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Adult Conceptions of Health

by

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THESIS

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ABSTRACT

This study was a secondary analysis of data from a larger study (Laffrey & Crabtree, in press). The purpose of the study was to explore the health conceptions of cardiovascular and healthy persons. A content analysis was performed on 30 cardiovascular and 33 healthy persons' responses to an open-ended question defining health. The following six themes were identified: 1) freedom from restrictions/independence/ability to function; 2) absence of disease/symptoms; 3) subjective well-being; 4) health habits/practices; 5) adaptation; and 6) holistic. The majority of the participants' responses contained more than one theme. Cardiovascular clients' responses were found to be more specific and personalized than healthy participants' responses in five of the themes. When compared with the healthy group, cardiovascular clients' definitions of health placed more emphasis on adaptation and the ability to function independently without restrictions. The healthy persons' responses placed a greater emphasis on an absence of disease/symptoms and holism.

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Chapter 1: Problem

Many authors have discussed the need for clarification of the term health (Eberst, 1984; Keller, 1981; Smith, 1981; Patrick, Bush & Chen, 1973). The term is repeatedly used by professionals and the public, yet the definition of health encompasses many factors and varies from person to person and from situation to situation. The meaning of the term health depends on the context in which it is used (Keller, 1981; Smith, 1981).

Smith (1981) discusses the significance of the consistent recognition of health as one extreme of a health-illness continuum and notes that:

> A continuum is an unbroken sequence of things arranged so that between any two points there is always an intermediate point. The variations between conditions of health and illness are smooth. There are no discrete points. Health then becomes a comparative term, rather than a classificatory (either/or) term ....Therefore the concept of health involves a "scale" or gradation of health or illness. The structure of gradations depends on what human traits or conditions are evaluated. (p. 44)

Keller (1981), also discusses the relativity of defining the term health, and the confusion resulting from the variety of definitions. Due to the complexity involved in defining health, persons with illness(s) should not be

automatically categorized as not healthy. As Hoke states "there is a healthy way to live a disease" (cited in Eckert, 1980, p. 166).

In addition, other authors stress the importance of the environment and history of the social group in defining health. The words health and disease are viewed as meaningful only when defined in terms of a given physical and social environment (Dubos, 1965). If the definition of health becomes meaningful when focused on individual functioning in specific social and physical environments, "notions about health transcend biological-reductionist statements and center attention on the complexities of behavioral, physical and social features of individuals in environments" (Eckert, 1980, p. 166).

Defining health becomes further complicated for clients with chronic disease. Improving health is an undisputed, universal goal of health practitioners delivering care to persons with chronic disease (Jette, 1980). However, if health is defined only as the absence of disease, health is not attainable for these individuals. Clients with chronic disease must deal with multiple difficulties in their daily lives. These difficulties are associated with their disease and medical regime which impact their normal processes of daily living. Long-term strategies consisting of social and environmental manipulations and self-care techniques become necessary for coping with these difficulties (Reif, 1975). At the same time, some of these clients with complicated

daily regimes and a variety of restrictions may live what they themselves, as well as others, consider a more active and productive life than a "healthy" person. Is the inactive, overweight, 24-year-old man more healthy than the 24-year-old controlled diabetic who is on the swim team? The definition of health becomes particularly individualized for the person with chronic disease.

Variations in the definition of health can create problems in communication and have an adverse effect on the assessment, planning, delivery, and evaluation of health care. An understanding of what the client and practitioner mean by the term health is necessary for clear communication of the concept of health.

Purpose

The purpose of this study was to explore the health conceptions of healthy adults and adults with chronic disease. A content analysis was done on the responses healthy adults and adults with chronic cardiovascular disease gave to the question:

> If you were to tell me that you were healthy, what would this mean for you? (What do you mean by the word health?).

A second purpose was to determine if adults with diagnosed chronic cardiovascular disease differ in their definitions of health from healthy adults.

Conceptual Framework

Two concepts are particularly important in this study. One is that health is multidimensional. The second is the importance of symbolic interaction in communications about health.

Health is Multidimensional

Health as a word was derived from hole in Middle English and from hal in Old English (hal->hole/ hale->whole>health) (Keller, 1981). This derivation indicates a philosophy viewing health as something that has many dimensions. Although some societies have perceived health as a relationship among humans, nature, and the supernatural (Keller,1981), through much of Western civilization's history health has been defined as simply the absence of disease (Eberst, 1984). In 1947 the World Health Organization (WHO), defined health as "a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity" (Keller, 1981, p. 45). The usefulness of this global definition has been criticized because the definition is unmeasureable (Hoke, 1968; Jette, 1980; Keller, 1981).

Several authors have proposed frameworks in which to explain or examine the concept of health. Eberst's (1984) model is a "health cube" which he compares to a Rubik Cube™. The health cube's six sides represent the following factors: mental, physical, vocational, emotional, social, and spiritual. Eberst suggests the spiritual dimension is more

than just one of the six health dimensions. The spiritual dimension is also the center, or axis, of the health cube. This dimension is composed of sub-elements such as "confidence, life force, enthusiasm, moral code and ethics" (Eberst, 1984, p. 101). The spiritual dimension may provide the supporting mechanism through which the other five dimensions articulate and interact with each other. Eberst emphasizes that changes in one dimension will affect the others. The model has not been tested.

Smith (1981) proposed four models or dimensions of health: (1) the clinical model, in which health is the absence of signs or symptoms of disease or disability; (2) the role performance model, in which health is the ability to function according to the expectations of the society in which one lives; (3) the adaptive model, in which health is flexible adjustment to changing circumstances; and (4) the eudaimonistic model, in which health is maximum self actualization or realization of one's highest potential.

These authors and those mentioned previously define health as multidimensional. Health becomes more than the absence of disease. The definition of health involves personal and social history and expectations. The definition may also vary in the context in which the definition is given (Strauss, 1975).

