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Health in Everyday Life:
A Phenomenological Study of Socio-economic
Status and the Health Experience

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ABSTRACT

Differences in health between people on different levels of the socio-economic status (SES) hierarchy have been observed through out history. While there is a vast body of quantitative research on the association of SES and health, there is a paucity of qualitative research that focuses on the meaning of health as it is experienced particularly in relation to SES. The purpose of this study was to explore and uncover the meaning of health as it is experienced in everyday life by persons of differing socio-economic status. Using a phenomenological method, 20 adults, 9 of high SES and 11 of low SES, were interviewed regarding their health perceptions and experience. Data were analyzed using the methodological approach of Giorgi. Identified from significant statements were five health dimensions; the physical, mental, emotional, social, and spiritual. These, in combination, revealed four specific perceptions of the totality of health; a solitary view considering only the physical dimension, a dualistic view taking into account the physical and mental/emotional dimensions independently, a complementary view with the physical and mental/emotional dimensions interactive, and a multiple view integrating all dimensions. Synthesis and integration of these four views led to the essential structure of health for both the low and the high SES participants. The findings revealed that perceptions of health did vary across participants and SES. Although viewpoints of health differed in that each participant's experience of health reflected differing degrees of specificity, centrality, values, education, and other influences, health for the low SES participants was generally emphasized more as a solitary or a dualistic construct compared to the high SES participants who generally emphasized health more as a complementary or a multiple construct. For the more externally oriented low SES participants, health meant a state that enabled ordinary social functioning and performance of the daily role activities expected by society. In contrast, the high SES participants, holding a more personal orientation, health was a process that enabled one to perform activities of daily life with usefulness, enjoyment and satisfaction. These findings should challenge health care professionals to broaden their perspectives of health and further develop their understanding of the SES health inequalities for future health care promotion and interventions. Implications include future research that will identify SES differentials that have consequences for health.

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Table of Contents

iii

	Page
Abstract	i
Acknowledgements	ii
Table of Contents	iii
List of Tables and Figures	iv
I. Introduction	
i. Introduction	1
ii. SES and Health Literature	5
iii. Purpose and Aims of the Research	11
iv. Research Approach	13
II. Method	
i. Participants	18
ii. SES Measurement	20
iii. Data Gathering	22
iv. Analysis	25
v. Credibility	28
III. Findings	29
i. Exhaustive Description of Health	32
The Physical Dimension	32
The Mental Dimension	37
The Emotional Dimension	39
The Social Dimension	42
The Spiritual Dimension	43
ii. The Totality of Health	46
A Solitary View of Health	46
A Dualistic View of Health	48
A Complementary View of Health	48
A Multiple View of Health	50
iii. Essential Structure of Health	54
IV. Discussion	57
References	64
Appendices	
A. Information Sheet	72
B. Demographic Questionnaire	73
C. Consent Form	74
D. Interview Framework	75
E. Follow-up	77
F. Summary Letter	79

List of Tables and Figures

iv

Table

Page

- I. Health dimensions and themes formulated from the participants descriptive expressions.

30

Figures

- I. Comprehensive view of the totality of health by health dimension.

52

- II. Comprehensive view of the totality of health by socio-economic status.

53

I. INTRODUCTION

I. i. Introduction

O health! O health! The blessing of the rich, the riches of the poore! Who can buy thee at to deare a rate, since there is no enjoying this world, without thee? (Ben Jonson, 1958, P. 48).

One of the most consistently documented associations throughout history is the relationship between SES and health. Differences in health between people in different socio-economic groups have been observed since the 12th Century, with a vast body of evidence consistently showing that those in the lower classes have higher mortality, morbidity, and disability rates for almost every disease and condition than do their higher status counterparts (Stockwell, 1961; Antonovsky, 1967; Illsley & Baker, 1991; Feinstein, 1993).

Although there is abundant evidence for a casual relationship between socio-economic position and health status, the reasons for its existence remain largely obscure, along with the widespread concern that these social class differentials in health between the various social groups have been widening rather than diminishing (Macintyre, 1986; Carr-Hill, 1987; Whitehead, 1987).

To assess the evidence on inequalities in health in Britain, consider possible causes and provide policy recommendations, a research working group was appointed by the Labour Government in 1977. The central findings published in *The Report of the Working Group on Inequalities in Health*, commonly known as the Black Report (Townsend & Davidson, 1982), showed that there were large differentials in mortality and morbidity that favoured the higher social classes, and that these differentials were not being redressed by health or social services. Contained within the Report were proposals for the explanations of the health inequalities, suggestions for policies for the reduction of these health inequalities, and measurement issues concerned with defining concepts of health and inequality.

The Report concluded that the inequalities were the result of many social inequalities that influence health, such as income, employment, working

conditions, education, housing, and diet, the explanations of which might be divided into four broad categories, namely artefactual, social selection, cultural/behavioral and materialist.

Whilst equating health with deprivation and following a social causation model, which emphasises class differences in health as the result of structurally determined differences in the way members of the social classes live their lives, the explanatory framework of the Black Report has proved useful in clarifying attempts to understand inequalities in health.

The evidence is varied and convincing, despite several limitations in the detailed analyses and quantitative conclusions. As a result of this publication, numerous other studies, using the same framework, have further contributed to a broader understanding of the extent of and explanations for health inequalities, with the general conclusion that health varies markedly with SES, and that social class differentials in health are a real and persisting feature of not only British society (Blaxter, 1981; Macintyre, 1986; Carr-Hill, 1987; Whitehead, 1987; Marmot, Davey Smith, Stansfeld, Patel, North, Head, White, Brenner & Feeney, 1991), but also many of the European countries (Fox, 1989; Dahl, 1991), the United States (Kitagawa & Hauser, 1973), Australia (Najman, 1994), and in New Zealand (Davis, 1981; Pearce, Davis, Smith & Foster, 1983a, 1983b, 1984).

However, there is much debate on the contribution of each explanation for the differences observed. The potential of these explanations has been hindered by much of the theoretical development and research conducted which has concentrated on aspects of one explanation to the exclusion of the others. It has also been hindered by an over-reliance on mortality and morbidity as indicators of health, and the way in which health is conceptualised and analyzed.

In the search for, and use of evidence to evaluate the relative importance of these competing explanations for the inequalities in health, the dominant approach has been quantitative in nature, based on the premise that answers are dependent upon statistical enumeration and

the apriorism of selected concepts and themes of analysis from the perspectives of the researchers, rather than of the people who are the subjects of analysis.

As a result of the holistic health movement, in which people are encouraged to become active participants in the healing process and to exert self-responsibility, and the self-care movement which challenges professional health care by reducing reliance on health care professionals and transferring medical competence to the individual, there has been a move from traditional scientific methodology towards a more qualitative approach that provides information on context, individual variation, and causality that can not be achieved by quantitative methods alone.

Although not customary as a scientific tool in psychology, this type of research inquiry is frequently used in sociology, anthropology and nursing. However, there are compelling arguments for extending the research on health inequalities to include phenomenological inquiry.

In unravelling and elucidating the link between SES and health, such an approach would examine health from the perspective of individuals, both high and low on the socio-economic ladder, exploring the meaning of health, what constitutes health, how health is interpreted and acted on, and how health is experienced in their own terms and in their own settings (Patton, 1980).

In view of the current trend toward increasing individual responsibility for health and increasing emphasis on health and health promotion with the World Health Organisation's new goal of "health for all by the year 2000" (HFA/2000; WHO, 1981), more precise knowledge and understanding is needed of the health beliefs, cognitions, and conceptions of different groups in society. This is required in order to develop and provide greater health care that is sensitive to SES related influences on health and health behaviours and to promote and advance social policies that address SES inequalities that have an impact on health. Although there is much evidence on SES and health, there is limited information on the meaning health has for people from different social groups.

As long as the health meanings of these people remain unknown and unappreciated, health care professionals, policy makers, and academicians are likely to continue to impose their own views and promote sociocentric health care.

If these professionals are to provide socially appropriate health maintenance and health promoting therapeutics, significant consideration needs to be given to the perspectives of health, that people from differing social groups hold, in the context of their ordinary lives. With the health conceptions of professionals often differing substantially from the social groups they serve, confusion, conflicting health promotion goals, and low adherence to treatment regimes often result, as evidenced by a variety of differing behaviours, influenced by perceptions and belief systems between socio-economic groups such as self-rated health (Najman, 1994; Blaxter, 1990), exercise and physical activity (Caspersen, 1986; Ford, Merritt, Heath, Powell, Washburn, Kriska & Haile, 1991), preventive activity (Coburg & Pope, 1974; Najman, 1994), utilization of health services and compliance with medical regimens (DiNicola & DiMatteo, 1984).

Not only does investigating the health meanings of people from all strata of society provide rich and interesting data, it also acknowledges that the beliefs, attitudes, and values of these people are important and worthy of consideration. By listening to their experiences of health in the context of their daily lives, they can be recognised as valuable participants in their social environment who are able to be included in discussions and decisions relevant to their lives.

Consequently, with the intention of broadening the conceptual framework from that commonly used to investigate SES differences in health, a phenomenological approach will be used in this exploratory study, not only to present a view of health from the perspectives of people both high and low on the socio-economic ladder, but also to uncover the meaning of health as it is experienced in their everyday life.

I. ii SES and Health Literature

Health: The quality, resulting from the total functioning of the individual interacting in his environment, that empowers him to achieve a personally satisfying and socially useful life. (Johns, Sutton & Webster, 1970, p.xiii).

Although much has been written about conceptualizations of health, a diversity of health meanings abound, varying in their specificity and in their description, with no consensus on a concise, operational definition (Keller, 1981).

Of the many definitions of health, some hold to the traditional view in which health is defined as the absence of disease (Natapoff, 1978), some view it as an evolving and changing process in which the individual participates knowingly and is responsible for the development and maintenance of health (Colantonio, 1988), whereas others describe it as a state of physical, mental, and social wellbeing (WHO, 1947).

Health is also seen as a part of everyday life - an essential dimension of the quality of one's life - influenced by other individuals, and by the social, economic and physical surroundings in which one lives. Wondolowski and Davis (1991) suggest that "health is a highly personalized phenomenon, and at the same time a generic experience of all humankind" (p 113). Additionally, Kozier and Erb (1987) see health as a highly individual perception.

Most definitions of health have been developed by health professionals, analysts, sociologists, and psychologists. Few studies have investigated the meaning of health for lay people from their perspectives, especially within the context of their social milieu. With the meaning of health varying among the professionals, so must it vary among lay people.

As health is a major concept in understanding the relationship between socio-economic position and health, as well as the HFA/2000 strategy, the health perceptions of lay people are important to the process, particularly since health concepts have been shown to vary depending on

the socio-economic position of the lay person (D'Houtard & Field, 1984) as well as between health professionals and lay people (Idler, 1982).

One of the earliest studies on health concepts was that of Spring Rice (1981) who investigated the health of working class married women in the 1930's in Britain. In her study she found that for many of the women, health was the interval between illnesses, or at the best, the absence of any incapacitating ailment. As long as they were able to continue to perform the tasks expected of them they considered themselves to be healthy. Although Spring Rice related her ideas of health to social position, she did not compare social groups.

In his sociological study into the commonly held beliefs and practices about health by members of all socio-economic levels in an American community, Koos (1954) found that adults of higher SES were more able to conceive of health as the absence of disease to a greater degree than adults of lower SES.

Interested in health and illness concepts in terms of Durkheim's social representations, Herzlich (1973) asked middle and intellectual class members in Paris how they thought about health and illness. She distinguished three ways in which lay people conceptualize health - as not-illness, as a reserve of strength, and as equilibrium. Although looking at differences within society in the emotional and behavioural implications of health concepts for different social classes, Herzlich's study does not consider the lower socio-economic groups.

After comparing his findings among Scottish people of all socio-economic groups with Herzlich's (1973) middle class French population, Williams (1983) suggested that there are similarities in the ways people conceive of health, across cultures and societies. Like Herzlich, he found three lay dimensions of health - health as a dimension of strength, weakness and exhaustion; health as the relative absence of disease; and health as functional fitness. However, he also found some cultural differences on the criteria for active participation in social life, expressed in the notion of health as equilibrium in France, and in Scotland, as fitness for normal obligation.

Inspired by Herzlich's study, D'Houtard and Field (1986) asked participants to indicate the extent to which they saw health in terms of 18 different factors ranging from good living and working conditions to not being sick. In their results, they found that the economically least well off manual workers perceived health more as a matter of luck whereas those more socially advantaged saw health depending on social environment.

