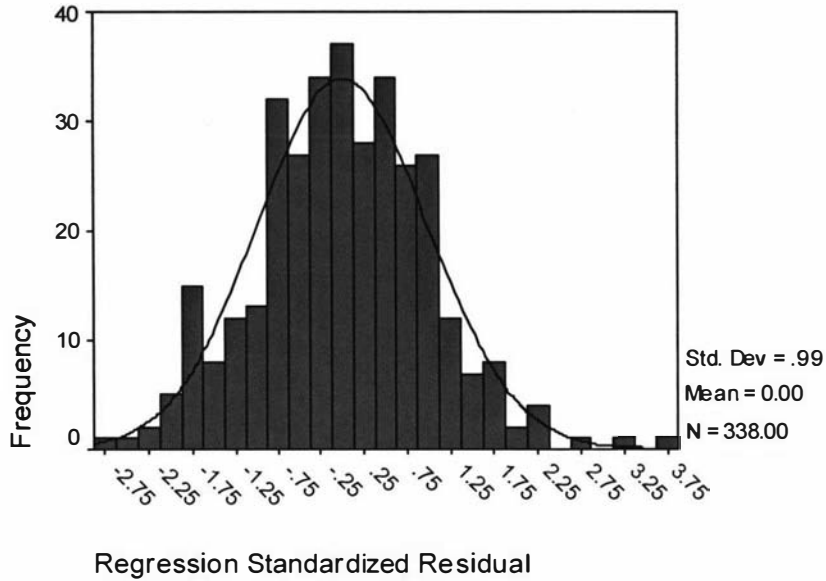
Histogram

Dependent Variable: interpersonal relations



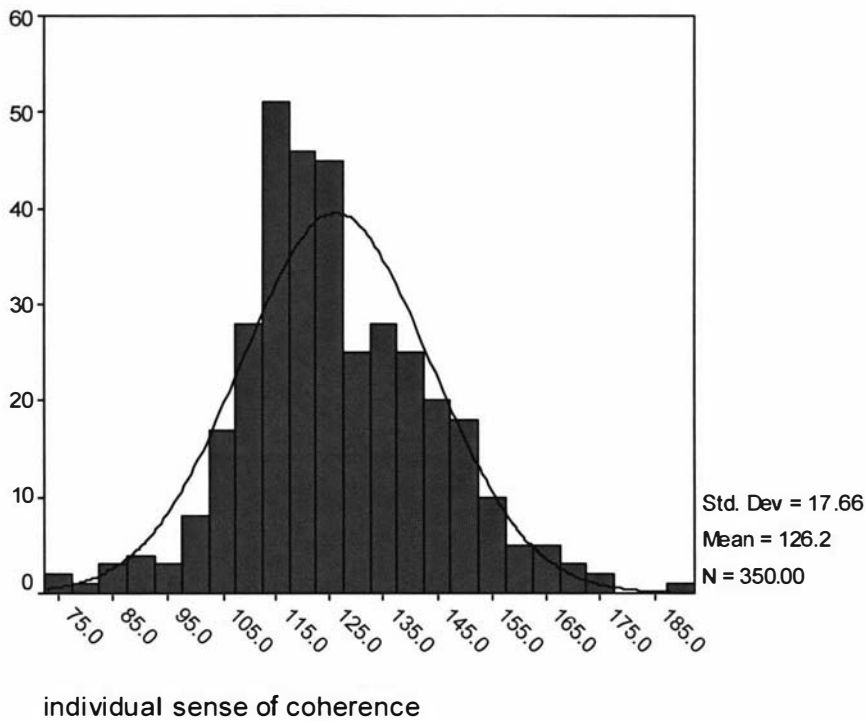
Histogram

Dependent Variable: stress management

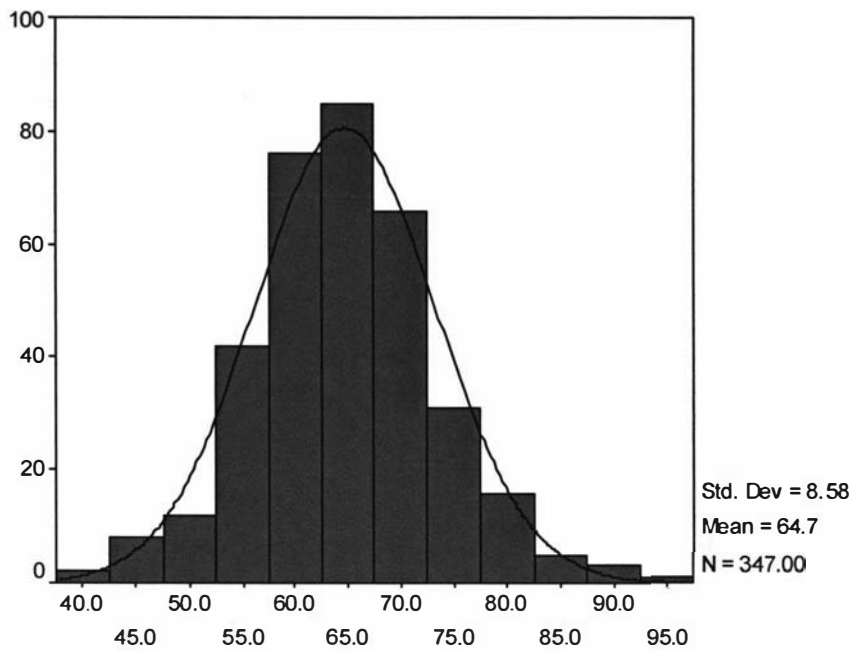


Independent Variables

Sense of Coherence

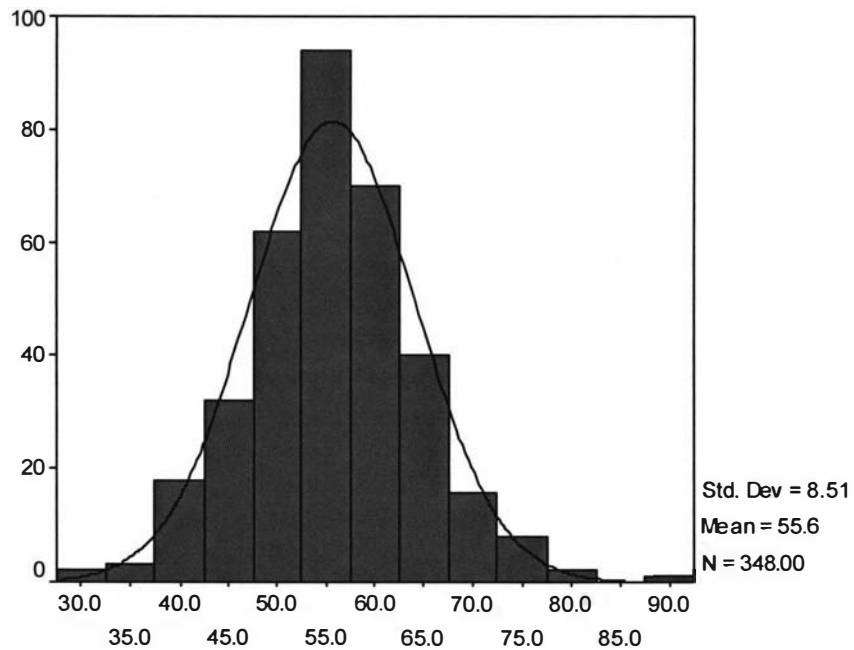


Identity Achievement



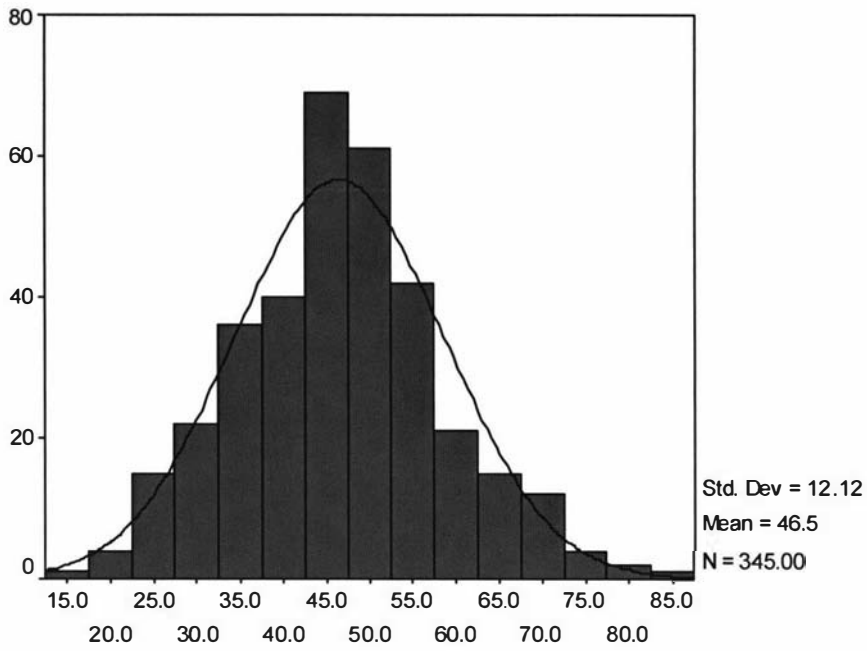
individual achievement

Identity Moratorium



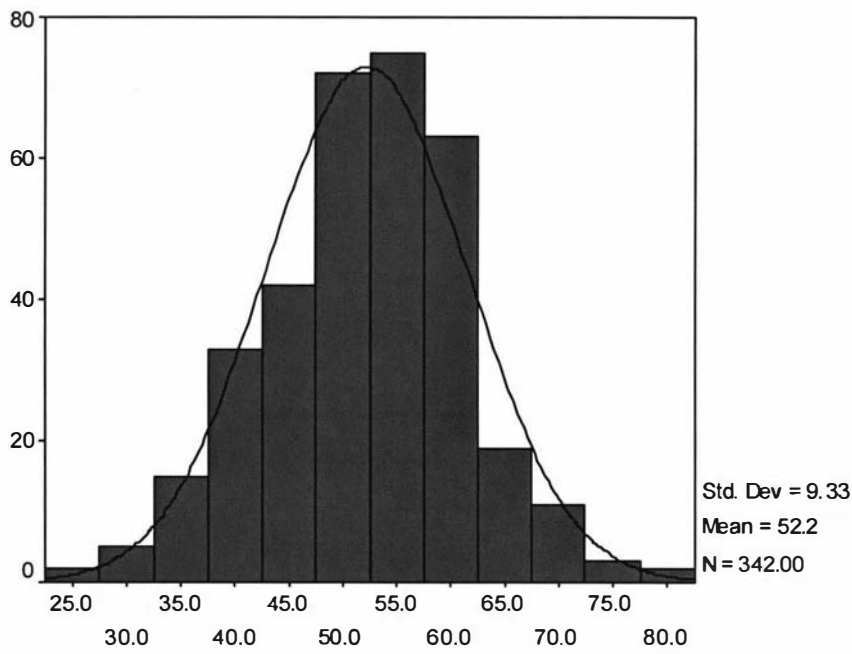
individual moratorium

Identity Foreclosure



individual foreclosure

Identity Diffusion

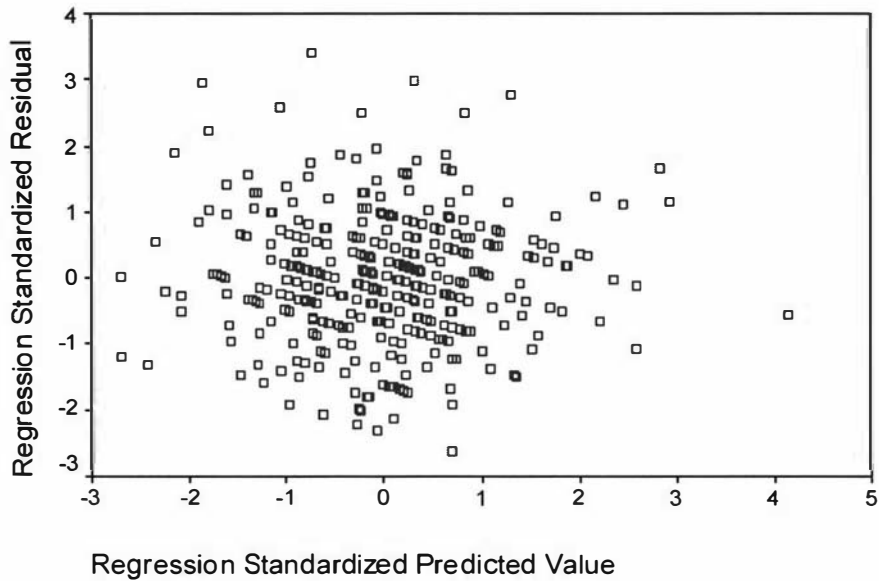


individual diffusion

APPENDIX 4
SCATTERED PLOT
OF THE VARIABLES IN STUDY A

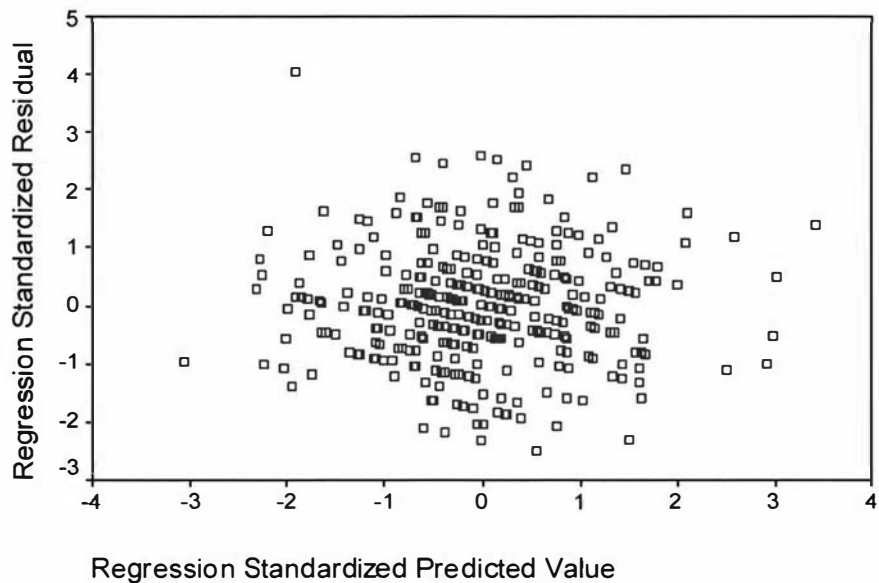
Scatterplot

Dependent Variable: health responsibilities



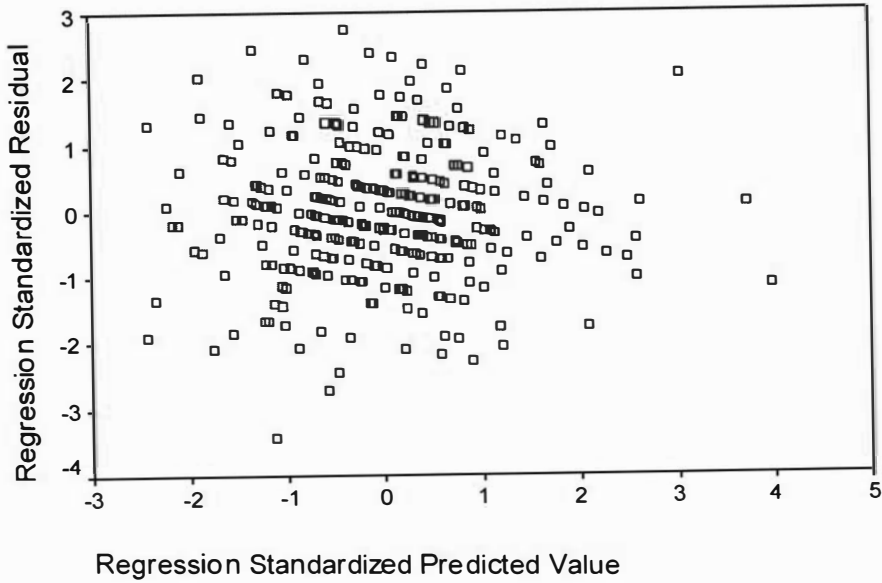
Scatterplot

Dependent Variable: physical activities



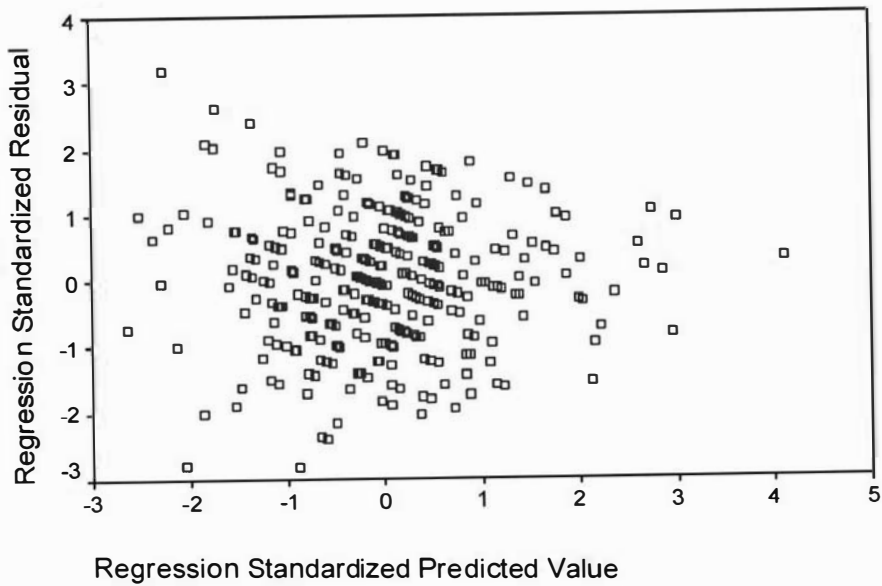