Symbolic Interactionism

Brodnax (1975) discusses the importance of symbolic interactionism in the interactions and exchanges between

health professionals and clients. According to Blumer symbolic interactionism is based on the following three premises: (1) human beings act toward things on the basis of the meanings that the things have for them; (2) a thing's meaning is derived from or arises out of, the social interaction with one's fellows; and (3) meanings are handled in, and modified through, an interpretative process used by the person dealing with the things he encounters (cited in Brodnax, 1975, pp. 63-64). Brodnax (1975) identifies the key concepts in these three premises as "actions are based on meanings, meanings are derived from interactions, and an interpretive process individualizes these meanings. Though interactions can be symbolic or nonsymbolic (for example, reflexes), it is the symbolic ones which involve the process of interpretation. In order for clear interactions to take place, the parties involved must have a shared understanding of each other's view point. Clarification of terms and gestures are essential for this shared understanding. "When the basis for understanding is not a shared one, outcomes occur which apparently differ from the original intent of the gesture" (Brodnax, 1975, p. 65).

Significance of the Study

The significance of this study relates to the importance of good communication between clients and health professionals.

Cassell's (1980a) research on taped patient/physician conversations reveals multiple problems due to ambiguity

about the words and concepts each person was using. Cassell has analyzed more than 1,000 hours of tape-recorded conversations between physicians and patients over more than five years. Cassell (1980b) argues "Language is one of the most powerful medical tools available" (p. 80). Language establishes and controls the client/practioner relationship. When the client/practioner relationship is examined, language is found to be the "key to that relationship" (Cassell, 1980b, p. 84). Cassell also stresses the importance of defining illness as the disease plus the meaning the disease has for the patient. The health professional can then "perceive the patient's conception of the disease and deal with the whole illness" (Cassell, 1980b, p. 84). A common understanding of terms between the client and health professional improves their communication and increases the health professional's ability to provide the right treatment or information at the right time (Baumann, 1961; Cassell,1980b).

Shuy (1976) also discusses the problems in the delivery of care to clients created by the miscommunication of words or concepts. Shuy attributes this miscommunication to the emotionally charged nature of the interaction, the use of medical jargon, and a critical lack of awareness of the linguistic and cultural systems which some patients bring with them to the medical interview.

Shuy (1976) conducted research on physician-patient communications. One-hundred-five questionnaires were

administered to clients in the waiting rooms of various clinics and private medical practices during a two-week period at Georgetown University Hospital. On the question of vocabulary, 45 per cent of the clients stated they sometimes felt the doctor did not understand their problem. In addition, 38% thought that "doctors, nurses, or interns sometimes use words that are difficult to understand, while 45% thought it was sometimes difficult for the patient to explain himself to the doctor" (p. 370). Over 100 taped client/physician interviews were analyzed by Shuy. The analysis documented multiple miscommunications due to a lack of common understanding about terms and concepts. These miscommunications created a variety of problems and decreased the effectiveness in the health care delivery (Shuy, 1976).

Clients with chronic disease frequently require information regarding not only their current status and regimes, but also what can be expected in the future. Strauss (1975) described this future course of illness as the disease's trajectory. A chronic disease trajectory is the course of the disease as defined by the participants with (or experiencing) the illness. Each chronic disease has some range of variation in trajectory, but each tends to have a general pattern. If a trajectory is fairly certain, then planning and preparation can be made in advance of each new downward trend. If there are reprieves or partial recovery trajectories, the trajectories are more uncertain.

This uncertainty increases the difficulty in preparation of changes in social and living arrangements. Sometimes the health professional knows the extent of the expected recovery but does not convey it to the client, or if conveyed, it is not completely understood by the client or the family. The defined chronic disease trajectory frequently influences the client's personal expectations and definition of health. The client may or may not concur with the defined trajectory. The client may choose to define his or her health within the trajectory differently to different persons. Miscommunication regarding chronic disease trajectories and the client's definition of health, can result in unrealistic expectations and regimes by the the client, the client's significant others and the health professional (Strauss, 1975).

As these researchers illustrate, the significance of the study problem lies in the communication between health professionals and clients. Clients are expected more and more to be active in their health care. Clients and health professionals are now expected to be partners in the client's health planning and care (Cassell, 1980b).

Increasing the clarity of what is meant by the term health improves this communication and partnership. Errors in diagnosis or treatment due to miscommunication are less likely if both parties share a common understanding of the terms involved (Shuy 1976). By understanding the client's concept of health, the professional can tailor information

and care planning to meet the client's needs. The professional also will be able to ask questions from the client's framework in order to obtain information useful in assessing the client.

When communication is clear between individuals, health care planning occurs more smoothly and effectively. The health professional better understands the client's priorities and special needs. The client gains a better understanding of treatment options for decisions regarding his care and treatments. Health care decisions made with a shared understanding between the client and health care professional regarding the treatment and/or care plan are more likely to be implemented by both parties.

Time is also used more efficiently when communication is accurate and clear. Today's health care financial climate emphasizes the efficient use of resources. One of the most valuable resource in the health care field is time. Increasing the effectiveness of professional/client communication also increases the efficiency of the use of their time together (Cassell, 1980b).

Chapter 2: Literature Review

A number of studies have investigated how clients perceive illness and treatment, however, few studies have investigated how clients view health (Laffrey & Crabtree, in press). Baumann (1961) conducted a study in which 201 clinic patients with chronic disease and 258 medical students were asked their conception of health and physical fitness. The content analysis revealed three categories of health conception: 1) feeling good, 2) performance of daily activities, and 3) absence of symptoms. Over half of the respondents in each group gave responses which contained more than one of the above categories. Among the clinic patients, 31% mentioned absence of symptoms, 31% mentioned feeling good, and 38% mentioned performance of daily activities. Among the medical students, 20% mentioned feeling good, 37% mentioned performance of daily activities, and 43% mentioned absence of symptoms. Among the clinic patients, feeling good and absence of symptoms were mentioned less often with increasing age whereas performance was mentioned slightly more frequently with increasing age.