Using an ethnographic approach, Cornwall (1984) talked to working class people about their perceptions of health. Substantiated by the discussions about health that took place in her interviews, Cornwall found that people's accounts of their health were grounded in their way of life which was structured by their social and economic circumstances. Like Williams' (1983) and Blaxter and Patterson's (1982) studies on lay concepts of health, Cornwall's subjects had difficulty in defining what they meant by health. In describing their health, her subjects not only held both public and private accounts of their health but also switched between commonsense concepts of health and medical concepts depending upon whom they were talking to and in what context. In their public accounts of health, her subjects' health actually bore no relation to their medical histories, for example, when one woman was asked about her health, she claimed to have never "been ill in her life" (p. 140) although it later emerged that she had had a number of acute illnesses over the past 10 years. On confrontation, the woman explained that she did not wish to be seen as someone with poor health, or mistaken as a "moaner". Cornwall also found that people did not see health as the absence of disease, rather, embedded in their accounts of health were the concepts of coping, of functional ability, and capacity to work.

Based on the suggestion that socially disadvantaged groups may be more likely to define health in a negative sense and in terms of the absence of illness which disrupts practical and necessary activities, Calnan and Johnson (1985) examined the health concepts of both professional and working class women. Supporting Blaxter and Paterson's (1982) assertion that adverse social and material circumstances lead people to use more functional definitions of health, Calnan and Johnson found that concepts of health varied by social class. When asked "What is health?", working

class women more frequently used a uni-dimensional definition, for example, getting through the day, whereas their professional counterparts used a multi-dimensional definition which involved a wider range of elements such as the absence of illness, being fit, and being active.

Stacey (1989) provides some evidence which suggests that working class groups and disadvantaged groups are more likely to define health in a negative way, such as the absence of illness, more than their middle class counterparts. That these groups held more negative concepts of health was seen to be, by Stacey, the result of the higher prevalence of ill health they experienced, in contrast to the middle class group, with the consequence that decisions to carry out preventive health behaviours were influenced by the negative concepts.

Although focusing on illness concepts rather than health concepts, Blair (1993) used a qualitative approach to investigate the ways in which people from different backgrounds communicate the meaning of the distress and suffering they experience. Using Bernstein's (1964, 1974 cited in Blair, 1993) thesis of a differential use of language associated with social class as the basis for his studies, Blair found interesting differences in how middle class and working class people conceptualize suffering. For the working class respondents, distress was more heavily emphasized in physicalistic terms, whereas the middle class, significantly more verbal in describing their and others distress experiences, used more mentalistic terms. The middle class respondents tended also to attribute more personal control over the course of distress than the working class respondents who had feelings of low personal control. Accordingly, the implications resulting from these different ways in which people from differing social backgrounds view illness extend into many areas such as the take-up, allocation and efficacy of treatment for distress, individual responsibility, and the allocation of mental health services.

From these studies, it is evident that people not only report multiple meanings of health but emphasise various aspects of health. While there may be diversities as well as similarities among social groups regarding health, it is obvious that health is a multifaceted phenomena that means

different things to different people. Although the studies address the issue of how concepts vary within and between societies, health is only describable by the person who is living it. Influenced by social (Herzlich, 1973) and environmental (Anderson, 1984) mechanisms, health is a continuously changing process in which the lay person participates and is involved in on a personal level regardless of socio-economic position. According to Townsend, Davidson and Whitehead (1988) "...any satisfactory explanation (of health) must build essentially on the ideas of the cumulative dispositions and experiences of the lifetime and multiple causation" (p104).

The widespread quantitative focus on socio-economic inequalities in health and paucity of literature on health as it is conceptualized and experienced in the context of everyday life has left a gap in our knowledge and understanding of SES influences on health. Although many quantitative accounts describe SES differences in health and the explanations as to why they exist, more qualitative studies are needed to reveal the personal experiences and perceptions of people of differing socio-economic status, in order to help in understanding the effect of these differences on their lives and how best they can be minimized.

In attending to the experience of health, the individual and the health professional do so from within the context of different worlds, each providing its own horizon of meaning (Husserl, 1973). As a result, a decisive gap exists between the individual's experience of health in everyday life and the way in which it is thought about by policy makers and health professionals in terms of maintenance, prevention, adherence, and promotion.

By disclosing the way in which the individual actively constitutes the meaning of his/her health experience, an expanded paradigm of health is provided, enabling the gap between the individual's world and the health professional's world to narrow, as well as incorporate an understanding of health-as-lived.

By uncovering the meaning of health as it is experienced in everyday life, it becomes a synthesis of values, a way of living, and not an entity that can be qualified by social class deprivation.

Hence, it is evident that research is required to explore the health perceptions of members of different socio-economic status.

I. iii. Purpose and Aims of the Research

To appreciate the nature of health, we must start with an understanding of the nature of consciousness, not with an awareness of how the body feels.....it is in consciousness, not sensation, that health begins. (R.Lleichtman, in Shealy & Myss, 1993, p. 67).

The purpose of this study was to explore and describe the meanings that people from two different socio-economic groups (high and low) ascribe to their lived experience of health, and to identify differences, if any, in health perception related to their socio-economic status.

Specific aims of the study were to seek answers to the following questions:

1. How do people of different socio-economic status perceive the phenomena of health and how do they experience health in their everyday lives?
2. What are the differences, if any, in the meaning and experience of health for people from the two socio-economic groups?

In deciding to carry out this research, these three factors were of consideration:

1. The convincing evidence of a widening of health inequalities between socio-economic groups, the need to reduce these health inequities, and the need to promote self-care individual responsibility for health maintenance (Townsend, Davidson & Whitehead, 1988; Boddy & Rice, 1992).

2. The increasing effects of poverty on health (Waldegrave & Coventry, 1987; Howe, 1972; Wilkinson, 1986; Pearce & Davis, 1983; Reinken, McLeod & Murphy, 1985).

3. The concept of health is central to health psychology, yet psychologists have limited empirical knowledge of the meaning of health to people of different socio-economic backgrounds.

In view of these three factors, seeking answers about the health meanings and experiences of people of different socio-economic backgrounds will expand existing knowledge on social differences in health, stimulate comparative studies related to the health of people of diverse social groups, and assist in the provision of socially relevant health care.

I. iv. Research Approach

Health is a highly individual perception. (Kozier & Erb, 1987, p. 50).

To investigate the member's, of two different socio-economic groups, perceptions and experiences of the phenomenon of health, a qualitative research method was used. Qualitative research methods are systematic modes of inquiry oriented toward understanding humans in ways which acknowledge holistically the nature of their interactions with themselves and with their surroundings (Benoliel, 1984).

Often inductive in approach, qualitative methods focus on the perspectives of the participants in their own settings. Using such an approach, the researcher attempts to understand the participants' reality within whatever context it arises (Field & Morse, 1985). Whilst acknowledging that each participant is a complex whole, interacting in a background of further complexities, the participants are viewed as authors of their own experiences, creators of themselves by their existential choices, and definers of their own reality (Oiler, 1982).

This perspective helps to make explicit the complexity of human experience and avoids a reductionist approach through recognizing that "individuals are not always reducible and measurable objects that exist independently of their historical, social and cultural contexts" (Duffy, 1987).

In order to uncover the meanings the experiences held for the participants, the qualitative research methodology of phenomenology was chosen. Not only a method, but also a philosophy and a perspective, phenomenology had its origins in the works of philosophers such as Husserl (1973), Heidegger (1962), Merleau-Ponty (1974) and Psathas (1973).

Introduced by Husserl (1973) as an alternative to the analytical-empiricism approach to research, phenomenology is an inductive, descriptive methodology which acknowledges and values the meaning people

ascribe to their own existence, essentially, it is the study of lived experience, the goal of which is to describe human experience as it is lived (Merleau-Ponty, 1974).

To gain an understanding of the subjective meaning of human experience from the individual's perspective, the researcher needs to approach the phenomenon exactly as it reveals itself to the experiencing subject, in all its concreteness and particularity, without any preconceived definitions, conceptual frameworks, or expectations (Giorgi, 1985).

To achieve the aims of phenomenological research, the researcher needs to expose her presuppositions, making them appear, so that they can be abstained from. This process of reduction, known as bracketing, is a matter of peeling away the layers of interpretation so that the phenomenon can be seen as it is, not as it is reflected through preconceptions (Merleau-Ponty, 1974). It is important that the researcher sees the experience as a phenomenon in its own right with its own meaning and structure, and not as an example of a particular theoretical perspective.

Within the phenomenological movement there are many interpretations and modifications, developed as a consequence of diverse views on epistemological and ontological questions. To give a "fuller and deeper grasp of the phenomena" (p.19) Spiegelberg (1970) has identified the processes common to most modifications of the methodology. Included in these processes are the operations of bracketing (setting aside personal and theoretical assumptions of the phenomenon and no imposition of prior knowledge on the emerging data), intuiting (grasping the particular uniqueness of the phenomenon), describing (explicating the phenomenon through use of metaphor and negation to see the uniqueness of the phenomenon), and analysing (investigating the elements and inter-relationships of the intuited phenomenon) (Munhall, 1994). As a viable and a valuable qualitative methodology, phenomenology seeks to understand the subjective meaning of human experience rather than control and predict behaviour as emphasized in experimental methods (Keen, 1975).

As one of the various phenomenological methodologies implemented in the social sciences, the descriptive approach of Giorgi (1975b, 1985) was adapted for use in this research, in combination with the procedure outlined by Colaizzi (1978) and guidelines from Hycner (1985). Giorgi's phenomenological method was selected for this study because it upholds the meaning of the phenomenon under study within the context of each participant's experience. Consideration was also given to such criteria as the descriptive nature of the method, the Husserlian philosophical underpinnings, the data analysis, and Giorgi's stance on reliability and validity. Although not purported by Giorgi, the additional step of validating the emerging themes with selected participants was later included as a measure of how well the participant's experience of health was captured and communicated, based on Colaizzi's procedure for phenomenological analysis.

Although largely interpretive, Giorgi's application of the method is systematic and strives to be faithful to the phenomenon as a whole and to preserve the integrity of the whole person. Although implied in phenomenological methodology the issues of validity and reliability are not addressed directly in the literature. The validity of the question posed to the participants depends on the extent to which they explore their experiences apart from their theoretical knowledge related to the subject (Colaizzi, 1978).

Giorgi's method recognises that all phenomenological research starts with a naive description of the experience under study. It is by being open to a phenomena in this way, without any particular theoretical framework at the outset, that it is possible to gain an understanding of the meaning of an experience from the individual's perspective. Within the qualitative framework, the subjective experience of the participant is valued and described. Through analysis of the participant's description the meaning of the experienced phenomenon is uncovered and described as it is consciously experienced allowing insight into the participant's world without theories about causes, preconceptions, and presuppositions (Spiegelberg, 1975).

Anyone who has lived the experience is a valid participant. Data are gathered in lengthy interviews, and because of the data to be analyzed, sample sizes are usually small. For Giorgi, the primary difference in the differing phenomenological methods is in the data analysis.

As the phenomenological approach demands an understanding of the meaning of the participants' experiences from their perspective, data obtained from them can be considered as having face and content validity if the participants have had experience with the subject matter and are able to communicate their experiences (Colaizzi, 1978).

Validity is also achieved through clarification from the participants in comparing the descriptive results with their experience as lived and recognising them as being true. From Giorgi's (1988) perspective, the use of participants as validation or the use of judges to review the analyses is not necessary. For Giorgi (1988), validity has been achieved if the essential description of the phenomenon under study truly captures the intuited essence. Unlike other phenomenologists, no additional judges are required, as a result of the use of phenomenological reduction. Instead every reader of the research study becomes a critical evaluator of the researcher's essential intuition.

According to Giorgi (1988), reliability is attended to when consistency is maintained throughout the entire data gathering process and all precautions, such as reduction, have been taken to arrive at an accurate description.

In summarising his stance on validity, Giorgi (1989) states:

".....a temporally unfolding process that possesses a certain quality that happens to an individual. The theory is that if it can happen to one individual, it certainly must be able to take place in another and so each reader is invited to participate in the process. This strategy is in stark contrast to the empirical strategy of using judges whereby no one can articulate how any one of the judges, or the researcher, his or herself, has arrived at the facts they did. In addition, there is the possibility that while all may agree, they could all be wrong in the same way. Thus, the phenomenological approach stresses the objective identity achievements constituted by the subjectivity of the researcher within the reduction which can be descriptively

expressed. The use of the reduction which one arrives at the beginning of the analysis and the unfolding nature of the process of achieving identity reflect the holistic approach of phenomenology as opposed to the more linear strictly empirical process." (p. 84).