Scatterplot

Dependent Variable: nutrition



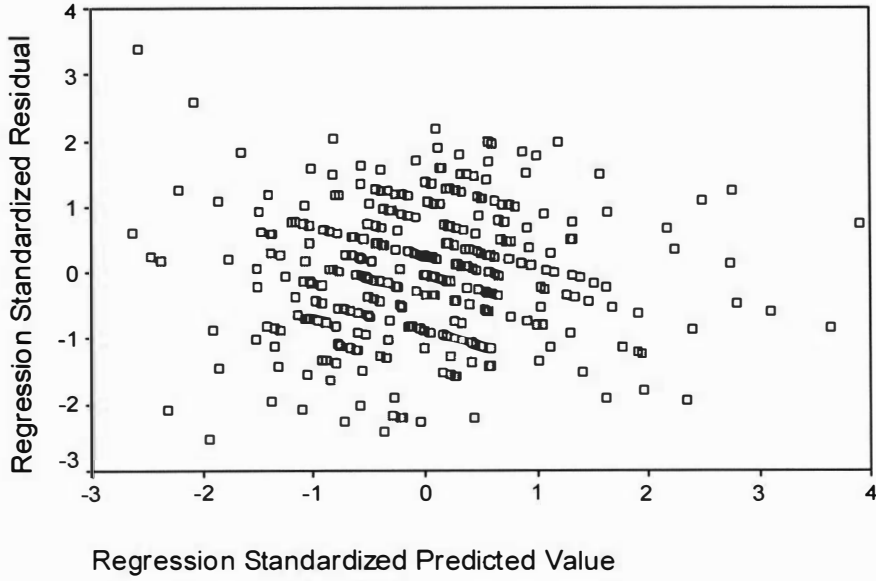
Scatterplot

Dependent Variable: spiritual growth



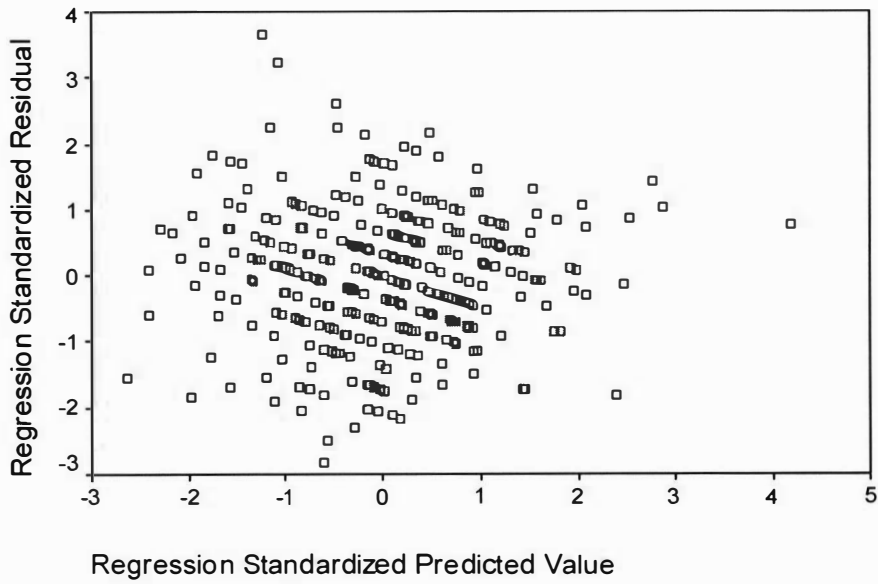
Scatterplot

Dependent Variable: interpersonal relations



Scatterplot

Dependent Variable: stress management



APPENDIX 5
LIST OF PARTICIPANTS
FOR THE IN-DEPTH INTERVIEWS IN STUDY B

CASE #	CODED NAME	YEAR OF STUDY	SOC SCORE	HPLP II MEAN SCORE	MAJOR STUDY / INSTITUTE
1	N1	3	-	-	Nursing / KKU*
2	N2	4	-	-	Nursing / KKU
3	N3	4	157	3.44	Nursing / BCNU**
4	N4	4	111	3.13	Nursing / BCNU
5	N5	4	132	3.00	Nursing / BCNU
6	N6	4	129	2.96	Nursing / BCNU
7	N7	4	130	2.94	Nursing / BCNU
8	N8	4	149	2.87	Nursing / BCNU
9	N9	4	131	2.85	Nursing / BCNU
10	N10	4	135	2.85	Nursing / BCNU
11	N11	4	110	2.81	Nursing / BCNU
12	N12	4	100	2.81	Nursing / BCNU
13	N13	4	129	2.77	Nursing / BCNU
14	NN1	4	-	-	Agriculture / KKU
15	NN2	4	-	-	Humanities / KKU