Educational level was also found to be relevant in this study. Among the clinic patients, those with 8th-grade education or less responded with a feeling good conception of health more often than those with education beyond the 8th-grade (58% vs. 46%). Responses incorporating absence of symptoms were more frequently found among those participants with education beyond the 8th-grade (44% vs. 60%).

Performance of daily activities responses remained the same in the two educational groups.

Clinic patients' responses were also categorized by the following diagnoses: artiosclerotic heart disease (ASHD); diabetes; psycho-neurosis; and multiple diagnoses. Some differences were noted among these four diagnostic groups. Diabetics emphasized the feeling-state more than the other diagnostic groups. Also, diabetics and psychoneurotics appeared more symptom-oriented than the ASHD patients or patients with multiple diagnoses. Baumann (1961) noted, however, that the diabetics and psychoneurotics were on the average more than 10 years younger than patients in the two other diagnostic categories.

Hautman & Harrison (1982) conducted a study about the health beliefs and practices in a middle-income Anglo-American neighborhood. The study was based on the interview responses of a convenience sample of 100 individuals 18 years of age or older who were of European ancestry and born in this country.

Subjects were asked to rate their health as good, fair, or poor, and define what they meant by their rating. Eighty-five percent of the subjects rated their personal health as good (even when clearly defined disease processes were present), 11% as fair, and 4% as poor.

Categories of descriptive terms of health in order of overall frequency were as follows: (1) 57% absence of sickness; (2) 35% feel good; (3) 26% have energy; (4) 18%

able to work; (5) 19% other; (6) 15% few doctor visits; and (7) 7% no pain. Most of these respondents identified at least two dimensions in their definitions. This lack of a single orientation to health corresponded to the findings of Baumann (1961).

Unfortunately Hautman & Harrison (1982) did not elaborate on their "other" category. Nineteen per cent of the responses were placed in this category and the lack of information about this category is a major flaw of the study. However, the study does provide useful information regarding how individuals define health.

Several of the respondents rated their health as good because they were able to function despite various diseases. Those who perceived their health status as fair or poor (15%) felt they deviated from good health on the basis of illness, frequent physician visits, inability to work and experience of pain. "Ten of these (67%) made their rating of fair or poor health on the basis on one or more diseases" (Hautman & Harrison, 1982, p. 54). One individual who rated her health as fair deviated from the traditional disease orientation. Her rating was based on her health practices, stating, "My health is not good because I do smoke and I could use more exercise and I could spend more time out in the fresh air" (Hautman & Harrison, 1982, p. 55).

In addition to the descriptions of health, Hautman & Harrison (1982) examined multiple dimension responses to determine which descriptive terms were mentioned first,

second, or third in the individual's narrative response. Absence of disease (50%) and feeling good (21%) were the focus of first responses. The focus of the second responses shifted from absence of disease to feeling good and having energy. Third response descriptive terms focused on having energy or the "other" category.

The researchers found diet, exercise, and vitamins were the predominant measures taken for maintaining health. Seventy-five per cent of the subjects verbalized a relationship between diet and health with a focus on a balanced diet and avoidance of foods claimed "not good for you," such as heavily processed food, sugar, salt, red meat, and "junk" food. Though over 50% mentioned exercise as a means of staying healthy, few respondents felt obligated to offer an excuse for not exercising. Many favored an eclectic approach to maintaining health.

Another study (Laffrey, 1986) was concerned with the health conceptions and perceived health status of 26 overweight and 33 normal weight adults. The Laffrey Health Conception Scale (LHCS) was used to measure health conceptions within Smith's four dimensions of health, clinical, functional, adaptive, and eudaimonistic or self actualization. No difference in health conceptions was found between the two groups. However, though the overweight participants realistically perceived themselves as overweight, they did not perceive themselves as less healthy than the normal weight participants (Laffrey, 1986).

This finding corresponded with the Hautman & Harrison (1982) study in which individuals with diagnosed illnesses perceived themselves as healthy.

Chapter 3: Methodology

Design

This study consisted of a secondary analysis of data from a previous study. The purpose of that study was to investigate the health conceptions, perceived health status, and health behaviors of a group of adults with chronic cardiovascular conditions and a control group of healthy adults (Laffrey & Crabtree, in press).

Interviews of participants were conducted in a metropolitan university hospital clinic and in the homes of participants living in an apartment complex near the hospital.

Sample

This study examined data which had been collected in the previous study (Laffrey & Crabtree, in press) from two different groups of subjects: (1) 30 adults receiving regular medical care at an ambulatory cardiovascular clinic; and (2) 33 healthy adults living at an apartment complex near the cardiovascular clinic.

The cardiovascular group included subjects: (1) with mitral or aortic valve replacement or mitral commisurotomy at least one year prior to data collection; (2) currently on long term anticoagulant therapy; and (3) able to read and speak English.

Criteria for inclusion in the healthy group included: (1) no known diagnosis of a chronic disease; no current acute illness; (2) no health professional care required for

illness or injury that kept the individual at home in the past two weeks; (3) no report of seven or more days of illness or injury that kept the individual at home during the past three months; and (4) the ability to read and speak English.

The total sample included 50 women and 18 men, ranging in age from 22 to 83 with a mean age of 52 years. Educational level ranged from fewer than 8 years of schooling to attainment of graduate degrees, with an average of 11 years of education reported by the cardiovascular group and 15 years by the health group. Annual family income level was lower in the cardiovascular group, with a mean of $10,000-$14,999 as compared with a mean of $15,000-$24,999 in the healthy group.