In summary, the phenomenological approach merits attention as an appropriate method for health research because it embraces a holistic approach to people interacting in their worlds, provides a means to reflect the everyday realities as they live their day-to-day lives, and enables a deeper understanding of the phenomenon being studied.

II. METHOD

II. i. Participants

By health I mean the power to lead a full adult, living, breathing life in close contact with what I love.
(K Mansfield, in Tomalin, 1988).

The data for this research derive from interviews conducted in April and May, 1995, with 24 adult residents of Palmerston North. Eligible participants included men and women aged 25 to 65, who were selected by the snowballing procedure (Taylor & Bogdan, 1984).

Initial interviews were conducted with persons who already had a trust relationship with the researcher and at the conclusion of these interviews, participants suggested possible names of friends and relatives who might be interested in participating in the study. Interested persons were contacted and screened for eligibility, and interviews at the person's place of residence, at a convenient time, were arranged. Thus, social networks were followed, rather than selecting a probability sample.

Participants were selected for this study if they met Colaizzi's (1978) criteria of being able to acknowledge that they have the lived experience of a specified phenomenon and of being able to articulate their experience as they live it in their daily life. As the investigation was undertaken to explicate the experience of health from people of two different socio-economic groups, participants were also selected on socio-economic criteria.

Of the 24 interviews, four were excluded from analysis because of mechanical failure with the recording equipment. Of the 20 remaining adults interviewed, 9 met the criteria for inclusion in the high SES group and 11 for the Low SES group.

Participants in the low SES group were employed in a variety of occupations such as shearer, cleaner, gardener's aide, fish process worker, scaffolder, store worker, and truck driver. Participants in the high SES group were engaged in various professional or managerial

occupations such as dentist, psychologist, teacher, computer programmer, mental health worker, and scientist.

The age of 25 - 65 was selected on the basis of an assumption that health is an ongoing process of change, and that perceptions change throughout the life process in both content and philosophy, by a legion of factors including life events, values, and beliefs. Early adulthood is a relatively healthy stage of life, both physically and psychosocially, whereas with old age, the impact of psychosocial risk factors and increasing biological vulnerability on health is greater, thus possibly impinging on perceived health.

Within this age range, an individual is usually established in a work role and is economically active, thus enabling social stratification. By the age 25 - 65, it was believed that the experience of health should be in the participants' consciousness and that they would be able to reflectively describe their perceptions through an awareness of their own being.

It is recognised that a limitation of this research is that although the analysis captures the experience of the participants at the time of their interviews, they have undoubtedly continued to evolve and change since that time. Additionally, the participants represent only European culture.

II. ii. Socio-economic status measurement

The people in a civilized state may be divided into many different orders; but, for the purpose of investigating the manner in which they enjoy or are deprived of the requisites to support the health of their bodies and minds, they need only be divided into two classes, viz the rich and the poor. (Charles Hall, 1805)

In understanding health inequalities, the importance of social stratification has long been recognised and much effort has been directed toward arriving at reliable and valid measures of socio-economic status.

These measures of SES identify groups in the population which differ in their social status, living and working conditions, economic resources, and attitudes and behaviour, and these differences in turn, are associated with differences in health.

As a measure of SES, occupational status is considered to be a powerful single indicator of relative standing (Daniel, 1984; Quine, 1986; Haug, 1977), not only because occupations constitute an important opportunity structure in modern industrial society, but also because occupation is considered to encompass income and education. These, in turn, are conceptualized as allocating persons to different lifestyles and power positions. Information on occupation is also more willingly available than information on income or education.

Although there is some controversy with regard to the use of a single indicator, such as occupation, in social stratification (Illsley & Baker, 1991; Najman, 1988, 1993), an occupational-based measure taking into account education and income, was deemed to be appropriate for use in this research, because of the small sample size and nature of the study.

Using occupational information gained from the demographic information questionnaire and within the interview, socio-economic position was defined as belonging to one of two socio-economic classes, namely high or low, according to occupational social class using the Elley-Irving and the Irving-Elley Scales (Elley & Irving, 1985; Irving & Elley, 1977).

fairly recent New Zealand scales compounded from education and income characteristics of each occupation.

These scales, developed by Elley and Irving, are based on occupations reported in the New Zealand 1971 and 1981 Census. Occupations are ranked on a 6 point scale (1 high status to 6 low status). The higher category of the occupational status index represents professional or managerial and technical workers whilst the lower category represents partly skilled or unskilled workers.

Participants in categories 1 through 3 of the socio-economic status scale were classified as having high socio-economic status and participants assigned low socio-economic status were in categories 4 through 6.

II. iii. Data Gathering

Health is a decidedly dynamic affair for individuals. It is experienced and remembered as a day by day, year to year and life time phenomenon. (L. Verbrugge, 1986, p. 1195).

Data for this project was collected by the researcher through the semi-guided interview technique employing open-ended questions.

Participants were interviewed privately in their own homes or the researcher's home, at a time convenient to the participant.

The prelude to each interview varied in pace with individual participants, but typically involved informal dialogue and refreshments, which helped to establish a trust relationship with the participant. During this time, demographic information was obtained and opportunity for the participant to become accustomed to the interview procedure and tape recorder.

As it was of primary importance to attend to the participant's well being whilst they described their meaning of health, the use of a tape recorder allowed attention to be given unreservedly. Not only did the use of a tape recorder capture the fullness and richness of the participants' experiences, but it also maximized the flow of information and ensured accuracy of the data collected.

Each participant was given an information sheet and was informed of the purpose and the nature of the research, the time commitment, the assurance of privacy and confidentiality, and of their rights according to the standard guidelines for the protection of human subjects (Appendix A), followed by clarification of any concerns or questions the participant might have had involving participation in the project.

After demographic information (Appendix B) and signed informed consent was obtained (Appendix C), the interview proceeded in an informed conversational style following an agenda in varying order, although not

always completing it, depending upon how the participant responded to the opening stages of the interview and where it progressed to.

As the only part of the interview that remained constant for the whole 24 participants, each interview opened with,

"I'm interested in what people think about health. The kinds of things I would like you to talk about from your own experience, and in your own words are: what you think health is, how would you define health, how do you perceive the meaning of health and what is your experience of health. Perhaps to start with, what does being healthy mean to you?"

Included in the agenda were questions related to health management, diet, smoking, awareness of health, and health perceptions, as set out in Appendix D. Although many of these items were raised spontaneously by the participants in the course of talking about their experience of health, probes seeking more information, examples, explanation, or clarification were used as necessary, to explore facets not touched upon or to elaborate upon what was. Many of the participants required little probing and it was usual for them to talk continuously for up to an hour without need of further question.

In encouraging the participants to describe their experience as fully and deeply as possible, the researcher had to set aside her own judgements and preconceptions about health in order to focus on the participants' experience and to avoid suggesting to them what to say. Continuing exploration was often prompted through the use of reflection, by reflective silences, and by repetition of statements.

By being an interested and sensitive listener, maintaining eye contact, an open-face posture, and responding frequently to the verbal narratives with utterances, such as "mm", the researcher conveyed empathy.

As there was no time limit placed on the length of the interview, each interview continued until the participant had nothing more to say about the phenomenon.

The length of interview times were from 20 minutes to 150 minutes with the average being 65 minutes. Time spent before and after each interview for establishing a trust relationship and closure added up to a further 2 hours to the session. After each interview, notes were made regarding the content of the interview. "Memos" (Field & Morse, 1985) were also written about ways of categorizing the data, as well as to act as memory joggers and to record ideas that the researcher had which were also used to help her understand what was meaningful and to make phenomenological transformation.

Following completion of the interviews, all tape recordings were transcribed verbatim, by the researcher, to provide the raw database for the data analysis. Transcriptions were then coded to preserve participant anonymity, if requested, and confidentiality.

The class-based nature of the research was not made explicit to the participants. The word "class" has considerable emotional overtones and highlights very noticeable differences in our society. As social class differentiation not only has implications for material wellbeing but also for peoples' lifestyles, knowledge of classification into either one of two social class categories may have possibly affected the participants' attitudes for participation and responses in the project, hence categorization was made using occupational information gained within the interview and the demographic questionnaire, without the participants' knowledge.

II. iv. Analysis

What is "health"? Is it a commodity to be possessed? A state which enables normal functioning? A reserve of strength? An ability? A resilient spirit? A means, an end or both? Is "health" some combination of these elements? Or is it a word which presents an intractable puzzle, a baffling maze of human creation within which we are destined to stumble forever? (Seedhouse, 1987, p.124).

Data obtained from the transcribed interviews were analyzed by the researcher using a combination of the phenomenological process of analysis described by Giorgi (1975a, 1987, 1985), the procedure outlined by Colaizzi (1978), and guidelines by Hycner (1985).

The individual steps were as follows:

1. During data analysis, the researcher attempted to set aside her preconceptions and presuppositions about the phenomena under investigation and be fully open to the experience as it was presented.
2. Each participant's audiotape was listened to twice to gain familiarity with any expressed or implied meanings, the language used, and to gain a sense of the whole. All non-verbal and para-linguistic levels of communication that had been noted were added to the left margin of the transcribed interviews along with any insights, feelings and observations the researcher had with regard to the interview.
3. Each participant's transcription was then read slowly and reflected upon with intuitive judgement to gain a full awareness of each participant's experience, and to identify the transition units or constituents from significant statements and phrases pertaining to health, which together made up the whole meaning of the experience.

Significant units of general meaning were marked with highlighter pens using a different colour for each emerging

theme, along with a coding system for each participant. For example, if a participant talked about her need to have important social relationships to maintain her health, it was coded under a social category as well as under her SES, and her identifying code letter. Multiple photocopies of the transcriptions were also made to ensure that the context of the coded sections was maintained as well as to keep a reference copy, if the transcription was cut up.

4. All redundancies within the constituents were eliminated, and then the meanings of the remaining constituents, still in the participants' language, were clarified or elaborated by relating them to each other and the whole. In addition, all descriptions not related to the experience of health were eliminated. Constituents of relevant meanings were then written on index cards, noting the code letter of the participant, to produce a visual and interchangeable display and to assist in sequential organisation of each excerpt. Over 200 significant statements were extracted from the transcriptions.

5. The constituents, still in the concrete language of the participants, were then intuited and reflected upon, and the emerging themes or meaning units were determined. Particular attention was paid to the language used and to the explicit and implicit meanings communicated. To help in the interpretation of meaning, the audiotapes were occasionally listened to again. The researcher then, from within a psychological perspective, transformed the constituent statements into a statement that expressed the implicit or the explicit meaning in psychological terms as opposed to the language of the participant. These statements then became part of a file established for each theme.

6. In this stage of the analysis, the transformed statements of each participant that were closely related and which expressed a central idea were grouped together. This grouping was as a result of constantly comparing participant to participant, to the emerging

themes, and to the evolving categories. It became apparent at this step that the themes fell into five broad categories which were labelled the physical dimension, the mental dimension, the emotional dimension, the social dimension, and the spiritual dimension.

7. The aggregated themes were then synthesized into a descriptive structure of the meaning or meanings of the experience of health from the general perspective of all participants. The meaningfulness of the exhaustive description was then reflected on. As a result, four different ways in which the participants' viewed the totality of their health became apparent. These four views, the solitary, the dualistic, the complementary, and the multiple were developed from combinations of the five dimensional categories, and named accordingly. From this, the essential structure of health was identified for both groups, through reduction, to specify the meaning of health.

8. To achieve validation, the researcher returned to selected participants (4) with the exhaustive description to determine that the description accurately captured the essence of their lived experience. An example of one participant's description can be located in the appendix of this report (Appendix E). Participants were asked to read through the descriptive results and indicate their agreement or disagreement with the description and to clarify any misconceptions. Changes were then integrated into the findings (Colaizzi, 1978; Guba & Lincoln, 1981).

9. Upon completion of the study, a letter summarizing the findings of the research was sent to all participants who indicated interest in receiving it (Appendix F).

II. v. Credibility

I can only conceive of health as experience - a result of a nondual interrelationship between consciousness and the physical world. Health is a realization, not an acquisition. (Dossey, 1984, p. 34).