16	NN3	4	-	-	Humanities / KKU
17	NN4	3	-	-	Engineering / KKU
18	NN5	4	-	-	Computer Science / RU***
19	NN6	4	-	-	Public Administration / RU
20	NN7	4	-	-	Public Administration / RU
21	NN8	4	-	-	Community Development / RU
22	NN9	4	-	-	Management Science / RU
23	NN10	4	-	-	Management Science / RU
24	NN11	3	-	-	Management Science / KKU
25	NN12	3	-	-	Management Science / KKU

All participants are female.

* KKU = Khon Kaen University

** BCNU = Boromarajonani College of Nursing, Udonthani

*** RU = Ratchapat University

APPENDIX 6

INFORMATION SHEET FOR STUDY A AND B

[Print on Massey University department letterhead]
[Logo, name and address of Department/School/Institute/section]

THAI WOMEN'S HEALTH BELIEFS AND HEALTH PROMOTING PRACTICES

INFORMATION SHEET (STUDY A)

Researchers Introduction

Researcher: Mrs. Pitsini Mongkhonsiri

Contact Detail: School of Health Sciences, Private Bag 11 222

In NZ Massey University, Palmerston North, New Zealand

Telephone: 64 6 3505799 ext. 2187 ; Facsimile: 64 6 3505668

Contact Detail: Boromarajonani College of Nursing Udonthani

In Thailand 88 Mittrapab Road, Umphur Muang, Udonthani 41330 Thailand

Telephone: 66 42 207886; Facsimile: 66 42 295404

Supervisors: 1. Professor Julie Boddy

2. Professor Steven LaGrow

Contact Detail: School of Health Sciences, Private Bag 11 222

Massey University, Palmerston North, New Zealand

Telephone: 64 6 3505799 ext. 2541 and 7719, respectively

Facsimile: 64 6 3505668

3. Associate Professor Dr. Khanitta Nuntaboot

Contact Detail: Faculty of Nursing, Khon Kaen University

Mittrapab Road, Umphur Muang, Khon Kaen 42000 Thailand

Telephone: 66 43 202407 ext. 156

I am doing this research project as a doctoral student enrolled at Massey University. I am a registered nurse currently on study leave from Boromarajonani College of Nursing, Udonthani.