The racial compositions of the two groups were similar. The healthy group contained 21 White, 3 Black, and 5 Asian participants; the cardiovascular group contained 21 White, 3 Black, and 3 Asian participants. One person in the cardiovascular group did not identify her race.

The religious affiliations for the healthy group were 10 (30%) Catholic, 10 (30%) Protestant, 4 (12%) Jewish, 3 (9%) Science of Mind, 1 (3%) Buddhist, 1 (3%) Bahai, and 1 (3%) Christian Science. Three (9%) of the subjects reported no religious affiliation.

The religious affiliations for the cardiovascular group were 14 (47%) Catholic, 7 (23%) Protestant, 2 (7%) Moslem, 2 (7%) Church of Jesus Christ of Latter Day Saints,

1 (3%) Christian, and 1 (3%) atheist. One (3%) of the of the cardiovascular subjects reported no religious affiliation.

Procedure

The study received approval by the University Committee for the Protection of Human Subjects. A letter was sent to each individual attending the clinic who met the study criteria and also to residents of the apartment complex. A telephone call was then made to each potential clinic participant during the following week to further explain the study and invite individuals to participate. The potential participants in the apartment complex were visited by the researchers after the letter. On this visit, potential participants' questions were answered and the investigators ascertained that an adult in the home met the study criteria. Subject participation in the study was then invited.

Clinic participants were interviewed when they came to the clinic for regular medical care. Apartment participants were interviewed in their homes. All participants were informed that their information was confidential. Any questions they had about the study were answered.

Instruments

Several instruments were administered as part of the original study (Laffrey & Crabtree, in press). For the current study, demographic data and the responses to an

open-ended question were content analyzed. Participants were asked the question:

> If you were to tell me that you were healthy, what would this mean for you? (What do you mean by the word health?).

A quantitative analysis was done to determine whether there were significant differences between healthy participants and the those with cardiovascular disease.

Chapter 4: Results

Theme Development

The participants' responses were examined and the following six themes were identified:

I. Freedom from restrictions/Independence/Ability to function

This theme defines health in terms of being independent and free of restrictions secondary to symptoms and/or medical regimes. This theme contains statements which link clinical symptoms to an ability or function. Emphasis is placed on the ability to perform tasks and roles without assistance or by making special arrangements. Statements regarding issues involving control and choice would also fall under this theme.

Examples:

- Work all day without becoming short of breath (SOB).
- The ability to do
- Being able to do what you want to do
- Doing what you want to do and going places without having to worry about eye drops or pills.

II. Absence of disease and/or clinical symptoms

Under this theme health was defined as the absence of disease and/or clinical symptoms. This theme's statements containing clinical symptoms were not linked to an ability or function. Statements which related to examples of

physical qualities of health were also associated with this theme. Objective, measurable criteria were frequently used to qualify the physical qualities, for example, a straight body, clean eyes. Statements relating to the frequency of the need to seek medical attention because of disease or symptoms were also included in this theme.

Examples:

- Not getting sick all the time
- No disease
- Being healthy is not seeing a doctor all the time--only when you have to.
- Clean skin.

III. Subjective sense of well-being

This theme defines health from a subjective sense of well-being. Health is defined in terms of an individual's subjective sense of positive well-being. Happiness, feeling in harmony, and a having a good mental attitude toward life are all examples of statements which reflected this theme. Comments regarding absence of pain were also included under this theme.

Examples:

- Happiness
- Good attitude toward life
- Not run down, not tired
- Absence of pain.

IV. Lifestyle habits and health practices

This theme defines health in terms of lifestyle habits and health practices. This theme includes comments regarding diet, sleep, smoking, drinking, exercise, etc.. Health is defined in terms of a person implementing or having the ability to implement certain practices.

Examples:

- Eat in moderation
- Clean life
- No smoking
- Drinking occasionally and in moderation.

V. Adaptation

This theme relates to a person's ability to adapt or adjust mentally and/or physically to the environment. Health is defined in terms of a person's successful interaction and adjustment with the social and physical environment around them. Statements relate to a person's ability to adapt in order to fulfill role and activities of daily living expectations.

Examples:

- Being able to cope with everything in daily life.
- If some something is wrong with you, you can still be healthy if body functioning properly.
- If [I] have some restrictions, the other parts work and if [I] have faith and love in these other parts these will compensate for the parts that are restricted.

VI. Holistic

This theme defines health as a combination of physical and mental well-being. Health is frequently viewed as more than a physical or feeling state. Health is defined as a combination and harmony of the physical and feeling states. Health is seen as greater than the sum of these two parts. Also included in this theme are statements relating to spirituality or comments concerning a person's "spirit" or spiritual dimension.

Examples:

- Health is a total sense of well-being--physical, emotional, spiritual.
- Unity of body and spirit.

Some overlapping exists among the themes. When discussing symptoms, many of the subjects attached a function or an ability to the statement, such as," [Health means I can] work all day without getting short of breath." This implied an additional meaning to the statements which identified them as being more than the absence of a symptom. Since this additional meaning related to an ability to function, symptoms which were connected to an activity or ability were categorized with the theme of independence and ability to function rather than absence of symptoms.

Many persons identified objective, measurable criteria in their definitions of health. Comments such as "clean skin," "good appearance," and being considered "a good

physical specimen" were included in the absence of disease category. Such statements indicated a positive physical assessment of health as opposed to freedom from symptoms or disease.

Though absence of pain is frequently identified with symptoms, the experience of pain is a subjective and individual perception (Luckmann & Sorensen, 1974). Therefore, comments relating to the absence of pain were categorized with the subjective comments relating to a sense of well-being found in the third theme. Since individuals may also define words such as stamina and energetic differently based on perception, comments relating to stamina and energy were also included within the third theme.