In establishing credibility the following steps were employed:

1. Participants were adequately described.
2. As the goal of phenomenological research is to understand human experience from the individual's perspective, it was essential to select participants who stated that they had the lived experience of health, that the experience was in their consciousness. Each acknowledged that they had the lived experience of health.
3. Interviews were audiotaped and transcribed verbatim to eliminate biases in perception and recollection by the researcher.
4. The researcher attempted to bracket her personal presuppositions and maintain consistency within each interview and throughout the data gathering process.
5. Data analysis methods were thoroughly described.
6. Although Giorgi (1989) does not purport validation, the additional step of validation, that of evaluating the emerging themes with participants, was used. It was decided that this credibility step was consistent with Giorgi's method. Selected participants (4) were requested to review the descriptive results. On reviewing the individual descriptions, the participants agreed that they were accurate profiles of their experience. Some minor adjustments and clarifications were made after discussion. Participants' overall agreement that the findings were valid for them attested to the credibility of the results.
7. Numerous verbatim statements from the participants were included in the findings in order to allow the reader to validate and establish adequacy of the study.

III. FINDINGS

III. Findings

Health has a great deal to do with the quality of our lives. It is an end and a means in the quest for quality, desirable for its own sake, but also essential if people are to live creatively and constructively. Health frees the individual to live up to his potential. (Gardener, 1968, p.55).

In the communicating of the findings, Giorgi (1975) stressed the importance of being faithful to the phenomena. He maintained, however, that this did not mean capturing the totality of the phenomena in every aspect, instead, it was necessary to set limits on the analysis and to make explicit only particular aspects of a more complex reality.

In the present study, the focus was on the meaning of health as it is experienced in the everyday lives of people from two different socio-economic backgrounds, namely high and low.

With respect to this, thirty major health themes representing commonalities related to the participants' health perceptions and experiences emerged from the data. Although similar common themes were found between participants of the two SES groups, some were unique to the high SES group participants. After the themes were identified from the participants' descriptive statements of their experience and perceptions of health, they were found to be concentrated within five principal dimensions of individual health, the physical, the mental, the emotional, the social, and the spiritual. The physical dimension pertained to physical status, the mental dimension was concerned with cognition, and the emotional dimension with feeling. The social dimension incorporated interpersonal relationships and the spiritual dimension encompassed meaning. Table I presents the common themes which emerged from the participants' descriptive statements. These themes are organized into clusters under the dimensions within which they were concentrated.

Table I. Health dimensions and themes formulated from the participants' descriptive expressions.

Health Dimension	Themes
physical	<ul style="list-style-type: none"> -absence of illness/disease -quality/quantity of sleep -physiological functioning -ability to perform daily tasks -levels of fitness/energy -good nutrition -ability to adapt/manage stress -substance abuse
mental	<ul style="list-style-type: none"> -adaptability -cognitive functioning -ability to control emotions/body -intellectual capabilities -ability to learn -meaningfulness
emotional	<ul style="list-style-type: none"> -enjoyment -expression of emotion -self-realization -love -hope -experiencing feelings
social	<ul style="list-style-type: none"> -contribution to society -ability to interact with people -ability to interact with the environment -satisfying interpersonal relationships -ethical responsibility -economic and social autonomy -achieving one's goals
spiritual	<ul style="list-style-type: none"> -belief in a higher power/God -meaning/purpose in life -awareness of mortality

Synthesis and expansion of the common health themes within the framework of the five principal dimensions led to the exhaustive description of the lived experience of health for all of the participants in this study. Within this framework, corresponding illustrative quotations from both the high and the low SES participants were used according to the ways in which the participants described aspects of their health within each

theme and as examples of how health fitted into each dimension. Although there is some SES differentiation in the exhaustive description to illustrate a noticeable difference, SES is not the major focus in this section of the findings.

Revealed from the participants' descriptions of health were the many and varied ways in which health in its totality was regarded in their everyday lives. For example, some participants saw health as being synonymous with physical health whereas others saw health as a composition of two or more dimensions that together created health.

These various ways in which health was viewed led to the development of four distinct perceptions of health: (1) a solitary view of health; (2) a dualistic view of health; (3) a complementary view of health; and (4) a multiple view of health. These four views were derived from the explicit statements of the participants and combinations of the five dimensions.

Presented initially is the exhaustive description of the common dimensions of health with corresponding illustrative quotations followed by a synthesis of each view describing the participants' perceptions of the totality of health, and then the stating of the essential structure of health for both groups.

III. i. The exhaustive description of the lived experience of health

Health can be defined as an active process through which the individual becomes aware of and/or makes choices toward a more successful existence..... and that one's daily life is constantly changing in the reflection of his or her intellectual, emotional, physical, social, occupational and spiritual dimensions. (Hettler, 1980, p. 77).

Physical Dimension

In their perceptions of health, all participants directly related health to the physical body. A number of components were expressed that are essential to health. These included the absence of disease/illness, the ability to perform daily tasks, levels of fitness and energy, abstinence of smoking, moderating levels of alcohol consumption, and satisfaction of basic needs.

In describing their health, all participants reported health problems that they had either experienced in the past or were experiencing at the time of interview. A healthy body was generally taken for granted, particularly by participants of low SES, until it became problematic.

When you're healthy, you're not sick. (Jack, low SES).

Health was considered by all to be the absence of disease, illness or pain, in that if no symptoms of disease, illness or pain were being experienced, then one was healthy.

People who are healthy are physically well. They're not ill. They don't have any problems with their bodies. (Julia, high SES).

This component, the absence of disease, illness or pain, also encompassed medical treatment such as hospitalization and the use of medication.

When I'm not taking any medication for my asthma, I feel a lot better. Taking the medication makes me feel as if there's something wrong with my breathing - even though there is! (Bronwyn, low SES).

Overall, participants from the high SES group experienced better reported health physically than participants from the low SES group. For example, more back problems, obesity, heart problems, asthma and diabetes were reported by low SES participants than by their high SES counterparts.

For most, health as the absence of disease/illness/pain tended to be based on experiences of ill health.

When I'm healthy I have no awareness of my body. (Theo, high SES).

I know when I'm not in good health. I feel it in my body. I don't function as well as when I do when I'm feeling healthy. (Audrey, high SES).

All participants confirmed the meaning of health as performance of daily role activities. The participants described many different vocational, domestic, familial, recreational and other roles. Whether it meant working, caring for the family, helping others, coaching sports, or just getting through the day, the participants agreed that health meant the ability to perform the tasks, activities and duties involved in daily living. Independence, in the sense of being able to do things by oneself for oneself, was stated as being essential in the performance of daily role activities by several high SES participants.

Being healthy is being able to carry out what ever you have to do to get through the day. If you're not healthy you can't do what you've got to do each day. (Julius, low SES).

When you've got a family, you can't get sick. You've got to stay healthy. You've got to get on with it. You have to cope, no one does it for you. (Sheryl, low SES).

If you have something wrong with your health, things go wrong at home, it affects the family. (Sylvia, low SES).

Health is the ability to carry out what you want to do when you want to do it. It's when you're able to get up and go to work and do what you're supposed to do. It's looking after yourself and taking care of yourself. (Malcolm, high SES).

Another component, satisfaction of basic needs, included such needs as good nutrition, adequate sleep, medical attention, cleanliness, adequate housing and warmth. In their descriptions, all the high SES participants suggested that securing these basic needs were necessary to maintain health, whereas only some low SES participants considered them. All participants acknowledged the necessity of good food as a basic requirement of health, expressed as "you are what you eat". Within this component was allowance for a certain quantity of "junk food" despite acknowledgement of its nutritional value. Some low SES participants expressed health exclusively in relation to food with no mention of any

other component. In response to a range of health problems, some participants expressed a growing awareness of the need to improve their diet.

To stay healthy, you've got to eat good food, not crap like greasies full of fat. They're bad for you. I like them though. (Sheryl, low SES).

I eat mainly mutton, for breakfast the standard meal is chops and some fried spuds, dinner is the front leg of the meat and maybe some potatoes, and tea is the back leg of the sheep, with maybe cabbage and potatoes. If you don't eat well, you don't keep up. (Jim, low SES).

I know I'm healthy. I eat good food, I ensure I get the necessary vitamins, and I don't need to diet. (Madeleine, high SES).

You are what you eat. If you eat right you'll stay healthy. (Andrew, low SES).

I think eating lots of processed food clogs your system up. I don't have starch and protein in the same meal. I make my own bread. (Julia, high SES).

Sleep as a constituent of satisfaction of basic needs was referred to by more high than low SES participants. Quality of sleep was deemed as important as quantity of sleep. Some participants remarked that if one slept well then one was healthy, and if one was healthy then one was able to sleep.

If I get some good shut eye, then, hey, I'm going well. (John, low SES).

When you're healthy, you're able to get out of bed, feel like getting out of bed, and get going. (Jack, low SES).

If I don't get enough sleep then my health suffers. (Vicki, high SES).

Only two low SES participants referred to adequate housing, warmth and cleanliness, along with three who reported the necessity of medical attention in maintaining health in comparison to most of the high SES participants who considered these aspects to be important.

You've gotta have a clean warm house, clean clothes, and keep your self clean or things go wrong. Anne (low SES).

I have checkups now after my heart attack. I go to the doctor so I won't have another. Julius (low SES).

Abstinence from tobacco and other addictive substances was connected with health. Some low SES participants used tobacco products with awareness of the detrimental effects of smoking. Marijuana was mentioned twice, with one participant no longer using the substance, and the other no longer smoking but eating it instead, the reason being interference with the bronchial tubes. The sociable nature of smoking was commented upon, less than the stress-relief effects and habituation.

Somebody offers you one in the pub and you just take it. I suppose it's a habit. I don't think about it. Jack (low SES).

I smoke heaps, about two packets a day. I worry about how much I smoke but it relaxes me. It's what I live on. What else have I got? Bronwyn (low SES).

I used to smoke dope (marijuana), but I've done time for selling it, so I don't touch it now. Probably feel better for it I suppose. Martin (low SES).

Equated with health, and one of the most frequently mentioned aspects, was energy and levels of fitness. Various levels of fitness, achieved through different forms of exercise, either work related or recreationally related, were described by the participants as being essential for health. More emphasis was placed on sporting and outdoor activities such as squash, swimming, tennis, and skiing as forms of exercise to maintain fitness levels by the high SES participants in contrast to the low SES participants who related exercise and fitness to the activities involved in performing their everyday domestic and vocational roles. Fitness and energy were more commonly described as requirements for avoiding sickness and getting through the day by the low SES participants whereas the high SES participants viewed energy and fitness as essential for enjoying life and as something that constantly needed to be attended to.

I get enough exercise through shearing. It keeps me bloody fit. I'm a bloody sight fitter than most blokes my age. You know, I wouldn't sort of run around the block, but I do run about a bit chasing the sheep. Jim (low SES).

My health is really bad, I'm not fit, I don't have any energy. I used to get more exercise but I can't afford to go to the gym. Bronwyn (low SES).

I keep healthy through my work, it keeps me fit. The type of work I do - working in a wool store, lifting bales of wool, moving them around on barrows, loading trucks, pressing wool, branding wool, just physical all the time. Gordon (low SES).

I base my health on my energy levels, because when I'm sick I don't have any energy and when I'm feeling really healthy, I have lots of energy. Julia (high SES).

I take a very preventive approach to my health. I tend to all my needs. For my physical health I jog and use weights, go for walks. Physically I'm about as fit as I need to be at the moment but I keep on top of it because I don't get any exercise at work. Ian (high SES).

In summary, health was primarily perceived by all participants to have a physical component. In the low SES participants, the predominant focus was on the body and physical health, whereas in the high SES participants, the emphasis was on the importance of physical health in the context of the other parameters of health.

Mental Dimension

The mental dimension of health was associated with knowing and understanding in contrast to the emotional dimension which related to feeling. Although two separate dimensions, they were often referred to as being one, or closely related.

Participants identified several aspects of this cognitive dimension. These included adaptability, ability to learn, ability to cope/relax, meaning, and a sense of control over the body and emotions. This sense of control also extended to activities and events that could lead to stress.

As an indicator of health, the cognitive dimension was not only described in terms of thinking and knowing but also as having the intellectual capacity and determination to confront any of life's crises and maintain a positive outlook on life. The need for a positive outlook or attitude was frequently mentioned as a pre-requisite for optimum health. A commonly held perception was that a positive attitude would maintain or reinstate health, and without it, one would not have health or be healthy.