Type of the research project:

This is a multi-method project combining a quantitative study with a qualitative study. There are two parts in this study

Study A: A quantitative study design will be applied to explore the extent to which sense of coherence and identity statuses predict health-promoting lifestyle behaviours. Three instruments will be used with 350-360 participants in four colleges in Udonthani Province.

Study B: A qualitative approach of in-depth interviews for deeper understanding of the sense of self in the Thai context. Qualitative data will be obtained from nurse and non-nurse participants studying in colleges and universities in Khon Kaen and Udonthani Provinces.

Purposes of the project:

The purposes of the project are to gain more understanding of the extent to which identity status and sense of coherence can predict health-promoting lifestyle behaviours among Thai college

women in northeastern Thailand, and to develop a model for health promotion for college women's health by analyzing their sense of self in the Thai context.

Participant Recruitment:

College women in year three or year four will be the population for the research. In Study A, I need 70-100 students from each of the four colleges in Udonthani Province to participate. I will approach students to explain the study and ask for volunteers to participate in Study A. The total sample for part A of the study is 350-360 participants from four colleges.

What will you have to do if you volunteer for the study?

Participants will be asked to answer three questionnaires which will take 1 hour at your college during your free time. Refreshments will be provided for participants in Study A. The questionnaires are:

1. 52 items of the Health-Promoting Lifestyle Profile II (HPLP II)
2. 64 items of the Extended Version of the Objective Measure of Ego Identity Status; and
3. 29 items of the Sense of Coherence Questionnaire.

Completion and return of the questionnaires implies consent to participate in the study. You will not have to put your name on the questionnaires. You have the right to decline to answer any particular question. All participants will be invited to indicate at the end of the last questionnaire if they wish to receive a summary of the results. Ten to twelve student nurses who gain top score in HPLP II will also be invited to indicate their willingness to be approached to participate in the in-depth interviews of Study B.

What will happen to the questionnaires?

The questionnaires will be coded. Sheets with names and addresses will be separated. Data will be entered into SPSS, and password protected for analysis. Questionnaires will be stored for 5 years in a secure filing cabinet separated from personal details, and then will be destroyed. A summary of the results will be sent to students who request it. After the end of the thesis project, all participants can access the research findings in all the four colleges' libraries.

What are the benefits for participants?

The benefits from the study will entail having contributed to the development of recommendations to education policy and health promoting strategies for Thai college women.

Participant's Rights:

You have the right to:

- decline to participate or answer any particular question
- withdraw from the study at any time
- ask any questions about the study at any time during participation
- provide information on the understanding that your name will not be used
- access the research findings in all the four colleges' libraries.

If you have any questions about the project, please contact the researcher or supervisors according to the contact details given above.

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 03/128. If you have any concerns about the conduct of this research, please contact Professor Sylvia V Rumball, Chair, Massey University Campus Human Ethics Committee: Palmerston North, telephone 0064 6 350 5249, email humanethicspn@massey.ac.nz.

THAI WOMEN'S HEALTH BELIEFS AND HEALTH PROMOTING PRACTICES

INFORMATION SHEET (STUDY B)

Researchers Introduction

Researcher: Mrs. Pitsini Mongkhonsiri

Contact Detail: School of Health Sciences, Private Bag 11 222

In NZ Massey University, Palmerston North, New Zealand

Telephone: 64 6 3505799 ext. 2187 ; Facsimile: 64 6 3505668

Contact Detail: Boromarajonani College of Nursing Udonthani

In Thailand 88 Mittrapab Road, Umphur Muang, Udonthani 41330 Thailand

Telephone: 66 42 207886; Facsimile: 66 42 295404

Supervisors: 1. Professor Julie Boddy

2. Professor Steven LaGrow

Contact Detail: School of Health Sciences, Private Bag 11 222

Massey University, Palmerston North, New Zealand

Telephone: 64 6 3505799 ext. 2541 and 7719, respectively

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3. Associate Professor Dr. Khanitta Nuntaboot

Contact Detail: Faculty of Nursing, Khon Kaen University

Mittrapab Road, Umphur Muang , Khon Kaen 42000 Thailand

Telephone: 66 43 202407 ext. 156

I am doing this research project as a doctoral student enrolled at Massey University. I am a registered nurse currently on study leave from Boromarajonani College of Nursing, Udonthani.

Type of the research project:

This is a multi-method project combining a quantitative study with a qualitative study. There are two parts in this study

Study A: A quantitative study design will be applied to explore the extent to which sense of coherence and identity statuses predict health-promoting lifestyle behaviours. Three instruments will be used with 350-360 participants in four colleges in Udonthani Province.

Study B: A qualitative approach of in-depth interviews for deeper understanding of the sense of self in the Thai context. Qualitative data will be obtained from nurse and non-nurse participants studying in colleges and universities in Khon Kaen and Udonthani Provinces.

Purposes of the project:

The purposes of the project are to gain more understanding of the extent to which identity status and sense of coherence can predict health-promoting lifestyle behaviours among Thai college women in northeastern Thailand, and to develop a model for health promotion for college women's health by analyzing their sense of self in the Thai context.

Participant Recruitment:

A group of willing student nurses will be invited to participate in in-depth interviews in Study B on the basis of their scores in the HPLP II questionnaire from Study A.

What will you have to do if you volunteer for the study?

The student nurses who are willing to participate in the in-depth interviews will be invited to sign the consent form and make appointment with the researcher. Each in-depth interview may take 45-90 minutes long and the researcher may meet each participant only once. These will take place in your college during your free time. During in-depth interviews, audio taping will be collected as data of Study B. Refreshments will be provided for participants in Study B.

What will happen to the audio tapes?

Collected data from the in-depth interviews in audiotapes will be transcribed by hired transcribers who have to sign a transcribers' agreement to keep confidential all the information provided to them. Thematic analysis will be carried out by the researcher. Audiotapes and transcripts will be stored for 5 years in a secure filing cabinet separated from personal details, and then will be destroyed.

What are the benefits for participants?

The benefits from the study will entail having contributed to the development of recommendations to education policy and health promoting strategies for Thai college women.

Participant's Rights:

You have the right to

- decline to participate or answer any particular question
- withdraw from the study at any time
- ask any questions about the study at any time during participation
- provide information on the understanding that your name will not be used unless you give permission to the researcher
- ask for the audiotape to be turned off at any time during the interviews
- access the research findings in all the four colleges' libraries.