Interrater Agreement

Five nurses with public health nursing background were asked to examine the data and identify themes. Four of these nurses either held or were in the process of obtaining a master's degree in nursing. Common themes identified by the nurses were: (1)independence/freedom; (2) ability to function; (3) a subjective sense of health; (4) absence of disease; (5) health behaviors; and (6) a spiritual or holistic sense of health. With the exception of adaptation, these nurses identified themes similar to the researcher's themes. Without knowledge of the researcher's themes, four of the nurses were asked to place the researcher's identified adaptation statements in their scheme. Three

placed them under independence or mental-state themes and one created a new category of adaptation. When asked to place the same statements within the researcher's themes, 75% of the interrater coding placed the statements under adaptation.

Using the researcher's themes, four nurses independently coded 45 individual statements from the data. Individual interrater agreement with the researcher's coding was 75%, 67%, 62%, and 41%. Total interrater agreement was 62%. When the coding of individual statements was examined, only 6 (13%) of the statements had no agreement with the researcher's coding. Based on the four nurses' coding, one of the responses was recoded.

The interrater coding was done on individual statements. The statements were out of context. This may have affected the interpretation of some statements which the coders stated were borderline between two themes. In addition, the nurses were not instructed to code a symptom associated with an ability as in the freedom from restrictions/independence/ability to function category rather than in the absence of disease/symptoms category. For example, without the above clarification, the statement "health means I don't get short of breath when I'm walking" could be interpretated as either freedom from restrictions/ independence/ability to function or as absence of disease/ symptoms. Such statements accounted for some of the differences found between raters.

The remainder of this chapter will present the results of the content analysis of the cardiovascular and healthy participants' responses. The content analysis utilized the six themes previously discussed.

Content Analysis Results

The results of the content analysis are presented in Table 1. The following differences were noted between the Cardiovascular and healthy participants responses: (1) number of each group's responses in four of the six themes; (2) the order in which five of the six themes were emphasized; and (3) the focus of the content within each theme.

In addition, the following similarities were noted between the two groups: (1) the response rate in two of the four themes; (2) the percentage of responses in each group containing one or more of the first three themes; (3) the order of emphasis given the health habits/practice theme; and (4) the percentage of participants identifying more than one theme in their response.

Differences in Theme Response Rates

More cardiovascular than healthy participants mentioned the freedom of restrictions/independence/ability to function (63% vs 24%) and adaptation (20% vs 3%) themes. On the other hand, more healthy than cardiovascular participants mentioned the absence of disease/symptoms (73% vs 47%) and holistic (42% vs 7%) themes.

Table 1. Number and Proportion of Persons in each group who identified the six themes in their definitions of health (N = 63)

	Themes	Groups			
		Cardio-vascular n = 30		Healthy n = 33	
		n	%	n	%
I	Freedom from restrictions/ Independence/Ability to function	19	63	8	24
II	Absence of disease/symptoms	14	47	24	73
III	Subjective sense of well-being	20	67	22	67
IV	Health habits/practices	8	27	9	27
V	Adaptation	6	20	1	3
VI	Holistic	2	7	14	42

Order in which Each Group Emphasized the Themes

The cardiovascular group's responses emphasized the themes in the following order: (1) subjective well-being (67%); (2) freedom from restrictions/independence/ability to function (63%); (3) absence of disease/symptoms (47%); (4) health habits/practices (27%); (5) adaptation (20%); and (6) holistic (7%).

The healthy group's responses emphasized the themes in the following order: (1) absence of disease/symptoms (73%); (2) subjective well-being (67%); (3) holistic (47%); (4) health habits/practices (27%); (5) freedom from restrictions/independence/ability to function (24%); and (6) adaptation (3%).

Differences in Responses within the Themes

Cardiovascular and healthy participants' comments within each theme were examined for general trends, similarities and differences. In the first theme, freedom from restrictions/independence/ability to function, many cardiovascular subjects comments focused on specific functions and restrictions. One 45-year-old woman commented:

> [Health means] being able to do everything I used to do before I got sick--do my work and not depend on anyone for anything.

A 64-year-old woman stressed functioning stating "Work all day without getting short of breath." One-51-year old woman

expressed a common sentiment with "Health means I can do heavy housework." Perhaps the focus of these comments was best expressed by a 75-year-old woman who stated:

> [Health means I] can go shopping, dancing, anything....When healthy you can go places and don't think something will come along and stop you.

Healthy participants' comments, on the other hand, tended to be more general, such as the 59-year-old man who stated "No restrictions on what I want to do physically at any time." A similar sentiment was expressed by a 65-year-old man who included the following in his definition of health:

> To perform within my capacity, do [my] assigned duties.

Both groups' absence of disease/symptom comments generally focused on being totally free of disease. However, five of the healthy participants allowed for some illness. One 28-year-old woman commented "[I'm] hardly ever sick." Another healthy participant, a 31-year-old woman, stated "[Health means] not getting lots of colds and flu." One 65-year-old woman qualified her definition by stating "[Health means] not having a lot of severe health problems." This contrasted with the cardiovascular groups' overall responses in this theme. Typical responses from this group included a 66-year-old man's reply that "Health means everything is perfect." This focus was repeated by a 42-year-old man who commented "no problems with health" and by

a 54-year-old man who stated "[Health means] Perfect specimen of body, no chronic complications, no injuries."

People in both groups mentioned physical traits such as "clean skin" and "stands up straight," however, the majority of comments under this theme related to the absence of disease/symptoms. One woman in each group discussed low frequency of doctor visits in her definition of health. The healthy participant who was 38 years old, qualified her statement by stating "not more than once a year." A 53-year-old woman from the cardiovascular group gave a more general comment:

> Being healthy is not seeing the doctor all the time - only when you have to.