When you're ill, it shows in the way you yell at the kids, you've got no patience. Every thing closes in on you, but when you're healthy, you get through the day okay. (Bronwyn, low SES).

Health is a state of mind. It's a positive attitude. When I'm healthy it reflects in my ability to think clearly, it's an awareness of myself, it's being independent. (Malcolm, high SES).

An important aspect of the mental dimension described by some high SES participants was that of having a sense of being in control - a belief that one has choices or is able to exert an effect on one's health. This sense of being in control was gained through making one's own decisions with regard to health matters rather than being the recipient if decisions were made by others. The making of autonomous decisions, especially in people with impaired health, was regarded as being fundamental to one's mental health.

A large part of being mentally healthy is having the ability to cope with the responsibilities of my life, of knowing my limitations, of being in control, choosing for myself, and accepting the challenges that confront me each day. (Jill, high SES).

I'd talk to the doctor but he'd look at me clinically, not mentally. He was hearing me but not listening to me. He wouldn't look further until I finally said "This is not right. I need help. There's still something wrong." I had practised what I was going to say. I just had to get it straight. I had to choose what to say so I told the Doctor, "I want help. I'm not leaving your office until I get help." Then I felt like, oh my God, did I really do that. It was great. It felt great. Talk about euphoria, it was like, yeah, I'm alive, it was sort of at long last I don't feel as if I am a nut case. (Vicki, high SES)

Central to one low SES participant and four high SES participants' mental health, and closely linked to the spiritual dimension, was their involvement in personally meaningful activities and relationships and the pursuit of personally meaningful goals. Although there were substantial differences in what was considered as meaningful in these participants' lives, all were perceived of as having an effect on one's health and wellbeing, self-esteem and life satisfaction. The level of involvement in goal directed instrumental and/or expressive activities was dependent on the level of commitment and emotional investment.

There's no stopping people with a purpose who know where they're going and who they are. They're filled with energy, with too much good health to even slow down. Nothing makes one sicker sooner than feeling useless, unneeded or unchallenged. You need a reason for getting out of bed in the morning, something toward which you are working, a purpose, something to keep you sane. (Jill, high SES).

I suppose what keeps me healthy is being part of a family, being a mother, being needed. (Anne, low SES).

Another essential feature of the mental dimension was the ability and motivation to cope with stress. Participants of both low and high SES described how effective coping contributed to their health by providing ways to deal with both chronic and acute life experiences. Included in the coping process used by these participants in the face of stress were such strategies as drawing on others as a source of support, matching various strategies to the demands of specific situations, and problem

solving strategies. Although the participants described differences in the degree to which they were able to cope with stress, all spoke of their coping skills as being very important to their everyday health.

In terms of being healthy, keeping a sound frame of mind is really important, and that includes making judgements when under pressure, like, if I'm feeling a bit down, I'd be saying "What's happening here?" I'd consciously make some attempt to objectively suss out what's going on, and then rise above it rather than succumb. (Theo, high SES).

Being able to cope with everyday things, not getting stressed out. I've been teaching myself how to relax, you know, relaxing's really good for me. (Martin, low SES).

My health really packed up when she (wife) died. I was so stressed out. I had to learn to cope. (Jack, low SES).

Identified as an important component of one's health, the mental dimension was primarily described in terms of subjective wellbeing. Although not mentioned by four low SES participants, all other participants differed in the degree of importance they attributed to components of this dimension.

For many of the high SES participants, there was a greater focus on protection from stress and involvement in personally meaningful activities in contrast to many of the low SES participants who focused more on cognitive abilities and skills that helped in the coping of their everyday lives.

SES differences between the participants were also more pronounced in the type of stressors reported, partly as a result of the different situations in which they lived and partly because of the ways in which they had available to deal with them.

Emotional Dimension

Differentiated from but also perceived to be an element of the mental dimension by some participants, the emotional dimension of health encompassed the affective processes, the ability to express and experience feelings. The main components which emerged within this

dimension were self-awareness, happiness, hope, love of self and others, and enjoyment. Of these components, happiness was a recurrent theme. Not only was happiness seen as an indicator of health, but it was also seen as an outcome.

If you're healthy you're happy. If you're happy you're healthy. (Bev, high SES).

Health is being happy, having enthusiasm, having a spark. (Vicki, high SES).

If I'm feeling good it's natural to feel healthy. Normally, like if I'm feeling good or happy, I suppose I'm feeling healthy. (Gordon, low SES).

Although often an element of the spiritual dimension, hope was considered a component of the emotional dimension by several of the high SES participants. Defined by these participants as that which enables one to move forward positively in life, hope was perceived to be essential to health. With hope, life became more meaningful and the challenges of life were able to be faced.

I think hope is something that pervades everybody's central being. I don't even know if you can stay physically well if you don't have something to hope for. It's either hope or despair in a sense so hope is important. It includes a sense of optimism, a joy of life, all those things. (Theo, high SES).

When I get sick, I just keep hoping I'll get better. I think it is the hoping that helps me get better. (Sylvia, low SES).

Another affective theme of this dimension was one in which health was experienced as love. A basic emotion involving a personal attachment to another, love for some participants was a necessary part of health, both in loving the self and others and in letting others love them. Without the ability to give and receive love, these participants felt they could not be healthy.

If no one loves you, you think no one wants you. You just curl up and get sick and worry. If you're loved, you get better. I suppose it's being cared for, it helps you stay healthy. (Sheryl, low SES).

I guess it makes a difference if you've got someone who loves you. When you don't have someone there it can affect you're

wellbeing. Not only is it important for your emotional health that someone cares for you, but it affects your physical health. It's just knowing that there's someone who bothers about how you are. (Jill, high SES).

Complementary to the other affective components of the emotional dimension was the theme of enjoyment in which health was experienced as something that is pleasurable. Being in health enables one to enjoy life, to feel good, enthusiastic, energized, and to participate in life.

It's (health) like a fountain bubbling away in me, a feeling of joy, just quietly bubbling away. (Bronwyn, low SES).

Being healthy's like being outside in the sun, just doing things I enjoy. (Gordon, (low SES)).

When you're healthy, you experience things that you don't feel when you're not healthy. It's like being out in the bush, it makes me feel really energized, it's just a totally different world - you feel well within yourself and you get a bit of a buzz, it's hard to describe, to put into words, it's enjoying being alive, I suppose. (Madeleine, high SES).

Generally discussed in terms of the affective processes, the emotional dimension was recognized by all high and about half of the low SES participants to be an important part of one's health. Within this dimension, health was identified as responding to a continuous process of attending to one's emotional needs. Without emotional wellbeing, one could not have health.

Social Dimension

The social dimension of health was concerned with social functioning, the ability to interact with people in a positive way, the ability to have satisfying personal relationships, recognition of oneself as a member of society, and social responsibility. This realm of health also encompassed the vocational aspects of achieving economic autonomy and achievement of one's goals, job satisfaction, and contribution to society.

Reflected in the experiences of the participants was the importance of one's personal relationships, in that the relationships and interactions these participants had with others, had a marked effect on their health. The term relationship encompassed physical, psychological, and emotional closeness and involvement.

Some of the participants had a vast network of community involvement and interactions with family and friends, whilst others had much less. It appeared that the larger the network the greater the health benefits, especially when changes occurred in a participant's life roles.

I guess it all comes down to your family and friends. Just the ongoing relationships are really important for health.
(Julia, high SES).

A sense of being part of a community, a part of a group, being special to some other person. I know that I was never born to be an island. I just wouldn't survive if I was in some isolated lifestyle. I'd take steps to make sure that I wasn't isolated for too long. You need people, it's important to get out, be with people. Social interaction is really important for one's health. (Theo, high SES).

Being a productive member of one's society was portrayed as being healthy socially.

I need to know that I've made a contribution. My relationships revolve around my jobs. I'm there all day for my clients. I need to feel useful. I do little things for them. (Vicki, high SES).

Not having a job is seen as a negative thing in the social context, the stigma of being unemployed, it puts the individual down a few notches in the eyes of many, you're down graded in society. Having a job gives you a sense of purpose, it gives you a sense of direction, it gives you exposure to other people, the whole dynamics of the

community. A job is important for your health. (Theo, high SES).

This dimension, unique to some high SES participants, reflected the importance of interacting with others for one's health. Although overlapping the other dimensions, the focus of the social dimension was on the quality and quantity of relationships, both personal and vocational, community involvement, and sexuality, in contrast to the other dimensions which focused mainly on personal aspects as indicators of health. Social interaction and social support were seen to have a positive effect on health promoting and self-care practices, in that the larger the social network, the greater the health protectiveness.

Spiritual Dimension

The spiritual dimension, as a facet of health, included a belief in some higher power or unifying force, recognition of one's mortality, and the meaning and purpose of one's life. Unique to the high SES participants, the spiritual dimension was seen an integral part of one's health and wellbeing.

Perceived as a unifying force integrating all the other dimensions of health, the spiritual dimension has to do with reviewing and reassessing one's experience, the asking of questions about one's life, and learning and understanding in relation to being in the world.

Spoken about as an awareness of that which is not subject to explanation, the spiritual dimension was identified as transcendence - a sense that life is something more than just living, it is a search for meaning and purpose in life, and is recognizable in every level of health.

A belief or commitment, either to God or some higher power, was perceived to be fundamental to one's health. This belief was portrayed as a strength that helped when difficulties arose in one's life.

It (faith) has every thing to do with your health because it helps you when problems arise. (Madeleine, high SES).

I don't feel alone on this earth, I think that there's a God, and for me, it's important to have interaction with a higher spiritual being, otherwise I don't know what there is to hope for and life doesn't have much meaning. (Theo, high SES).

Health, to me, has to involve spiritual dimensions not only because I believe that spiritual things affect physical and mental health, but because of the soul, the core of our being, the divine element that resides in all human beings. Jesus said, if you rediscover your divine past, then you'll have perfect health. (Ian, high SES).

My greatest source of strength is my belief in God. It has helped me to get through each day especially when my health was poor. (Bev, high SES).

Some of the participants believed that avoiding one's mortality was not healthy. In facing the fact that death is inevitable, one was made healthier in that a true appreciation of life was gained, priorities were reorganized, and a greater degree of spirituality was achieved. Death, as a part of life, was essential to health, and denial of one's death was seen to be denial of an important part of life.

I think in terms of spiritual health. I want to look after my spirit or soul so that when my physical body dies and the other goes on, then I'm prepared. I never used to think about dying but the God I believe in is not a God of punishment and coercion, forcing people by threat of sickness or plague, so there is nothing to fear. (Audrey, high SES).

I used to think I was immortal, untouchable, and wasn't aware of my health, then I nearly died... that was a turning point in the sense that I realized life is very fragile. Now I draw a lot of strength from my relationship with God because what I do is turn to Him when I feel there is a need. I have a greater reliance on God, but that's contingent upon having been through a life crisis. My spirituality evolved from the crisis. It made me aware of how important it is to maintain my health. (Theo, high SES).

Another component of the spiritual dimension had to do with what one saw as meaningful and purposeful in life. Considered part of this aspect was an awareness of loving oneself and others, of being loved, of being happy in life, integrity, trust, and the morals by which one lives.

I guess Pope John's a good example of what I mean. Even though he was dying of cancer, he was healthy. He'd done his time in earth. He was charismatic in the sense he'd affected lots of people, he had so much to give, the meaning and

purpose of his life was immense. He died in a healthy way because of that even though he had to go through the disease process. (Ian, high SES).

My religion guides me in finding meaning in my life. I thank God for my health. By being able to appreciate people and be open to them I have enhanced the meaning in my life, I can reflect on the meaningfulness of life. (Jill, high SES).

Thought of as the central core around which the other dimensions were grounded, the spiritual dimension was seen to play an important role in determining the health of several of the high SES participants. Although somewhat different from the other dimensions in that it transcended the participant, it had the capacity to be a common bond. Based upon individual experiences and perceptions, this health dimension considered the participants' relationships with a higher power/God, recognition of one's mortality, a reviewing and a reassessment of one's experience, what one identified as meaningful in life, the principles which governed one's conduct, and the desire to live a healthy life.

In summary, the health experiences of the participants were organized into five separate yet inter-related dimensions, the physical, the mental, the emotional, the social, and the spiritual. Composed of many elements, these five dimensions revealed the varied ways in which health was viewed in its totality by the participants. On reflection of these variations, and through intermixing of the dimensions, four different views of the totality of health became apparent, these of which are described in the following section.