If you have any questions about the project, please contact the researcher or supervisors according to the contact details given above.

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 03/128. If you have any concerns about the conduct of this research, please contact Professor Sylvia V Rumball, Chair, Massey University Campus Human Ethics Committee: Palmerston North, telephone 0064 6 350 5249, email humanethicspn@massey.ac.nz.

APPENDIX 7
CONSENT FORMS

[Print on Massey University department letterhead]

[Logo, name and address of Department/School/Institute/section]

THAI WOMEN'S HEALTH BELIEFS AND HEALTH PROMOTING PRACTICES

CONSENT FORM (For Study B)

THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF FIVE (5) YEARS.

I have read the Information Sheet and have had the details of the study explained to me.

My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to the interviews being audio taped.

Yes No

(If you do not agree, you should not consent to participate in Part B.)

I agree to participate in this study under the conditions set out in the Information Sheet.

Yes

Signature:

Date:

Full Name—printed

APPENDIX 8

THE HEALTH-PROMOTING LIFESTYLE PROFILE II

Health-Promoting Lifestyle Profile II (HPLP II)

Direction: This questionnaire contains statements about your *present* way of life or personal habits. Please respond to each item as accurately as possible, and try not to skip any item. Indicate the frequency with which you engage in each behavior by circling:

N for never, S for sometimes, O for often, or R for routinely

- | | |
|--|---------|
| 1. Discuss my problems and concerns with people close to me. | N S O R |
| 2. Choose a diet low in fat, saturated fat, and cholesterol | N S O R |
| 3. Report any unusual signs or symptoms to a physician or other health professional. | N S O R |
| 4. Follow a planned exercise program. | N S O R |
| 5. Get enough sleep. | N S O R |
| 6. Feel I am growing and changing in positive ways. | N S O R |
| 7. Praise other people easily for their achievements. | N S O R |
| 8. Limit use of sugars and food containing sugar (sweets). | N S O R |
| 9. Read or watch TV programs about improving health. | N S O R |
| 10. Exercise vigorously for 20 or more minutes at least three times a week (such as brisk walking, bicycling, aerobic dancing, using a stair climber). | N S O R |
| 11. Take some time for relaxation each day. | N S O R |
| 12. Believe that my life has purpose. | N S O R |
| 13. Maintain meaningful and fulfilling relationships with others. | N S O R |
| 14. Eat 6-11 serving of bread, cereal, rice and pasta each day. | N S O R |
| 15. Question health professionals in order to understand their instructions. | N S O R |
| 16. Take part in light to moderate physical activity (such as sustained walking 30-40 minutes 5 or more times a week). | N S O R |
| 17. Accept those things in life which I can not change. | N S O R |
| 18. Look forward to the future. | N S O R |
| 19. Spend time with close friends. | N S O R |
| 20. Eat 2-4 servings of fruit each day. | N S O R |
| 21. Get a second opinion when I question my health care provider's advice. | N S O R |
| 22. Take part in leisure-time (recreational) physical activities (such as swimming, dancing, bicycling). | N S O R |
| 23. Concentrate on pleasant thoughts at bedtime. | N S O R |
| 24. Feel content and at peace with myself. | N S O R |

25. Find it easy to show concern, love and warmth to other.	N	S	O	R
26. Eat 3-5 servings of vegetables each day.	N	S	O	R
27. Discuss my health concerns with health professionals.	N	S	O	R
28. Do stretching exercises at least 3 times per week.	N	S	O	R
29. Use specific methods to control my stress.	N	S	O	R
30. Work toward long-term goals in my life.	N	S	O	R
31. Touch and am touched by people I care about.	N	S	O	R
32. Eat 2-3 servings of milk, yogurt or cheese each day.	N	S	O	R
33. Inspect my body at least monthly for physical changes/danger signs.	N	S	O	R
34. Get exercise during usual daily activities (such as walking during lunch, using stairs instead of elevators, parking car away from destination and walking).	N	S	O	R
35. Balance time between work and play.	N	S	O	R
36. Find each day interesting and challenging.	N	S	O	R
37. Find ways to meet my need for intimacy.	N	S	O	R
38. Eat only 2-3 servings from the meat, poultry, fish dried beans, eggs, and nuts group each day.	N	S	O	R
39. Ask for information from health professionals about how to take good care of myself.	N	S	O	R
40. Check my pulse rate when exercising.	N	S	O	R
41. Practice relaxation or meditation for 15-20 minutes daily.	N	S	O	R
42. Am aware of what is important to me in life.	N	S	O	R
43. Get support from a network of caring people.	N	S	O	R
44. Read labels to identify nutrients, fats, and sodium content in packaged food.	N	S	O	R
45. Attend educational programs on personal health care.	N	S	O	R
46. Reach my target heart rate when exercising.	N	S	O	R
47. Pace myself to prevent tiredness.	N	S	O	R
48. Feel connected with some force greater than myself.	N	S	O	R
49. Settle conflicts with others through discussion and compromise.	N	S	O	R
50. Eat breakfast.	N	S	O	R
51. Seek guidance or counseling when necessary.	N	S	O	R
52. Expose myself to new experiences and challenges.	N	S	O	R

S.N. Walker, K. Sechrist, N. Pender, 1995. Reproduction without the author's express written consent is not permitted. Permission to use this scale may be obtained from: Susan Noble Walker, College of Nursing, University of Nebraska Medical Center, Omaha, NE 68198-5330.

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 03/128. If you have any concerns about the conduct of this research, please contact Professor Sylvia V Rumball, Chair, Massey University Campus Human Ethics Committee: Palmerston North, telephone 09 350 5249, email S.V.Rumball@massey.ac.nz.

APPENDIX 9

THE SENSE OF COHERENCE QUESTIONNAIRE

Orientation to Life Questionnaire (Sense of Coherence)

Here is a series of questions relating to various aspects of our lives. Please mark the number which expresses your answer. If the words under 1 are right for you, circle 1; if the words under 7 are right for you, circle 7. If you feel differently, circle the number which best expresses your feeling. Please give only one answer to each question.

1. When you talk to people, do you have the feeling that they don't understand you?

1	2	3	4	5	6	7
never have this feeling						always have this feeling

2. In the past, when you had to do something which depended upon cooperation with others, did you have the feeling that it:

1	2	3	4	5	6	7
surely wouldn't get done						surely would get done

3. Think of the people with whom you come into contact daily, aside from the ones to whom you feel closest. How well do you know most of them?