When comments regarding the subjective sense of well-being were examined, several trends were discovered. Many healthy participants mentioned the phrases "feel good" and "energetic," whereas the focus of the cardiovascular clients' comments was on "being happy." "Feel good" cardiovascular client statements tended to be qualified such as one 38-year-old woman's comment that health meant "<u>consistently</u> feeling good." Cardiovascular clients' comments also included having energy, however, more emphasis was placed on not being tired or not feeling weak than was found among the healthy participants' comments. Only four cardiovascular and three healthy participants specifically included "not being in pain" in their definitions of health.

Both groups stressed the importance of diet, exercise, not smoking, drinking in moderation and being active in their comments which related to the health practice/habit theme. In addition, five of the healthy participants specifically emphasized a need to be interested in outside activities and being involved in relationships with other people. One 58-year-old woman included the following in her definition of health:

> Be ambitious and interested in what's going on around them, participate in an interest, and be active physically. Be involved with other people.

Another woman who was 69-years-old commented:

> [Health means I] enjoy normal things, reading, breathing, normal interest in life around me and current events. I like all my neighbors.

One 71-year-old woman placed an importance on being with younger people stating:

> Associate with other people who are younger.... engage in activities that are satisfactory/enjoy.

One cardiovascular client, a 54-year-old man, stressed seeking medical consultation and taking medication when discussing health practices.

The one adaptive response from the healthy group was made by a 39-year-old woman and was similar to a response made by a 45-year-old women from the cardiovascular group. Both participants stressed health involved an ability to cope. Three of the cardiovascular clients' comments focused

on mental attitudes such as "make allowances and have patience." Several of these comments included judgmental statements such as the 71-year-old woman who commented:

> Health is they may have something wrong with them but they have the intestinal fortitude to rise above it and not be buried in self pity.

A 62-year-old man also discussed the importance of "attitude" stating:

> ...even if [I] have some restrictions--the other parts work and if [I] have faith and love in these other parts these will compensate for the parts that are restricted.

One 60-year-old woman's adaptive comment from the cardiovascular group mentioned family involvement stating:

> Even if health not good, if you study yourself then you can do everything. Do what you feel better. If I need help, my family can help me.

The two cardiovascular clients' holistic comments were similar to the holistic comments made by the healthy participants. Many people mentioned a spiritual component as well as physical and mental well-being. One-62-year old male from the cardiovascular group commented:

> [Health is] not just medical--Its the whole system--mind, body--heart.

A 53-year-old woman from the healthy group stressed personal control as well as the holistic theme stating:

> Health is a total sense of well being--physical, emotional, spiritual. Health is a mental state not just physical. We have control over our health--not leave it to fate or chance.

Similarities in Theme Response Rates

Both groups had the same response rate in the subjective well-being (67%) and health habits/practices (27%) themes. Additional analysis of the data revealed 90% of the cardiovascular subjects' and 91% of the healthy subjects definitions of health contained one or more of the first three themes, freedom from restrictions/independence/ability to function, absence of disease/symptoms, and subjective sense of well-being.

Eighty per cent of the cardiovascular subjects and 82% of the healthy subjects identified more than one theme in their definitions of health. Six (20%) of the cardiovascular subjects identified only one theme in their definition of health. Of these six, one identified the first theme (freedom from restrictions/independence/ability to function), one identified the second theme (absence of disease/symptoms), two identified the third theme (subjective sense of well-being), one identified the fourth theme (health habits/practices), and one identified the fifth theme (health practices).

Six (18%) of the healthy subjects identified only one theme in their definition of health. Of these six, one identified the first theme, one identified the second, one

identified the third, and three identified the sixth theme (holistic).

Chapter 5: Discussion

This study's purpose was to explore cardiovascular and healthy persons' conceptions of health. The content analysis of their definitions documented some interesting differences and similarities. This chapter discusses these similarities and differences. In addition, the implications of the results for future nursing practice and research are addressed.

Similarities

Ninety per cent of the cardiovascular and 91% of the healthy groups' responses contained one or more of the first three themes, freedom from restriction/independence/ ability to function, absence of disease/symptoms, and subjective well-being. Baumann (1961) and Hautmann & Harris (1982) found a similar focus in their studies of adult health conceptions.

In addition, both groups gave the same response rates for health habits/practice and subjective well-being. However, when the themes were listed in order of emphasis the cardiovascular group listed subjective well-being first whereas, the same theme was listed third in the healthy group. The health habits/practice theme was listed fourth in each group.

Both groups demonstrated a working knowledge of current beliefs about "good" health habits and practices. Though previous literature does not discuss this focus for adult health conceptions, Hautmann & Harris (1982) had one

participant in their research who defined health by this theme. What is interesting to note is the use of specific health habits/practices in the context of defining health rather than maintaining health. Public focus on fitness and diet over the last 10-15 years may account for some of the emphasis in this area. In addition, several cardiovascular responses indicated the participant had received information regarding proper health habits for their cardiovascular illness.

Pender (1982) proposes that health is an evolving rather than static concept. Over the centuries changes in history and public opinion have changed the scope of health as a concept. For example, psychological trauma caused by high-stress situations in combat during World War II increased the scope of health to include consideration of the mental status of the individual (Pender, 1982). Perhaps these study participants' focus on health habits/practices is a reflection of this ongoing evolution.

In addition, the majority of both groups' responses were multidimensional. This multidimensional orientation of health was also found by Baumann (1961) and Hautmann & Harris (1982). This supports the vast amount of literature regarding health being multidimensional and contrasts with the absence of disease medical model.

Differences

The content analysis noted the following differences between the cardiovascular and healthy groups responses:

(1) the response rate within four of the six themes; (2) the group's emphasis of each theme; and (3) the generality of the content in five of the six themes.

More cardiovascular group responses contained the freedom from restrictions/independence/ability to function (63% vs 24%) and adaptation (20% vs 3%) themes. More healthy group responses contained the absence of disease/ symptoms (73% vs 47%) and holistic (42% vs 7%) themes.