III. ii. The Totality of Health

Health is an expression of each person functioning as an integrated whole, a totality of body, mind and spirit. (Cmich, 1984, p. 31).

Derived from the inter-mixing of the five dimensions constituting the experience of health, and from the participants' explicit statements that were fundamental to their health experience, were four distinct views of the totality of health as experienced by the participants. These four views, a solitary view, a dualistic view, a complementary view, and a multiple view, are each described separately.

A Solitary View of Health

A solitary perception of health citing only physical indicators was described by four participants, all of low SES. Within this view, there were differences in the degree to which each of these participants considered the various components of the physical dimension necessary for health and as indicators of health.

Of these, the most accentuated measure of health was dietary, what one ate and the amount one ate.

Health is having a healthy diet, meat, vegetables and that sort of thing. As I've got older I eat better things cos when I was younger, I just used to eat pies and this and that and wasn't very healthy. Occasionally I have pies and things but not as much as I used to because I want to be healthy. (Andrew, low SES).

Regarded as the next most significant measure was the amount of energy one had available to do what one needed to do each day.

I know I'm healthy becous I've got energy to do things, now that I'm eating vegetables and stuff like that, I have heaps more energy. You've gotta eat good food to work up a good sweat, if you're not eating good food, you're not healthy. (Julius, low SES).

Although the physical dimension consisted of many components, there were differences in which ones the participants considered both necessary for

health and as indicators of health. For these participants primarily focused on health in relation to physical properties, health was experienced as a state of body, and perceived only in terms of the physical dimension. However, the underlying assumptions of these participants were that the state of their health was a consequence of their lifestyles. Because of their position in the economic class structure, they believed that their chances to remain healthy were not as equitable as those in better economic positions in that they were less able to buy the nutrition necessary for good health or afford health care.

I know a lot of it's got to do with money. I've got diabetes, but it costs so much for all the things, It's either go to the doctor or spend the money on food. I've got kids to feed and I can't feed them properly now that they're teenagers, and I can't afford to send them to the doctor when things go wrong because they don't eat properly. (Bronwyn, low SES).

Although some self-responsibility toward maintaining their health was acknowledged, these participants believed that good health was their right as a tax payer and should not be based on their ability to pay for it.

I think the government should make sure we've got enough food to stay healthy. If we don't earn enough, it's up to them. What do we pay taxes for otherwise? (Jack, low SES).

Three of these low SES participants stated that they lacked the education to identify and deal with symptoms that could lead to major health problems, that they hesitated to seek health care because of lack of experience in dealing with health professionals and that the stigma of being poorer prevented them from returning for treatment.

You know how it is, those bloody doctors and their big words. That's enough to scare the shit out of anyone. I don't know what the hell they're talking about. I didn't have no bloody education like them. Why should I take the stuff they give me when I don't know what the hell they're talking about. (Jim, low SES).

Within this solitary view of health, the participants focused only on aspects of the physical dimension as indicators of health.

A Dualistic View of Health

Five low and one high SES participants ascribed to a dualistic view of health in which the physical dimension and the mental/emotional dimension of health were regarded as two separate realities which were parallel to each other but without either influencing the other in any way.

Based largely on a biomedical model in which the individual is divided into various parts, health for these participants was determined by the level of functioning in each dimension separately. Within this framework, one, at any point in life, could be healthy or unhealthy in either one or both dimensions.

You've got to be healthy in your body and in your mind, I guess physical health is more important than mental health. Luckily I have both, unlike my friend I told you about, she was relatively healthy but she didn't have a healthy attitude. Bev (high SES).

There's two ways to look at it (health) - there's your mental health and your physical health. Physically I'm not that healthy but I suppose I'm mentally healthy. I haven't cracked up or anything. Jack (low SES).

Primarily perceived in a dualistic way, these participants' idea of health encompassed concepts in two dimensions. Health could consist of either physical or emotional properties. Although primarily focused on health in a mind-body dualistic way, what is not known is if these participants' view of health would change if and when they experienced ill health.

A Complementary View of Health

Explicitly stated by one low and three high SES participants was a view of health as a complementary reality. Spoken of in terms of a connection between the body and the mind, the physical and the mental/emotional dimensions of health were seen as interacting and interdependent.

For these participants, this connection was experienced as balance. When one was not in health, the mind and the body were perceived as being out

of balance, or going in different directions. The interaction between these two dimensions varied depending upon the participants' state of health, their health experiences, and their health beliefs. It was believed that either the mind or the body could increase or decrease its functioning at different times, depending on life events, and which accordingly affected the balance of health. Whatever way the pendulum swung, from health to unhealth, these two dimensions were synchronous.

Whether it was stated that physical health was essential for mental/emotional health or that physical health was not possible without mental/emotional health, there was agreement that health was influenced by demands to either dimension. The interaction between these two dimensions varied depending on the participants' experiences and beliefs. Whether it was stated that physical health was essential for mental/emotional health or that physical health was not possible without mental/emotional health, there was agreement that health was influenced by any demands to either dimension.

With respect to this, the mind could be in a state of readiness to do things before the body was physically able to collaborate, or the body could be in fine functioning form but the mind not in a state to cooperate. Discussed in a synchronous way, this view of health focused on both the physical and the mental/emotional dimensions of health separately as well as on the interdependence and interaction of them together.

I guess it's (health) a combination of the physical and emotional parts of a person. They really go hand in hand, if one's no good then the other's not either. If something had to be wrong, I'd rather it be physical than emotional because I'd still get by. If I wasn't emotionally okay, I probably wouldn't be physically okay either. (Madeleine, high SES).

If your mental health is good, then your physical health is good as well. If your mental health goes, then physical health goes. You know, healthy mind, healthy body! (Martin, low SES).

A Multiple View of Health

Five high SES participants described a multiple perception of health. For these participants, the phenomenon of health was conceptualized in a holistic fashion - an integration of the physical, psychological, social, and spiritual dimensions into a meaningful whole.

Within this meaningful whole, there were no clear boundaries between the dimensions, rather, considerable overlap. Although overlapping, all dimensions were considered essential constituents of health. Different values were placed on each of these dimensions contingent upon what was occurring in the participants' life. If one dimension was affected, or more emphasis placed upon one, all dimensions were affected. For example, if one's focus was on the physical dimension as a result of physical injury, then the participant had to work on incorporating this experience into his/her total health experience and learn how to function with the physical restriction. The return to health after such an event was seen as regaining an integration of all the dimensions, an achieving of balance, a putting together of the parts that together make up the totality of health. When this balance in integration was achieved, good health was experienced.

It's (health) to do with balance. Being healthy is sort of a balance between physical and mental health, not just those, but also my emotional and spiritual health, yeah, kind of everything. If things got out of balance I would know it. Yeah, health is having a good balance of things, finding the balance of things, but it's, you know, constantly shifting. I guess everything is connected, they're all tied in with each other. (Vicki, high SES).

Health is a global thing, it's all embracing, which is why the word holistic creeps in. Health involves my attitude to my work, the way I do my work, it involves my attitudes to people, it involves spiritual dimensions, not just my body and my mind. It's not whether I've got warts on my bum or rotten teeth or something like that you know, health for me

is all the things psychologists worry about, all the things sociologists worry about, all the things that doctors worry about and all the things that the Pope worries about. Health is central, it's basic, it's the ground upon which I walk. It's every thing. (Ian, high SES).

Health to these participants was far more than just physical capacities and mental/emotional functioning. In living and maintaining their health, the social and spiritual dimensions were also considered essential. Health for these participants was viewed as a positive state of functioning, influenced by other people, and by one's social, economic, and physical surroundings - the total community. Embodied within this view was the central principle that the development and maintenance of health was the individual responsibility of the participant, not the health care system or society. In sum, health for these five high SES participants was viewed as a mind-body-spirit concept, interacting in a synergistic way.

In essence, these four views of health reflect that health is not a simple phenomenon, that there are a myriad of ways in which it is viewed. In visualizing the health phenomenon, two concentric circles epitomized the participants' perceptions of the totality of health, and the way in which the dimensions were located within each view: the inner circle showing the dimensions, and their continuity, and the second circle, the views within which the dimensions were contained (Figure I).

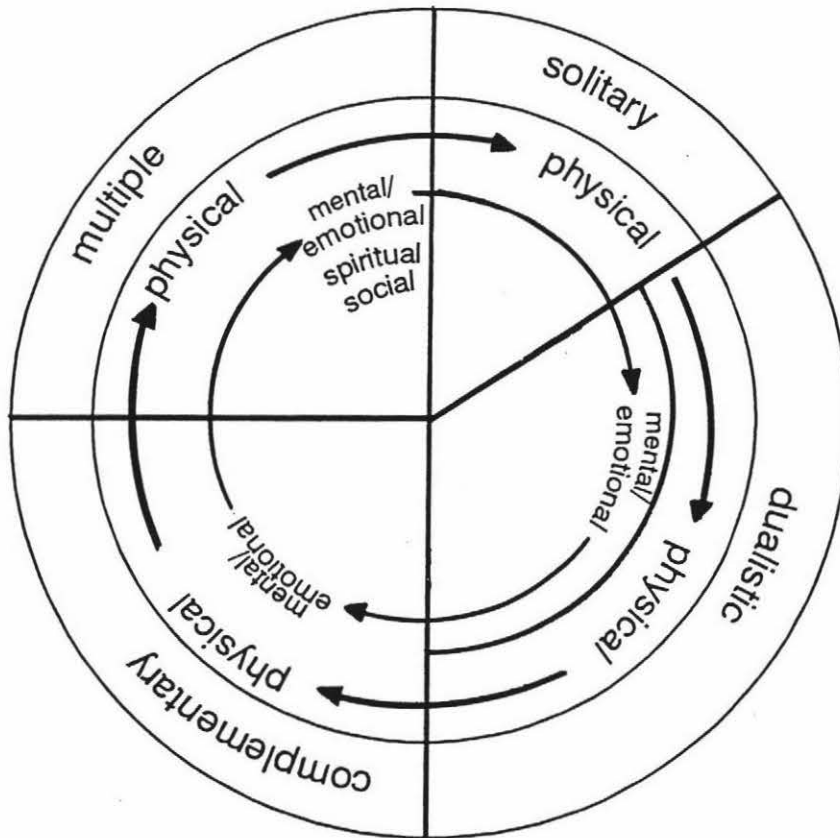


Figure I. Comprehensive view of the totality of health by health dimension.

In examining the ways in which the dimensions were located within the four views, SES differences were noted. Although all participants reported components of either the mental/emotional and/or the physical dimensions of health in their descriptions of the totality of health, only high SES participants reported components of the social and spiritual dimensions. A solitary view of health citing components of the physical dimension exclusively was unique to low SES participants in contrast to a multiple view of health, incorporating components of all five dimensions, which was unique to high SES participants. A complementary view of health was emphasized more by participants of high SES than participants of low SES, whereas the reverse was applicable for a dualistic view of health. These SES differences are represented in Figure II.