1	2	3	4	5	6	7
you feel that they're strangers						you know them very well

4. Do you have the feeling that you don't really care about what goes on around you?

1	2	3	4	5	6	7
very seldom or never						very often

5. Has it happened in the past that you were surprised by the behavior of people whom you thought you know well?

1	2	3	4	5	6	7
never happened						always happened

6. Has it happened that people whom you counted on disappointed you?

1	2	3	4	5	6	7
never happened						always happened

7. Life is:

1	2	3	4	5	6	7
full of completely interest						routine

8. Until now your life has had:

1	2	3	4	5	6	7
no clear goals or purposes at all						very clear goals and purposes

9. Do you have the feeling that you're being treated unfairly?

1	2	3	4	5	6	7
very often						very seldom or never

10. In the past ten years your life has been:
- | | | | | | | |
|--|---|---|---|---|---|---------------------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| full of changes without your knowing what will happen next | | | | | | completely consistent and clear |
11. Most of the things you do in the future will probably be:
- | | | | | | | |
|------------------------|---|---|---|---|---|---------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| completely fascinating | | | | | | deadly boring |
12. Do you have the feeling that you are in an unfamiliar situation and don't know what to do?
- | | | | | | | |
|------------|---|---|---|---|---|----------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| very often | | | | | | very seldom or never |
13. What best describes how you see life:
- | | | | | | | |
|--|---|---|---|---|---|--|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| one can always find a solution to painful things in life | | | | | | there is no solution to painful things in life |
14. When you think about your life, you very often:
- | | | | | | | |
|---------------------------------|---|---|---|---|---|-----------------------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| feel how good it is to be alive | | | | | | ask yourself why you exist at all |
15. When you face a difficult problem, the choice of a solution is:
- | | | | | | | |
|-----------------------------------|---|---|---|---|---|-------------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| always confusing and hard to find | | | | | | always completely clear |
16. Doing the things you do every day is:
- | | | | | | | |
|--|---|---|---|---|---|------------------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| a source of deep pleasure and satisfaction | | | | | | a source of pain and boredom |
17. Your life in the future will probably be:
- | | | | | | | |
|--|---|---|---|---|---|---------------------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| full of changes without your knowing what will happen next | | | | | | completely consistent and clear |
18. When something unpleasant happened in the past your tendency was:
- | | | | | | | |
|-------------------------------|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| "to eat yourself up" about it | | | | | | to say "ok, that's that, I have to live with It," and go on |
19. Do you have very mixed-up feelings and ideas?
- | | | | | | | |
|------------|---|---|---|---|---|----------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| very often | | | | | | very seldom or never |

20. When you do something that gives you a good feeling:
- | | | | | | | |
|---|---|---|---|---|---|--|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| it's certain that you'll go on feeling good | | | | | | it's certain that something will happen to spoil the feeling |
21. Does it happen that you have feeling inside you would rather not feel?
- | | | | | | | |
|------------|---|---|---|---|---|----------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| very often | | | | | | very seldom or never |
22. You anticipate that your personal life in the future will be:
- | | | | | | | |
|------------------------------------|---|---|---|---|---|-----------------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| totally without meaning or purpose | | | | | | full of meaning and purpose |
23. Do you think that there will always be people whom you'll be able to count on in the future?
- | | | | | | | |
|------------------------------|---|---|---|---|---|-------------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| you're certain there will be | | | | | | you doubt there will be |
24. Does it happen that you have the feeling that you don't know exactly what's about to happen?
- | | | | | | | |
|------------|---|---|---|---|---|----------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| very often | | | | | | very seldom or never |
25. Many people – even those with a strong character – sometimes feel like sad sacks (losers) in certain situations. How often have you felt this way in the past?
- | | | | | | | |
|-------|---|---|---|---|---|------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| never | | | | | | very often |
26. When something happened, have you generally found that:
- | | | | | | | |
|--|---|---|---|---|---|--|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| you overestimated or underestimated its importance | | | | | | you saw things in the right proportion |
27. When you think of difficulties you are likely to face in important aspects of your life, do you have the feeling that:
- | | | | | | | |
|--|---|---|---|---|---|--|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| you will always succeed in overcoming the difficulties | | | | | | you won't succeed in overcoming the difficulties |
28. How often do you have the feeling that there's little meaning in the things you do in your daily life?
- | | | | | | | |
|------------|---|---|---|---|---|----------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| very often | | | | | | very seldom or never |
29. How often do you have feeling that you're not sure you can keep under control?
- | | | | | | | |
|------------|---|---|---|---|---|----------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| very often | | | | | | very seldom or never |

APPENDIX 10

**THE EXTENDED OBJECTIVE MEASURE OF
EGO IDENTITY STATUS (EOM-EIS)**

The Extended Objective Measure of Ego Identity Status (EOM-EIS)

Read each item and indicate to what degree it reflects your own thoughts and feelings. If a statement has more than one part, please indicate your reaction to the statement as a whole. Indicate your answer by choosing one of the following responses.

- 6 = strongly agree
- 5 = moderately agree
- 4 = agree
- 3 = disagree
- 2 = moderately disagree
- 1 = strongly disagree

1. I haven't chosen the occupation I really want to get into, and I'm just working at whatever is available until something better comes along.
1 2 3 4 5 6
2. When it comes to religion, I just haven't found anything that appeals and I don't really feel the need to look.
1 2 3 4 5 6
3. My ideas about men's and women's roles are identical to my parents'. What has worked for them will obviously work for me.
1 2 3 4 5 6
4. There's no single "lifestyle" which appeals to me more than another.
1 2 3 4 5 6
5. There are a lot of different kinds of people. I'm still exploring the many possibilities to find the right kind of friends for me
1 2 3 4 5 6
6. I sometimes join in recreational activities when asked, but I rarely try anything on my own.
1 2 3 4 5 6
7. I haven't really thought about a "dating style." I'm not too concerned whether I date or not.
1 2 3 4 5 6
8. Politics is something that I can never be too sure about because things change so fast. But I do think it's important to know what I can politically stand for and believe in.
1 2 3 4 5 6
9. I'm still trying to decide how capable I am as a person and what jobs will be right for me.
1 2 3 4 5 6
10. I don't give religion much thought and it doesn't bother me one way or the other.
1 2 3 4 5 6