In addition, the cardiovascular group responses placed the most emphasis on the subjective well-being (67%), freedom from restrictions/independence/ability to function (63%), and absence of disease/symptoms (47%) themes.

The absence of disease/sypmtoms focus of the healthy group concurred with the study findings of Baumann (1961) and Hautmann & Harris (1982).

Several factors may have influenced the cardiovascular group's greater emphasis of subjective well-being and freedom from restriction/independence/ability to function themes. In the Baumann (1961) study educational level was found to significantly influence health orientation. Individuals with an 8th-grade or less education responded with a feel good orientation more often than did those with and 8th-grade or above education. Individuals with an 8th-grade or above education incorporated more absence of disease responses than those with less education. Though the average educational level of the cardiovascular group

was 11th-grade, 27% of the group reported an 8th-grade education or less. Ninth-grade was the lowest educational level reported in the healthy group who had a 15-year average educational level. This difference in educational level may have accounted for the different the emphasis cardiovascular group gave these two themes.

The cardiovascular group's focus on the freedom of restriction/independence/ability to function theme supports the literature which discusses the disproportionately intrusiveness of syptomology for indiviauals who are chronically ill (Strauss et al., 1984). These authors explain how constant demands of a regimen and the limitations in activities imposed by symptoms can create a reorganization of lifestyle, commitments, and activities for the chronically ill. This would be true for many of the cardiovascular group. Due to their compromised cardiac condition, many of the cardiovascular clients must take medications with unpleasant side effects, and constantly monitor their activity level to avoid over exertion. In addition, some clients may need to request assistance with tasks which previously could be performed independently. Strauss et al (1984) state that the chief task of the chronically ill is to live as normally as possible despite the symptoms and the disease. The dislike for the constant monitoring and increased dependency perhaps is best expressed by the 75-year-old woman who stated:

> [Health means you don't] feel anything, can go shopping, dancing, anything. When healthy you can go places and don't think something will come along to stop you from going.

The "ability to do" and "get around" and "not be restricted" were frequently expressed by this group. One study of the health needs and opinions of older adults, found a similar emphasis of participants on being active and maintaining independence (DiCicco & Apple, 1960). These authors speculated that being active allowed older persons to satisfy their needs for independence and live up to society's requirements. Though this study was based on a population 65 years and older with the majority of participants in their seventies rather than individuals with specific chronic disease, many of the DiCicco & Apple participants experienced one or more chronic illness and/or some of the problems of the chronically ill such as isolation and increased dependence on others.

The healthy participants on the other hand did not have to deal with the cardiovascular daily restrictions and adjustments. For these individuals any experience with restrictions secondary to an illness would have been time limited.

The cardiovascular group therefore may have placed greater emphasis on the freedom from restrictions/ independence/ability to function, rather than the absence of disease/symptom because of the daily focus on the management

of symptoms caused by the disease. This emphasis on independence over absence of disease/symptoms is illustrated by the focus of the cardiovascular comments on specific restrictions and functions.

The theme which was least mentioned by the total sample was adaptation. The cardiovascular group ranked this theme fifth and the healthy group ranked this theme last. Though the literature emphasizes this theme (Smith, 1983), the participants in this study did not.

Part of this lack of emphasis could have been due to the operationalization of the adaptation theme. In addition, the freedom from restriction/independence/ ability to function theme may have incorporated responses Smith would have classified as adaptation. However, the author of the current research views the differentiation between the freedom from restriction/independence/ability to function theme and adaptation as an important distinction to make.

Though the cardiovascular group mentioned adaptive responses more frequently than the healthy group, the responses contained a moral or judgmental tone. The vast majority of cardiovascular clients in this sample did not view health from an adaptive viewpoint. Health was defined as not needing to adapt. The need to adapt was viewed as restrictive and as a greatly unwanted inconvenience and annoyance.

The holistic theme was ranked third in the healthy group responses and last by the cardiovascular clients. This difference could be accounted for by the inability of the cardiovascular participants to be both physically and mentally healthy. In addition, the inability to be physically healthy or symptom free may have accounted for some of the content focus of the subjective well-being responses. Since the cardiovascular participants could not view themselves as achieving a physical health which was symptom free, many from this group may have focused their comments on attitude and feeling states when defining health. This could account for some of the cardiovascular clients' "being happy" and "positive attitude" statements which contrasted with the healthy groups' more general "feel good" comments.

Limitations

The limitations of the study relate to: (1) the predominance of woman participants; (2) the differences between the two group in educational level and income; (3) the Western Civilization orientation of the participants; (4) and small sample size.

Though both groups contained equal proportions of women, care should be taken in generalizing findings to the general population. Research on sex differences in health have focused on the causes of women's higher morbidity and men's higher mortality (Gove & Huges, 1979). Little research has been done on possible sex differences in health

beliefs. Research has shown women tend to be better informed about health practices and services (Suchman,1965). Women also use health services more frequently then men (Olesen & Lewin, 1985). Diseases common to men are more fatal than diseases common to women. This may be due to the late development and/or recognition of symptoms among men (Fingerhut, Wilson & Feldman, 1980). On the other hand, self-rated health is consistently higher for men throughout the life cycle (Verbrugge, 1982). These studies indicate differences exist between sexes in health practices and self-ratings of health. Until more research regarding possible differences in health beliefs between sexes is done, the possibility of such differences existing cannot be eliminated.

Differences in socio-economic-status (SES) has been noted to affect how individuals view health (Olesen & Lewin, 1985; Steiger & Lipson, 1985). The healthy group had higher income and educational levels than the cardiovascular group. The effect of a higher educational level has already been discussed. The higher income level may have also affected the results.

Though the participants were from various religious and cultural backgrounds, the majority of the participants would be expected to have a Western Civilization view of health. A multitude of anthropological studies have documented that health conceptions vary among cultures (Foster & Anderson,

1978). Caution is again advised when generalizing these results to a different population.