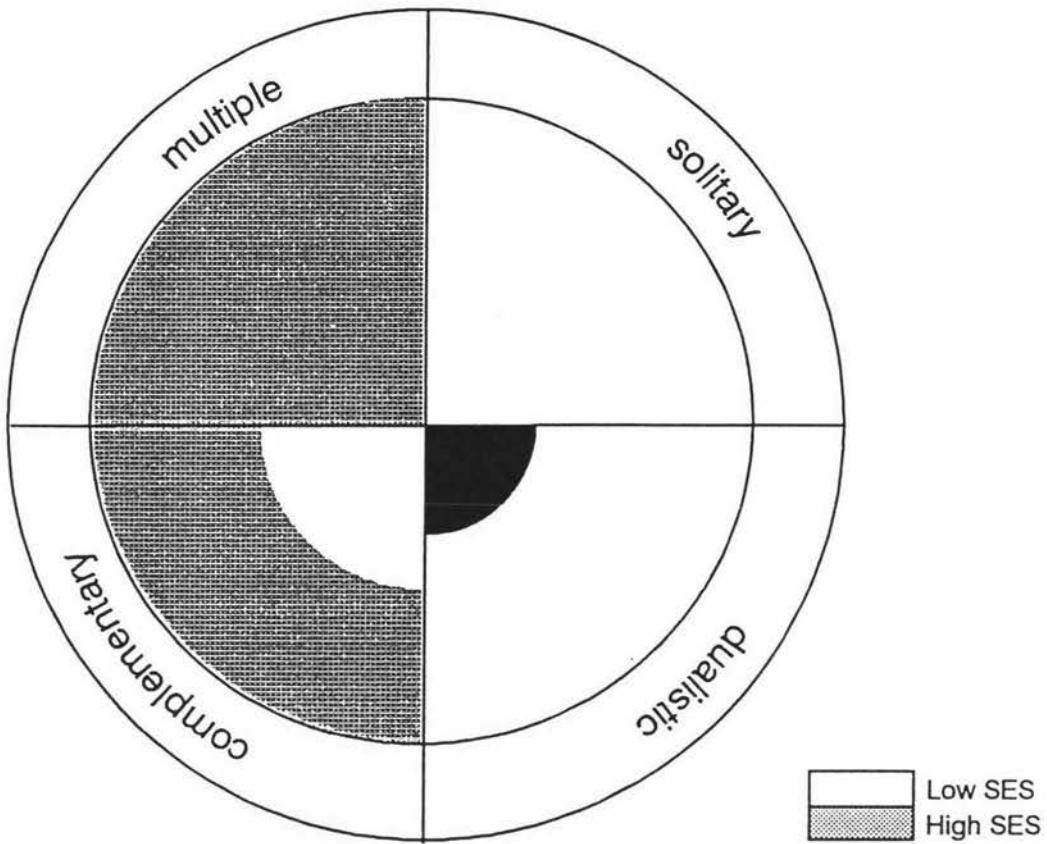


Figure II. Comprehensive view of the totality of health by socio-economic status.

In noting that there were differences in the ways in which the totality of health was viewed and that within these views there were SES differences, the importance of seeking answers about the health meanings and experiences of people of different SES backgrounds was confirmed. At this stage of analysis, synthesis and integration of the four views led to the essential structure of health for both the low and the high SES participants.

III. iii. The Essential Structure of Health

The term healthy can be defined in two ways. Firstly, from the standpoint of functioning society, one can call a person healthy if he is able to fulfil the social role he is to take in that given society - if he is able to participate in the reproduction of society. Secondly (or alternatively), from the standpoint of the individual, we look upon health as the optimum of growth and happiness of the individual. (E. Fromm, cited in Lewis, 1953, p. 110).

For the essential structure of health, the insights gained from all stages of analysis were synthesized and integrated into a total description of the meaning and experience of health for the participants of both SES groups. This description, the final point in the phenomenological approach is for sharing with other researchers for critique, or for health professionals for the planning and implementation of health care.

Health as it is experienced in the everyday lives of the participants was a dynamic, multidimensional state or process concerning the whole of the person in interaction with the environment - dynamic because of its ever changing nature and multidimensional because it encompassed one or more of the overlapping dimensions that synergistically interact to compose the totality of health.

Participants lower on the SES hierarchy with fewer social and economic resources were more likely to hold health perceptions that reflected their environmental, material, and social circumstances. For these participants, the meaning and experience of health was described as a state that enabled ordinary social functioning and performance of the daily role activities that society expects. This state of health incorporated not only the self but also one's family, work, and society.

Emphasized in the context of one's material and social circumstances and one's living conditions, health was more of a social than personal matter. Health was having the ability to realize options and work within the constraints and reserves of one's environmental, educational, and economical position. An insufficient income to meet more than basic

needs had a marked effect on the health behaviours and perspectives of most of these participants - for example, seeking medical care, participating in health promotion activities, living in more impoverished conditions, and often having an inappropriate diet. Income was also related to education in that financial restraints limited access to higher education. The educational achievements and aspirations of these participants had important effects on their health perceptions and health status. Connected to education was the perception of personal control. Some of these participants had a limited sense of personal control with the belief that luck rather than effort, planning, and self-responsibility led to the attainment of health. The observation that a few of the low SES participants had a low income because their health was poor was also made, in that they were unable to work at regular jobs because of such diseases as asthma and hypertension. With regard to this, there was no indication based on demographic information gained from the interview that their status on the socio-economic hierarchy had changed as a consequence of their health, in fact, they saw their poor health as a product of their low SES.

For the low SES participants, health was a way of life, a way of coping, a way of making it through the day, whether one was healthy or not and whether one felt like it or not. Health was a way of accepting and of being.

For the high SES participants, health was described as an awareness of a process that enabled one to perform activities of daily life with usefulness, enjoyment, and satisfaction. Accentuated in the framework of holism, health was an ever evolving and changing process in which one was individually responsible in a personal way. Health was a central point of life, an awareness, it was being able to interact with others, transcend worries, and be in control.

For these participants, health was having a balance in their lives, of being productive, of having energy, not only to get through the day, but to enjoy both work and leisure. It was having the knowledge and education to access and use the health care available along with the opportunity to realize optimal healthfulness.

High SES participants with more education and income held more positive and expansive health perceptions, were more motivated, and behaved in healthier ways. A greater income enabled these participants to implement the knowledge gained from their higher education to acquire and act more readily on information regarding health, to have greater opportunities to influence the events that affected their health, to have better access to preventive health services, to practice positive health behaviours, and to make lifestyle choices that were relevant to their health.

For many of the high SES participants, education was seen to facilitate the acquisition of the social, economic, and psychological skills and assets that provided protection from adverse physical and social influences with regard to their health. Different patterns influenced by income were also observed, in that some of the high SES participants described changed consumption patterns, occupations, and lifestyles. As their incomes rose, some chose more adverse diets, less exercise, more sedentary occupations, and more stress. Also, in order to obtain higher income, one participant selected an occupation with a higher risk of accident and more stress.

Overall, health for the high SES participants was personal, empowerment, personal control, and mastery over being.

IV. DISCUSSION

IV. Discussion

There is nothing alive which is not individual; our health is ours; our reactions are ours - no less than our minds and our faces. Our health, diseases, and reactions can not be understood in vitro, in themselves, they can only be understood in reference to us, as expressions of our nature, our living, our being here (da sein) in the world. (Sacks, 1982).

The aim of this study using the phenomenological method was an attempt to discover how the phenomenon of health was perceived and to determine variations in the meaning of health between participants living in contrasting socio-economic circumstances. What this study has demonstrated is the diversity of health perceptions and meanings reported by the participants.

The findings reveal that the overall perception of health did vary across participants and socio-economic status. Although four different perceptions expressing the totality of health were developed from combinations of the physical, mental, emotional, social and spiritual dimensions, not all participants described the same aspects of health. Most of the participants perceived health as a multidimensional and comprehensive concept, however, each participant's viewpoint of health differed in that each participant's experience of health reflected differing degrees of specificity, centrality, values, education, and other influences, as illustrated in the findings.

However, several interesting SES differences were found in the study. First, the low SES and the high SES participants tended to perceive health in somewhat different manners. The low SES participants emphasized health more as a solitary or a dualistic construct in which neither the social nor the spiritual dimensions were present. The high SES participants, in contrast, emphasized health more as a complementary or a multiple construct in which all the health dimensions interacted to contribute to the phenomenon of health in its totality. This finding, that health perceptions did vary depending on the socio-economic position of the participant, is congruent with much of the existing literature on SES and health conceptualizations (D'Houtard & Field, 1984, 1986; Spring-

Rice, 1981; Herzlich, 1973; Williams, 1983; Calnan & Johnson, 1985; Stacey, 1989; Cornwall, 1984).

Second, the low SES participants were more externally oriented in their perceptions and experiences of health than the high SES participants. The low SES participants tended to attribute control over their health more to external factors - other people, luck, society, and the health care system, whereas the high SES participants tended to hold more of a personal orientation in that they believed that one controlled and was responsible for one's health personally. This finding corroborates that of D'Houtard and Field (1986) who found that those who were socially disadvantaged were more likely to hold the view that health and its absence were a matter of luck, than those more socially advantaged.

Linked to the participants' attributions of control over their health was the social environment in which they lived. Factors such as social isolation and social support, both in the participants' families and communities, were seen to influence their health perceptions and experiences. More high SES participants than low SES participants mentioned the family and friends as important to their health. As an instrument of socialization, family and friends transmit many of society's beliefs and values with regard to health, and provide the social support that may help reduce stress and facilitate health enhancing behaviours. According to Berkman and Breslow (1983) people who have social support are healthier than those who do not.

Third, SES differentials in the language used by the participants in describing their health perceptions and experiences were noted. Like Blair's (1993) finding that middle class members used more mentalistic language in contrast to working class members who used more physicalistic language in describing their stress, and D'Houtard and Field's (1984) finding that the manual classes used more negative, socialized, and institutional terms in conceiving of health than the non-manual classes who used more positive, personalized, and expressive terms, the low SES participants, in this study, differed to the high SES participants in their discourse.

Although not a finding analyzed or reported, the way in which the participants' used language to describe their health perceptions and experiences deserves mention, as use of language seemed clearly to have been influenced by SES. The high SES participants presented a more coherent, logical, and semantic structure of health with grammatically complex descriptions whereas the low SES participants used a higher proportion of grammatically simple statements with more deviations from standard English in their dialogue, and were less verbal and less fluent in their descriptions of health than the high SES participants.

That the low SES participants were generally confined to a restricted code usage and that the high SES participants operated both elaborated and restricted codes is congruent with Bernstein's (cited in Blair, 1993) thesis of a differential use of language associated with social class. Although the SES differences on semantic, lexical, and grammatical aspects did not detract from the communicative efficiency of the participants' descriptions at the time of interview, they were significant as artefacts of the participants' education, income, and occupational status.

Not only did education, income, and occupational status have an effect on the language the participants used to describe their health perceptions and experiences, but they also shaped many of the participants' life conditions and events that are associated with having and maintaining health. As a component of SES, income was constantly associated with health by many of the low SES participants and a few of the high SES participants, not only in the purchasing of nutritious food or the services essential for maintaining health but also in the opportunity to exercise and in having leisure time. Having significantly less income placed the low SES participants at higher risk for ill health with regard to basic needs such as food, medical care, and warmth. In keeping with much of the research on health inequalities (Black, 1980; D'Houtard & Field, 1984; Calnan & Johnson, 1985; Blaxter, 1987; Calnan & Williams, 1991; Feinstein, 1993) the high SES participants were more likely to experience good health as a result of their income than their more financially disadvantaged counterparts. For these participants, their health was also governed by their occupational status in that

income is proportionately less for those who are less skilled. As Blaxter (1990) concluded, income and occupational status are primary determinants of the health of much of the population.

SES differences in health perceptions and experiences were also noted as a result of the participants' references to education. Many of the low SES participants attributed their inability to describe features of their health in the way they wanted to, the fact that their health was beyond their control, and their limited access to health care, to their lack of education rather than to personal failings. Indicative of their higher educational achievements, many of the high SES participants reported more positive assessments of health, more health promotion, lower levels of ill health, and more positive health behaviours. In explaining the relationship between education and health, Liberatos, Link and Kelsey (1988) argue that education may protect against disease by influencing lifestyle behaviours, problem solving abilities, and values. Moreover, Winkleby, Fortmann and Barrett (1990) suggest that education may facilitate the acquisition of positive social, psychological, and economic skills and assets, that may provide insulation from adverse influences to one's health.

Consequently, the key issue in the current status of SES health inequalities has to do with the ways in which the health of individuals in any SES group is poorly understood. Not only do the conceptual frameworks that individuals use to think about health, and which influence many of their health beliefs, behaviours and choices, vary as a function of socio-economic status, but they also do not always correspond to those of the health professionals, providers, and policy makers (Tillich, 1961; Greene, 1971; Sussar, 1974; Idler, 1982; Wright, 1982; Long, 1984; Colantonio, 1988). In attending to the experience of health, these health professionals and lay people do so from within the context of different worlds, each providing its own realm of meaning. Understandably there is a definite gap between the lay person's experience of health and the way in which health professionals think about it. If a shared world of meaning with the lay person is to be constituted and if he/she is to be assisted in dealing with the existential circumstances of his/her health, then the nature of this gap

must be recognized. In having recognition, awareness, and understanding that individuals of contrasting socio-economic status have different notions as to what health is, more effective and appropriate information, interventions, and programs that meet the needs of these diverse groups can be implemented.

Given the multiple perspectives of health held, any interventions that are to be successful need to be developed with this diversity in mind, along with a clear sense of what they hope to achieve, in order to maximize the potential for health for all individuals, no matter what their socio-economic status.