11. There's so many ways to divide responsibilities in marriage, I'm trying to decide what will work for me.
1 2 3 4 5 6
12. I'm looking for an acceptable perspective for my own "life style" view, but I haven't really found it yet.
1 2 3 4 5 6
13. There are many reasons for friendship, but I choose my close friends on the basis of certain values and similarities that I've personally decided on
1 2 3 4 5 6
14. While I don't have one recreational activity I'm really committed to, I'm experiencing numerous leisure outlets to identify one I can really get involved in.
1 2 3 4 5 6
15. Based on past experiences, I've chosen the type of dating relationship I want now
1 2 3 4 5 6
16. I haven't really considered politics. It just doesn't excite me much.
1 2 3 4 5 6
17. I might have thought about a lot of different jobs, but there's never really any question since my parents said what they wanted.
1 2 3 4 5 6
18. A person's faith is unique to each individual. I've considered and reconsidered it myself and know what I can believe.
1 2 3 4 5 6
19. I've never really seriously considered men's and women's roles in marriage. It just doesn't seem to concern me.
1 2 3 4 5 6
20. After considerable thought I've developed my own individual viewpoint of what is for me an ideal "lifestyle" and don't believe anyone will be likely to change my perspective.
1 2 3 4 5 6
21. My parents know what's best for me in terms of how to choose my friends.
1 2 3 4 5 6
22. I've chosen one or more recreational activities to engage in regularly from lots of things and I'm satisfied with those choices
1 2 3 4 5 6
23. I don't think about dating much. I just kind of take it as it comes.
1 2 3 4 5 6
24. I guess I'm pretty much like my folks when it comes to politics. I follow what they do in terms of voting and such.
1 2 3 4 5 6
25. I'm really not interested in finding the right job, any job will do. I just seem to flow with what is available.
1 2 3 4 5 6

26. I'm not sure what religion means to me. I'd like to make up my mind but I'm not done looking yet.
1 2 3 4 5 6
27. My ideas about men's and women's roles come right from my parents and family. I haven't seen any need to look further.
1 2 3 4 5 6
28. My own views on a desirable life style were taught to me by my parents and I don't see any need to question what they taught me.
1 2 3 4 5 6
29. I don't have any real close friends, and I don't think I'm looking for one right now.
1 2 3 4 5 6
30. Sometimes I join in leisure activities, but I really don't see a need to look for a particular activity to do regularly.
1 2 3 4 5 6
31. I'm trying out different types of dating relationships. I just haven't decided what is best for me
1 2 3 4 5 6
32. There are so many different political parties and ideals. I can't decide which to follow until I figure it all out.
1 2 3 4 5 6
33. It took me a while to figure it out, but now I really know what I want for a career.
1 2 3 4 5 6
34. Religion is confusion to me right now. I keep changing my views on what is right and wrong for me.
1 2 3 4 5 6
35. I've spent some time thinking about men's and women's roles in marriage and I've decided what will work best for me.
1 2 3 4 5 6
36. In finding an acceptable viewpoint to life itself, I find myself engaging in a lot of discussion with others and some self-exploration.
1 2 3 4 5 6
37. I only pick friends my parents would approve of.
1 2 3 4 5 6
38. I've always liked doing the same recreational activities my parents do and haven't ever seriously considered anything else.
1 2 3 4 5 6
39. I only go out with the type of people my parents expect me to date.
1 2 3 4 5 6
40. I've thought my political beliefs through and realize I can agree with some and not other aspects of what my parents believe.
1 2 3 4 5 6

41. My parents decided a long time ago what I should go into for employment and I'm following through their plans.
1 2 3 4 5 6
42. I've gone through a period of serious questions about faith and can now say I understand what I believe in as an individual.
1 2 3 4 5 6
43. I've been thinking about the roles that husbands and wives play a lot these days, and I'm trying to make a final decision.
1 2 3 4 5 6
44. My parents' views on life are good enough for me, I don't need anything else.
1 2 3 4 5 6
45. I've tried many different friendships and now I have a clear idea of what I look for in a friend.
1 2 3 4 5 6
46. After trying a lot of different recreational activities I've found one or more I really enjoy doing by myself or with friends.
1 2 3 4 5 6
47. My preferences about dating are still in the process of developing. I haven't fully decided yet.
1 2 3 4 5 6
48. I'm not sure about my political beliefs, but I'm trying to figure out what I can truly believe in.
1 2 3 4 5 6
49. It took me a long time to decide but now I know for sure what direction to move in for a career.
1 2 3 4 5 6
50. I attend the same church my family has always attended. I've never really questioned why.
1 2 3 4 5 6
51. There are many ways that married couples can divide up family responsibilities. I've thought about lots of ways and now I know exactly how I want it to happen for me.
1 2 3 4 5 6
52. I guess I just kind of enjoy life in general, and I don't see myself living by any particular viewpoint to life.
1 2 3 4 5 6
53. I don't have any close friends. I just like to hang around with the crowd.
1 2 3 4 5 6
54. I've been experiencing a variety of recreational activities in hopes of finding one or more I can enjoy for some time to come.
1 2 3 4 5 6
55. I've dated different types of people and now know exactly what my own "unwritten rules" for dating are and who I will date.
1 2 3 4 5 6

56. I really have never been involved in politics enough to have made a firm stand one way or the other.
 1 2 3 4 5 6
57. I just can't decide what to do for an occupation. There are so many that have possibilities.
 1 2 3 4 5 6
58. I've never really questioned my religion. If it's right for my parents it must be right for me.
 1 2 3 4 5 6
59. Opinions on men's and women's roles seem so varied that I don't think much about it.
 1 2 3 4 5 6
60. After a lot of self-examination I have established a very definite view on what my own lifestyle will be.
 1 2 3 4 5 6
61. I really don't know what kind of friend is best for me. I'm trying to figure out exactly what friendship means to me.
 1 2 3 4 5 6
62. All of my recreational preferences I got from my parents and I haven't really tried anything else.
 1 2 3 4 5 6
63. I date only people my parents would approve of.
 1 2 3 4 5 6
64. My folks have always had their own political and moral beliefs about issues like abortion and mercy killing and I've always gone along accepting what they have.
 1 2 3 4 5 6

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