Though the sample size was adequate for this study, more research with a larger population is necessary to validate this study's findings.

In addition, differences in other studies have been found to exist between diagnostic groups (Baumann,1961). Caution should be exercised in applying this study's results to other chronically ill populations.

Future Research

Future research should address some of the limitations of this study such as gender and SES. In addition, research in other specific illnesses may prove fruitful in increasing our knowledge about adult conceptions of health.

Implications

This study documented significant differences in the health conceptions of cardiovascular clients and healthy persons. This study also documented a multidimensional orientation to health. Both of these have implications for nursing practice.

Previous chapters discussed the need to have clear communication regarding the concept of health in care planning and delivery. The findings from this and other studies would indicate that clients are likely to have a multidimensional orientation to health. In addition, cardiovascular clients' health conceptions may differ from healthy persons' health conceptions. The nurse must be

sensitive to these differences when working with clients. Effective communication between the nurse and client will be facilitated if the nurse clarifies the client's health conception.

Though income and educational level may have affected some of the results, this study's findings indicate a need to be sensitive to subjective well-being and freedom from restrictions/independence/ability to function issues when dealing with cardiovascular clients.

The lack of emphasis by both groups regarding adaptation, may indicate a need to reexamine care plans which place a focus on adapting or adjusting. Perhaps the focus should be placed on increasing independence with the least amount of intrusion on the client's current lifestyle. This is a fine line of distinction which perhaps involves more of a shift in attitude and approach to a health problem rather than a change in solution.

Conclusion

This study found significant differences between cardiovascular clients and healthy people's conceptions of health. In addition, clients are likely to have a multidimensional orientation to health. Health professionals, when working with clients, need to be aware that significant differences may exist between cardiovascular and healthy clients' health conceptions. Cardiovascular client's may have an increased emphasis on subjective well-being and freedom from restrictions/

independence/ability to function. The healthy person may emphasize absence of disease/symptoms and holistic viewpoints.

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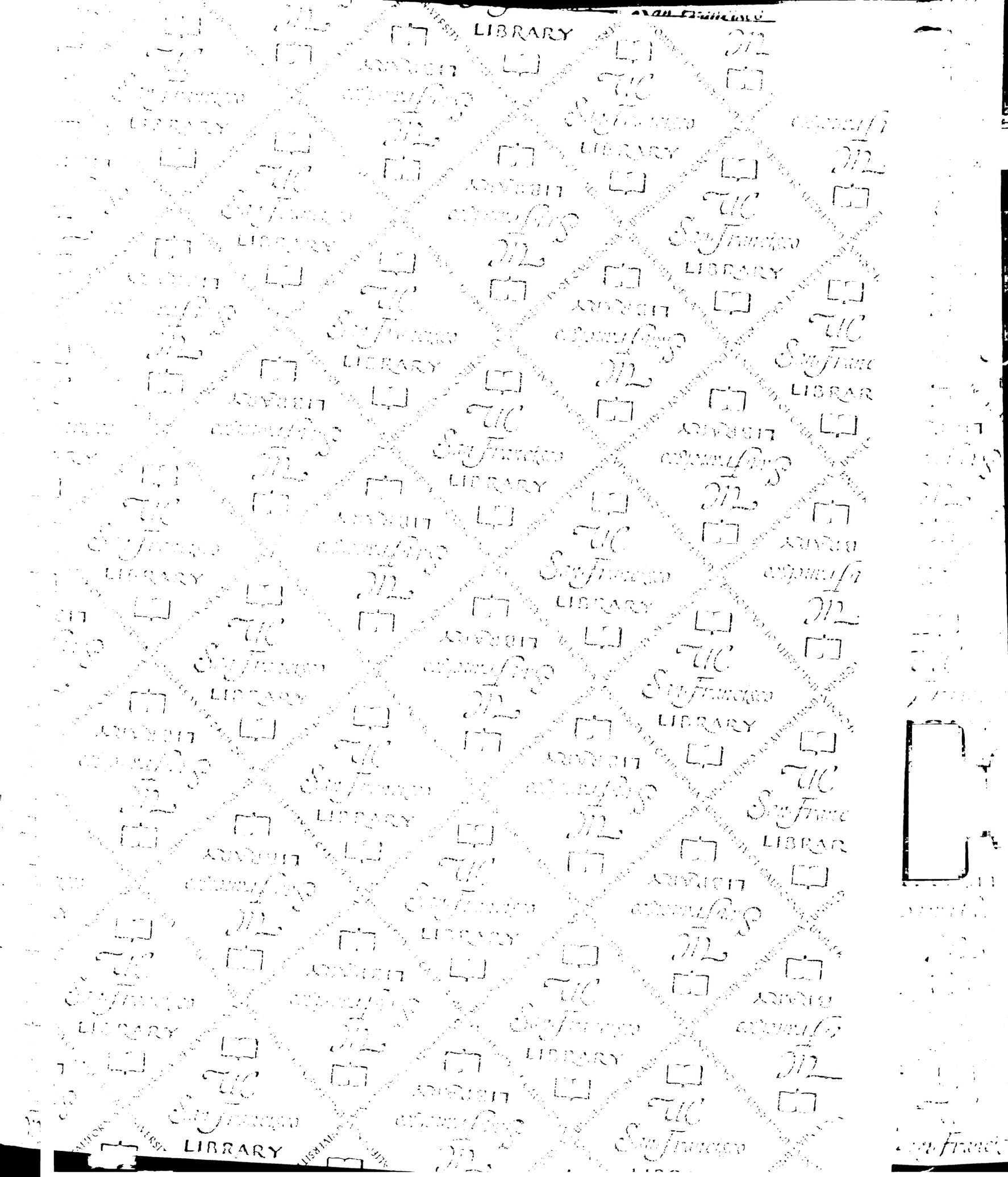
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