Constituting the population of New Zealand are individuals from a variety of SES groups, and, although not included in this study but deserving mention, a variety of ethnic and racial groups. There is a growing body of New Zealand literature which reveals that ethnic and racial identity are strongly associated with differences in health status, health perceptions and beliefs, health promotion, and health service utilization (Rose, 1960, 1972; Pomare, 1980; Davis, 1981, 1984; Pearce, Davis, Smith & Foster, 1984; Edward, 1992; Peters, 1991; Pomare & deBoer, 1988). Because of differences in education, SES and background, language, income, employment, and experience with health, not to mention race or ethnicity, many different views are held by these individuals, both lay and professional, hence the impact of sociocentrism can be far reaching.

Although there are commonalities within the five dimensions between lay perceptions of health and professional perceptions of health, there are also many aspects presented by the lay person as indicators of health that differ to those of the health professional. There are also variations in the components of health that have the highest priority for both the lay person and the health professional. Health is experienced, encountered, attended to, and explained in terms of the individual's unique situation in life. The lay person and the health professional both attend to different aspects of the experience, thus both experience and explain it in qualitatively different ways. The health professional is trained to see health as a super value, a distinct set of behaviours, attitudes and emotions, whereas the lay person focuses on a different

reality - a reality that is socially constructed and has great variety. In this reality, health is experienced essentially in terms of its effect upon everyday life. These quite separate realities and different frames of reference between health professionals and lay people make it quite likely that the health professional neither knows, nor even values, many lay views of health.

As some health promotion activities, interventions, or strategies offered by health professionals are inappropriate of conflict with lay peoples' health views, while others may be more readily accepted, it is important that lay peoples' health views are understood, in order that socially appropriate and sensitive health care can be delivered. In addition, an understanding of the lay person's perspective must be acknowledged and worked with, so that it can be incorporated into the provision of health care.

Further phenomenological studies are required with many individuals from contrasting socio-economic circumstances to provide a broader base for understanding social class differences in health. Studies of this nature need to be done with people of all ages and social contexts to determine how their social position shapes their health experiences.

In summary, progress in understanding the relationship between SES and health requires re-definition of what health really is, recognition of how health is perceived by people of different SES, and acceptance of why what lay people say about health differs from what health professionals, policy makers, and providers say about it.

Phenomenological reduction has revealed a view into the meaning of health as it was experienced and described by the participants in this study. This led to health being experienced as a complex quality of life composed of five overlapping dimensions that interact synergistically.

The findings of this investigation demonstrate that health is not a simple phenomenon, that it is an enigma, that there are no global norms of health, that people define health in accordance with their world views, that health is a multidimensional and expansive concept, that it

is subjectively experienced, and that it varies across individuals and social classes. In addressing the socio-economic inequalities in health, health needs to be defined in the ways in which individuals of differing SES live their every day lives, in the context of their social, economical and political environments.

In achieving the World Health Organisation's goal for "health for all by the year 2000", and in reducing the existing social class inequalities in health, a synthesis of expertise from both the health professionals and the health consumers is required, so that health in its totality and its aggregate dimensions can be understood.

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The gift of health is the gift of life, which raises the value of the whole idea exponentially. The gift of health, then, is the gift of happiness, of completeness, of love and of being. To abuse it, or to fail to seek it out with all our power is a denial of the value of self. Anyone who disregards the magnificence of life deserves only pity. (L. Grant, 1978. p. 10).

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APPENDICES

Appendices

The only true way to health is that which common sense dictates to man. Live within the bounds of reason; eat moderately; drink temperately; sleep regularly; avoid excess in everything, and preserve a conscience void of offence. (Chase, 1907, p. 82).



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Appendix A

THE LIVED EXPERIENCE OF HEALTH.

INFORMATION SHEET.

WHAT THIS STUDY IS ABOUT.

I am a post-graduate psychology student undertaking research for a Master's Degree at Massey University. The purpose of this study is to explore the phenomenon of health, with a focus on how individual's perceive their health and how they manage their health, and to evolve a structural definition of health as it is experienced in their every day life.

WHAT WOULD I HAVE TO DO?

Participation in this study would involve an in-depth guided interview employing open-ended questions at which you would be asked to describe your experiences of health and to share your thoughts, perceptions, and feelings about these experiences. The interview would be audio-taped in full and there would be no time limit placed on the length of the interview. On completion of this study all tapes will be destroyed.

AM I ELIGIBLE?

To participate in this study you must be

- willing and able to discuss and examine your experiences.
- between the ages of 25 - 65 years.

WHAT CAN I EXPECT FROM THE RESEARCHER?

If you participate in this study you have the right to

- refuse to answer any particular question at any time.
- ask any further questions about the study that occur to you during your participation.
- provide information on the understanding that it is completely confidential to the researcher. All information will be coded and it will not be possible for any individual to be identified in any published report.
- be given a summary of the findings from the study on completion.

If you require any further information on the study, or wish to contact me for any reason, you can write to me care of the Psychology Department, Massey University, or telephone me at home (06) 35 49798.

Your participation will be greatly appreciated, and if you choose to do so, I look forward to interviewing you.

Thank you.

Appendix B

The Lived Experience of Health

AGED under 35 35-49 50 or over

MALE FEMALE

OCCUPATION.....

WAGES SALARY

EMPLOYER SELF EMPLOYED

INCOME	< \$20000	<input type="checkbox"/>
	\$20000-29999	<input type="checkbox"/>
	\$30000-39999	<input type="checkbox"/>
	\$40000-49999	<input type="checkbox"/>
	\$50000 +	<input type="checkbox"/>

LEFT SCHOOL UNDER 16	<input type="checkbox"/>
LEFT SCHOOL OVER 16	<input type="checkbox"/>
SCHOOL CERTIFICATE	<input type="checkbox"/>
BURSARY	<input type="checkbox"/>
TRADE CERTIFICATE	<input type="checkbox"/>
OTHER CERTIFICATE	<input type="checkbox"/>
DIPLOMA	<input type="checkbox"/>
DEGREE	<input type="checkbox"/>

PREFERRED PSEUDONYM.....

Appendix C

THE LIVED EXPERIENCE OF HEALTH

CONSENT FORM.

I have read the information sheet and have had the details of the study explained to me, and I understand what is required of me as a participant.

I also understand that I am free to withdraw from the study at any time, or to decline to answer any particular question.

I agree to provide information to the researcher on the understanding that it is completely confidential.

I agree to the researcher using brief quotations in the final report on the understanding that I will not be able to be identified.

I wish to participate in this study under the conditions set out on the Information Sheet.

Signed: _____

NAME: _____

DATE: _____

Appendix D

Interview Framework

Commencement of interview

I'm interested in what people think about health. The kinds of things I would like you to talk about from your own experience, and in your own words, are : what do you think health is, how would you define health, how do you perceive the meaning of health, and what is your experience of health? Perhaps to start with, what does being healthy mean to you?

Probable questions

Health Definition: the lived experience of health as defined by the personal experiences described by the participant.

Initial question: what is, according to you, the best definition of health?

Additional questions:

- what does being healthy mean to you?
- what is health like for you?
- what is your experience of health in your everyday life?
- what comes to your mind when you think of health?
- what would you mean if you said you were in good health?
- what is your general philosophy for being healthy?

Health Perceptions: to seek the meaning of health for participants of different SES.

Initial question: describe a situation in which you have experienced a feeling of health. Share all the thoughts and feelings you can recall until you have nothing more to say about it.

Additional questions:

- how aware are you of your health?
- how does your awareness and understanding influence your perceptions of health and associated behaviours?
- how would you describe your health generally?
- what images of health do you have?
- what do you think about health?
- how is your health?
- do you consider yourself a healthy person?
- are you limited by any aspect of your health?

Health management: the health effects of lifestyles or elements of lifestyles. Construction of health beliefs and management of health behaviour.

Initial question:

- what does health mean to you in terms of the way you manage your everyday life and what do you do to stay healthy?

Appendix E

Follow-up

Example letter to participant

Dear Jill

Earlier this year, I interviewed you about your perceptions of health and what health means to you in your everyday life.

I would like you to read through this description of what you talked about, and indicate your agreement or disagreement as to whether it accurately reflects your experience. In doing so, I would like you to write down any additions, deletions, or clarify any misconceptions you consider necessary. I have enclosed a self-addressed stamped envelope for your convenience, and as discussed on the phone with you, please feel free to call me to talk over any concerns you may have. Thank you for your participation and I look forward to your response.

Health was revealed by you to have three inter-connected aspects, these being physical, mental, and spiritual. The physical aspect encompassed being able to do the things that were important to you such as being able to go to work, to have the ability and energy to get out and involve yourself in physically demanding activities such as swimming and playing tennis, and not have to worry about your body coping with the physical demands placed upon it. Physical health was being able to live your everyday life without experiencing aches and pains, to get through the day without thinking about your body, to enjoy and eat regular meals and ensure your body was receiving adequate nutrition to keep it working in the best way possible. Physical health was keeping your body in good shape so that you were able to partake in everyday life and achieve the goals that you set for yourself.

In order to achieve these goals, you believe it is important to keep a positive attitude. This mental aspect, keeping a positive attitude, was seen to be very important in that you experience health negatively when you find yourself thinking negative thoughts. When you experience stress in your everyday life, you notice an effect on your physical health, in that you develop headaches and stomach pains. In identifying the healthiest thing about yourself, you cited a positive self concept and your affirming attitude toward life.

This affirming attitude toward life was perceived by you to be related to you religious beliefs. You said you were able to cope in a more positive healthy way with any problems and stress in your everyday life, by thinking about God and God's plan for you. In turn, this gives you

the strength to go on and face any difficulties that might arise in your life. It is important to you to have faith, to forgive and to love, and through living your life with these beliefs, you are able to experience your physical and mental health more positively.

In your definition of health, you saw that maintaining some sort of balance between these three aspects was vitally important to be a healthy functioning person, although in your opinion, physical health is the most important, because if you are not physically healthy, it affects your mental health, as well as your spiritual health. They all go together. Overall, health to you was being able to perform all your daily activities and enjoy doing so.

Once again, thank you for your participation. I enjoyed meeting you and feel honoured to have shared some of your experiences.

Kind regards

Margaret Williams

Appendix F

Summary

Example letter to participant.

Dear Jack

In May this year, I interviewed you about your perceptions of health, what health means to you, and how you experience health in your everyday life. At the time of interview, you expressed interest in receiving a summary of the findings on completion of this study, accordingly, here is a synopsis of the findings.

The purpose of the study was to explore the phenomenon of health among diverse members of our society. More specifically, the study focused on how individuals from two contrasting socio-economic status groups perceived their health and how they experienced health in their everyday lives, and if there were any variations in the same.

Using a phenomenological method, findings indicated that the overall perception of health did vary across participants and socio-economic status. Although each participant's viewpoint of health differed in that each participant's experience of health reflected different lifestyles and values, most participants perceived and experienced health in a multidimensional way.

In describing how health was perceived, five dimensions that explicate the phenomenon emerged. These dimensions, the physical, mental, emotional, social, and spiritual separately contained a variety of components that together made up each dimension.

Emanating from various combinations of these five health dimensions were four different views that described the participants' perceptions of the wholeness of their health. These views were: a solitary view of health in which only physical aspects of health were described such as nutrition, exercise and energy levels; a separate view of health in which the physical and mental/emotional dimensions were seen as operating independently; a combined view of health in which the physical and mental/emotional dimensions were seen to be interdependent; and a multitudinous view of health in which all the dimensions were considered to be related and function in a synergistic way with each other.

In general, health was experienced in the everyday lives of the participants as either a dynamic state or process concerning the whole of the person in interaction with the environment.

Participants who were less educated and in less well paid occupations tended to describe health as an awareness of a state that enabled ordinary social functioning. Seen more as a social matter than a personal matter, these participants emphasised health in the context of their social and material circumstances. Health, to them, was having the ability to work within the constraints of their environment.

For those with better paid occupations and higher education, health was described as an awareness of a process that was constantly changing. Health was seen more as being the responsibility of the individual as one had choices and the opportunity to realize optimal healthiness.

Overall, health for all the participants was viewed as a part of everyday living, of belonging, of working, of participating, and of being, a phenomenon that reflects a myriad of factors, interacting and functioning with one another.

I hope you find this summary of interest. I enjoyed meeting you and feel privileged to have shared such personal aspects of your life. Thank you for your participation in this research and your co-operation.

Kind regards

Margaret Williams